USAID/INDIA
STRATEGIC OBJECTIVE CLOSE OUT REPORT

1. **Basic Information**

SO Name**:**	**Reduced Fertility and Improved Reproductive Health in North India**	
SO Number:	2	
SO Period:	FY 1994-2002	
Geographic Area (Code):	India (386)	
Total Cost of SO:		
	DA	$136,470,000
	CSH	$ 31,816,000
	Total	$168,286,000

2. **Principle Implementing Partners:**

Bilateral Projects:

1. Department of Economic Affairs, Ministry of Finance, Government of India, New Delhi
2. SIFPSA, Lucknow, Uttar Pradesh
3. ICICI Limited, Mumbai, Maharashtra

Field Support:

CEDPA, JHU, POPTECH, AVSC, CARE, CONRAD, BUCEN, POPULATION COUNCIL, FUTURES GROUP, INTRA-HEALTH, JHPEIGO, POPULATION REFERENCE BUREAU

3. **Background to SO 2:**

Achieving worldwide reproductive health (RH) goals depends largely upon achieving reproductive health goals in India as it accounts for one-sixth of the world's population. Within India, there are important differences between northern and southern states. The northern states, with more than 40% of India's population, are growing at a substantially higher rate and have poorer reproductive health conditions than the rest of the country. Therefore, improvement in the reproductive health status of the northern states is crucial in helping to meet India's population and reproductive health goals. Keeping this in view, this SO was initiated in 1992 to directly address reproductive health and fertility in northern states of India, with the majority of its activities focused in the state of Uttar Pradesh (UP) - a state home to over 166 million people that would be the sixth largest country in the world were it an independent nation. Two bilateral projects that made direct contribution towards the achievement of SO2 goals were:

- The Innovations in Family Planning Services (IFPS) project that focused its activities primarily on UP, and

- The Program for the Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH) project complemented the efforts of IFPS by addressing Reproductive and Child Health (RCH) issues in urban areas of north Indian states.

3.1 **Intermediate Results (IR):**

In order to assess objectively the progress of this SO, the SO had three intermediate results (IR):

- IR 1 - Increased quality of family planning services
- IR 2 - Improved use of family planning services
- IR 3 - Increased use of RH services.

The progress of IR 1 was measured through the number of IFPS-trained public sector providers performing to standards as defined by standardized (IFPS and Government of UP) protocols in the 28 districts of UP (referred as PERFORM districts).

The progress of IR 2 was measured through contraceptive prevalence rate (CPR) for the 28 PERFORM districts of UP.

And the progress of IR 3 was measured by two indicators:

- Indicator 1: Percentage of deliveries attended by a trained provider, in 28 PERFORM districts of UP; and
- Indicator 2: Percentage of pregnant women receiving two doses of tetanus toxoid during their last pregnancy.

In addition to the above IRs, the SO level objective was measured by the Total Fertility Rate (TFR). The SO level indicator (total fertility rate) pertained to the entire state of UP, however, all other IRs were measured in the 28 PERFORM districts of UP. These (28 PERFORM) districts represent half of UP (over 88 million people per 2001 census) which received more focused attention under the IFPS project. Various sources of data were used for tracking the indicators, including USAID funded annual household surveys in the project area, Government of India's (GOI) Sample Registration System (SRS), National Family Health Survey (NFHS)-2 1998-99, implementing agency's training data verified by independent provider surveys, and retail audit data carried out by market research organizations. The NFHS-1 (1992-93), SRS data, the PERFORM Survey (1995), retail audit data and project training data provided the baseline values for the different indicators.

3.2 **Activities/Projects under the SO:**

3.2.1 **The Innovations in Family Planning Services (IFPS) project:**

IFPS was designed as a ten year project with a funding of $325 million over its Life of Project (LOP), which was matched by a $400 million host country contribution (HCC) from the Government of India (GOI). Out of the total LOP funding, $225 million was available for bilateral assistance and $100 million was kept aside for providing technical assistance. Although the project was signed in late 1992, it was not until 1994 that the key implementing agency, the State Innovations in Family Planning Services Project Agency (SIFPSA), was formed and project activities got underway. As mentioned earlier, the geographic focus of this project has been the state of UP. Most activities of IFPS project are centered primarily in 28 districts of UP (referred as PERFORM districts) which represent half of the total population of the state. Additional activities, including contraceptive marketing; information, education and communication (IEC) efforts; and contraceptive logistics management were implemented statewide.

The basic goal of the project was to reduce fertility by substantially increasing contraceptive use in UP through public, private and marketing channels. Based on the mid-term assessment, in 1998 a new reproductive health focus was added to the project alongwith new interventions designed to improve the health of women and children. Key interventions were added include training traditional birth attendants on safe delivery practices, increasing coverage of maternal iron-folic acid (IFA) and increasing tetanus toxoid (TT) immunization for pregnant women. A mid-term project assessment also determined that the project was on track in meeting most of its objectives and recommended that the project be extended to 2004 to compensate for the start-up delays. After a series of consultations, the project was amended in 2001 to:

a) Extend the life of the project period to 2004;

b) Expand the scope of the project to include HIV/AIDS prevention and control activities in addition to the ongoing project interventions in family planning, reproductive health and child survival interventions;

c) Scale up the IFPS project to the entire state of UP, and continue supporting activities in Uttaranchal (a new state carved out of UP) which were initiated prior to the formulation of the new state; and

d) Extend the geographical coverage of the IFPS project by including the newly created state of Jharkhand (27 million people).

3.2.1a **IFPS adopted a unique bilateral funding mechanism:**

A major element distinguishing IFPS from most other USAID-financed activities is the nature of its funding. Bilateral activities conducted under IFPS were funded through a mechanism known as performance based disbursement (PBD). In this funding mechanism, a set of targeted results were agreed upon between USAID and SIFPSA. Thereafter, a dollar value was attached to the activities that would produce those results. The benchmarks were then incorporated into project implementation based on an agreement with the GOI. When the results were achieved and verified, payments of the benchmark's value were made to the GOI, which passed on the funds to SIFPSA as payment for the activities that resulted in the achievements outlined in the benchmark. The targets for achievement were set at an achievable yet ambitious level to emphasize the focus on achieving results.

3.2.1b **Technical Assistance provided to the IFPS project:**

Early, timely and sustained technical assistance (TA) was critical to the project. A key element of the IFPS project was the provision of technical assistance through the USAID/Washington field support mechanisms. The Mission had engaged organizations such as Engender Health, Futures Group International, CEDPA, IntraHealth International, Futures Group, Johns Hopkins University (JHU), Population Council, JHPIEGO, BUCEN, ORC Macro and Population Reference Bureau to provide technical assistance. Technical assistance was focused on developing quality competency-based training in the public and private sector, monitoring of provider skills back in the work setting, institutional strengthening, supporting private sector development, expanding commercial markets, logistics improvement, management information systems development and information, education and communications support for the project.

3.2.1c **Key Public Sector approaches supported under the IFPS project and some related outputs/accomplishments were:**

- **Up-gradation of public health facilities:** All (over 500) primary and secondary health care facilities in the project areas (i.e., PERFORM districts) were assessed and strengthened to make them ready and safe to provide quality RH services, including the full range of GOI supplied family planning services. Of these, 84% (452) facilities were certified as performing to standard for RH quality services. Also, the project was able to institutionalize an initiative called the Quality Improvement circles, to improve and sustain the quality of strengthened sites.

- **Enhancement of clinical and counseling skills of providers:** The project has made significant contribution in enhancing clinical and counseling skills of public and private sector health providers. Over 8,000 providers have been trained in clinical skills and of these 6,000 were ascertained as performing to standards. In addition, close to 9,500 service providers in infection prevention, 6,700 medical and para-medical staff in family planning counseling skills, 7,600 trained birth attendants (TBA) on home-based life saving skills and clean deliveries, and 8,500 practitioners of indian systems of Medicine on family planning skills have been trained under this project.

- **Micro-planning – Districts Action Plans (DAP):** IFPS successfully developed, piloted and replicated decentralized health improvement plans at the district level (an administrative unit

with an average population of 2.5 million). By the end of 2003, District Action Plans covered 38 districts of UP, home to more than 94 million people. The rationale for district planning was to encourage bottom-up planning, taking into account local needs and resources. District planning ensured the devolution of administrative and financial authority to the districts, with continued technical assistance from SIFPSA to streamline service delivery systems. The district planning exercise also created District Innovations in Family Planning Services Agencies (DIFPSA) and Project Management Units (PMU) to provide operational linkage between SIFPSA, the districts, and the public and private sectors.

DAPs have served as a model for UP and India. The IFPS DAP guidelines have been sent to every state in the country along with the instruction to use them when formulating district-specific plans as part of state activities in conjunction with the national RCH-II program, $8.7 billion five-year initiative of the GOI. This decision of the GOI to implement DAPs in all districts of India has resulted in USAID's investments in a single state affecting health programming throughout the entire country.

- **Integrated services through RCH camps:** RCH camps, which are popular as Parivar Swasthya Sewa Divas (Family Health Days) organized at Community Health Centres (CHC) and Primary Health Centres (PHC), provide an opportunity to integrate the efforts of providers and increase access to reproductive health services. Each camp included a gynecological check-up, child examination and immunization, family planning counseling and services and provision for transportation to clients who utilized sterilization services. Though sterilization camps have been part of the family planning program for many years, these RCH camps were different in that IFPS was able to:

  - Provide an array of maternal and child health (MCH) and family planning services under one roof;
  - Provide assured services as per a pre-determined calendar; and
  - Combine benefits of rural outreach and high quality services.

  The organization of camps involved detailed planning relating to publicity, manpower deployment, camp arrangements, and post-camp services including transportation, availability of consumables and medical equipment. Each camp was scheduled in advance and publicized. In rural areas, attractive jingles on audio cassettes were played. Since most of these camps were in remote rural areas, the availability of a team of surgeons, anesthetist and female gynecologist were ensured from the district level. Enhanced budget for maintenance and fuel for vehicles was provided so that an adequate number of vehicles could be deployed to transport doctors to RCH camp sites and sterilization clients to their homes. District health officials monitored these camps regularly contributing significantly to their success. SIFPSA has funded 47,889 camps over a six-year period from 1998. On an average, 100 clients attended each camp and more than half of these accessed integrated MCH services.

- **Campaigns to provide TT and Iron Folic Acid (IFA) to pregnant women:** Special drives (once in six months) were undertaken to identify and enroll all pregnant women for RH services, particularly for TT immunization and IFA supplementation. As a result of these drives, the TT and IFA coverage among pregnant women increased significantly. The maternal TT coverage in UP has increased from 41% in 1998 to 63% in 2003, and the IFA coverage has increased from 20% to 34% during this period.

- **Policy, leadership, and advocacy efforts undertaken under the IFPS project:** To achieve change in UP, a comprehensive program for family planning and reproductive health was needed. With technical assistance from the IFPS project, the Government of UP (GOUP) adopted a holistic population policy, and extended its physical presence into each IFPS district. The IFPS project also provided Technical Assistance for the development of state population policy for Jharkhand, integrated population and health policy for Uttaranchal

(India's first and only integrated state policy), and essential medicines policies for Uttaranchal and Jharkhand.

3.2.1d **Key Private Sector Approaches supported under the IFPS project and some related outputs/ accomplishments were:**

- **Expand access through private networks**: A community-based distribution (CBD) approach was developed, tested and replicated through dairy cooperatives, Non-Governmental Organizations (NGO) and employment sector to cover more than 13 million people in the project areas of UP. More than 70 CBD projects through a network of approximately 7,500 CBD workers were engaged to provide RH/FP services in IFPS project districts of UP. Data from the 2003 population-based survey shows that the Contraceptive Prevalence Rate (CPR) in CBD areas was significantly higher than in non-CBD areas. Contraceptive Prevalence Rate (CPR) in areas where community-based distribution (CBD) projects were in place was 30%, significantly more than other non-CBD project areas which was 22%. In addition to CBD, other networks—Integrated Child Development Services and Nehru Yuvak Kendra were also utilized to strengthen RH/FP community outreach activities.

- **Community Midwife (CMW) initiative:** To extend the reach of trained midwives, a pilot project was initiated in four districts of UP to train community-based midwives. Candidates for the 18 month training course were selected from rural communities. The curriculum developed for this initiative has been adopted by the GOUP as a resource for all auxiliary nurse midwife (ANM) training in the state. GOUP and USAID are exploring ways to scale-up this activity.

- **Enhance demand for services through information, education and communication campaign:** A communication strategy for health and family planning in Uttar Pradesh was developed and released by SIFPSA in 1995. As part of this overall strategy, the "Aao Batien Karien" or "Come Let's Talk" logo and message were developed and produced. "Aao Batien Karien" served as the unifying theme for selected FP/RH IEC activities and materials. It was prominently featured in a multimedia campaign promoting discussion of spacing methods among and between family members and providers and is widely used by NGO outreach workers in their home visits. In addition, 18,500 NGO workers and ANMs in IFPS districts were trained in the use of these IEC materials. In addition to the "Aao Batien Karien" campaign, several other statewide multimedia campaigns on priority FP/reproductive/child health themes had been conducted, some of these used private sector advertising and media production agencies. Also, under the project, statewide IEC efforts were undertaken to promote reproductive/child health camps, non-scalpel vasectomy, and safe motherhood. The project also provided IEC support to the districts for purposes such as measles vaccination and promotion of Intra Uterine Contraceptive Device (IUCD) use. FP/RH messages were placed on the panels of 300 state buses and on the walls of village sub centers in 15 districts. In smaller villages in 24 districts, 6,800 folk performances were given to carry (RCH) messages to rural audiences in an entertaining way. Mobile fairs were also used to promote awareness and immunization services in villages in 18 districts, with an average of 2,013 immunizations per district during the functions. Numerous staff members from SIFPSA and other Indian organizations received training in communication planning and IEC at international workshop venues.

- **Social marketing of pills & condoms:** The original IFPS project did not envision SIFPSA as the conduit for bidding and awarding contraceptive social marketing contracts. However, an agreement was reached between the GOI and USAID in 1998 that allowed SIFPSA to function as the contracting entity in social marketing. SIFPSA launched the first contraceptive social marketing pilot project (with Hindustan Latex Limited (HLL), a para-statal distributor and manufacturer). In the interim, USAID's global support mechanism funded social marketing projects in western U.P. from 1994 to 1998. These efforts were directed at

areas within minimal access to contraceptives, primarily focused on reaching 60% of the 112 million rural people residing in mid-sized villages. As a result of these initiatives, a good increase in the availability of oral contraceptives and condoms was recorded. Availability of both pills and condoms in villages of UP increased from 19% in 2000 to 45% in 2003.

3.2.2 **The Program for the Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH) project:**

PACT/CRH is a twelve-year $29.8 million collaborative project with the ICICI Bank, which is one of the largest financial institutions in India. The goal of this project is to increase the use of RCH, and HIV/AIDS related products and services through the private sector. The project objectives are to: a) introduce and commercialize new RCH and HIV/AIDS technologies; and 2) improve quality and use of private sector, primarily commercial sector RCH and HIV/AIDS products and services.

3.2.2a **The Goli Ke Hamjoli (GkH) or Friends of the Pill Campaign:**

This campaign was initiated in November 1998 to improve the reproductive health of women in eight north Indian states. The oral contraceptive (OC) pill was identified because the affordable, high quality products were already widely available in the market, yet their use remained very low. The GkH strategy utilized an integrated communication and marketing approach to promote the entire category of low dose estrogen OCs to consumers and health providers, while encouraging industry partners to promote their own brand. The communication campaign used a multi-pronged approach of advertising, public relations, and interpersonal communication to create demand, dispel myths and misconceptions and encourage correct use of OCs. Improving provider knowledge and attitudes, and encouraging industry partners to expand distribution, helped increase consumer access to the product. The GkH campaign focused on the urban areas of eight Hindi speaking states of Northern India which has over 40% of India's population, with poor health indicator and high need for modern methods of spacing. After five years, results of this initiative are very encouraging. Tracking surveys show increases in positive attitudes towards OC's and in the target audience group, use of OCs increased from 4% to 11%. Knowledge and attitudes amongst providers have also improved. As result of this initiative, sales of all OC's have increased by 48% in volume over the five years of the campaign in urban ares of north India, while non-campaign areas have been stagnant. In terms of value the market grew by over 110% thereby encouraging OC marketers to make greater investments in this category. In addition, for the first time in decades, new OC brands were launched during this period of market expansion. GKH has clearly demonstrated the power of the private sector in India in meeting social goals while expanding the market.

4. **Impact:**

The overall performance of the SO was more than satisfactory. Data from different independent sources show that this SO was able to meet/exceed all SO and IR level indicators.

SO level: The objective of the IFPS (which has been implemented under SO2 and continued under SO14 of current strategy) project was to decrease the TFR in UP to 4.2 by 2002 and to 4.0 by 2004, which meant the project aimed to decrease the TFR by 1 child in 10 years (1993-2002). Per the Sample Registration System (SRS) data of GOI, the TFR in UP has declined from 5.2 in 1993 to 4.2 in 2002. A decade prior to the initiation of the project, between 1983 and 1992, the TFR in UP declined by only 0.6 child, nearly half a child less than what has been achieved during the project period. Thus, the project appears to be on track to reach its life of project goal of 4.0 by 2004. TheTFR data from SRS for 2004 is likely to be available in 2006.

IR level: As mentioned in section 1.1, this SO had three IRs that were measured through four indicators.

IR 1 Increased quality of family planning services was measured through the number of IFPS-trained public sector providers performing to standards as defined by standardized (IFPS and Government of UP) protocols in the 28 PERFORM districts of UP (Indicator1). The project planned to create a pool of 4343 trained providers performing to standards (PTS). Against this target, the project was able to train more than 8,000 public sector providers; of these nearly 6,000 were ascertained as PTS.

IR 2 Improved use of family planning services was measured through CPR for PERFORM districts of UP (Indicator 1). The CPR defined as the use of modern methods of contraception, has increased from 20.9% in 1995 Source: (PERFORM 1995) to 27.6% in 2003 Source: (USAID Annual Survey) in the project area. The objective of the project was to increase the CPR to 26% by 2003 in the project area. Therefore, the expected level of CPR has exceeded the planned level. A comparison of the project areas and non-project areas of UP shows that the project areas have done significantly better than the non-project areas. The CPR in project areas has gone up from 18.4% in 1992 to 27.3% in 2003, nearly 9 percentage points. However, during this period, the CPR of non-project areas has increased by around 5 percentage points, from 17.2% to 22.4%.

IR 3 Increased use of RH services were measured through two indicators - Indicator 2.3.1: Percentage of deliveries attended by a trained provider in PERFORM districts of UP; and, Indicator 2.3.2: Percentage of pregnant women receiving two doses of tetanus toxoid.

- **Indicator 1:** Percentage of deliveries attended by a trained provider, in PERFORM districts of UP - The percentage of deliveries attended by trained providers in the project area has increased from 32.8% in 1998 to 48.8% in 2003, an increase of twelve percentage points in a span of six and a half years. The objective of the project was to increase the percentage of deliveries attended by trained providers in the project districts to 37% by 2002. The training of TBAs was the key intervention supported under the project for increasing the percentage of deliveries attended by trained providers as the proportion of institutional deliveries was extremely low (about 15%). In addition, the project has embarked on a community midwives program. The follow-on IFPS project has discontinued its support for TBA training as available data indicates that deliveries attended by TBA have no or little impact of the maternal mortality.

- **Indicator 2:** Percentage of pregnant women receiving two doses of tetanus toxoid - The original objective was to increase the TT coverage in the project districts from 1993 level of 37.4% to 47% by 2001. During this period, the TT coverage in the project area increased to 61.8%, 15 percentage points more than what was expected. Keeping this in view, a highly optimistic target of 70% was set for the year 2002. The project failed to achieve this revised target as the 2003 TT coverage rate was 62.5%.

5. **Changes in the Results Framework during the life of the SO:**

Per the results framework that was established in 1996, "Reduced Fertility in North India" was the SO level statement. It had one IR stated as "Increased contraceptive use and Improved reproductive health in target areas." Subsequently, in 1998, the SO framework was broadened to emphasize RH and quality of services. The SO level statement was changed to "Reduced Fertility and Improved Reproductive Health in North India." The old IR (increased contraceptive use and improved reproductive health) was broken into two IRs i.e., increased use family planning services and increased use of RH services and a new IR on quality of care i.e., increased quality of family planning services) was added. Moreover, the planned/target values for most of the indicators were adjusted based on past performance.

6. **Prospects for sustainability and threats:**

In 2004, a new government came to power in India that pledged significant increases in health budgets. The new government also started paying increased attention to health care in rural areas as well as fertility issues in high fertility parts of the country. Additionally, the central government followed an open, transparent and highly consultative process to develop its five-year, (2005-2010) $8.7 billion RCH II program and each Indian state were encouraged to develop state-specific Program Implementation Plan (PIP). SIFPSA, the implementing agency for IFPS project, took the lead in developing the RCH II PIP for U.P. State and was able to include most of the innovative components of IFPS project in this PIP. Therefore, most IFPS innovative activities are likely to be funded by the GOI's RCH II program. In addition, GOI has also provided resources to SIFPSA to expand decentralized-planning activities to the non-IFPS districts of UP. Additionally, GOI is considering SIFPSA to be the implementing agency for the RCH II program in UP. If RCH II is implemented through SIFPSA, SIFPSA will have to undergo a dramatic evolution and expansion as its mandate and its activities grow. Keeping these factors in view, the new technical assistance contract (signed under IFPS-II, the IFPS follow-on project) proposes to help with this evolution process. In short, most of the successful components of the IFPS project are likely to be expanded and extended through GOI's RCH II resources. In addition, USAID is planning to provide technical assistance at the national level, in support of the RCH II program. This offers the potential for nationwide impacts with relatively small investments. However, USAID must remain aware of the tendency for India to resort to incentives and disincentives for adoption of family planning methods, which may be problematic due to USAID's legislative requirements.

7. **Evaluations, Assessments and Lessons Learned:**

Key lessons learned over the course of the IFPS project are:

- **An intermediary is necessary.** An intermediary organization (like SIFPSA) is needed to manage implementation of the wide variety of initiatives that were carried out under IFPS, particularly when dealing with the large number of diverse actors that make up the private sector. In a federal structure like India, transfer of funds for specific activity from the central government to state government seemed to work much better when an intermediary is involved, as opposed to working directly through the state treasury or central government. The intermediary ensures that program resources are available for the intended purpose and do not get diverted for other priorities, as is common with funds routed through the state treasury in select states. Unlike some other bilateral programs, IFPS has never encountered any significant problem related to funds flow from GOI to SIFPSA. Additionally, an intermediary is useful for undertaking large-scale private sector contracts since the government (both central & state) lack the capacity to undertake large competitive contracts because of cumbersome procedures that are often not transparent as well as a lack of trust to provide substantial amounts of funds to the private sector. This model of creating an intermediary has been adopted by other state governments to implement various developmental projects.

- **The society (intermediary) model can achieve significant results.** Under SIFPSA, results have been achieved, greater NGO involvement fostered, new approaches instituted (DAPs, RCH camps, TT campaign, contraceptive rural marketing, and CBD networks), and monitoring systems established that can track progress. There has been a significant increase in contraceptive use in IFPS districts as compared with non-IFPS districts: IFPS districts have increased at 0.9 percentage points annually compared to the state average of 0.6 percentage points.

- **Building capacity of the states to access GOI and donor assistance necessary.** Management capacity, especially in the areas of planning and budgeting, is weak in most North Indian states, including UP. Consequently, states are not able to access resources

from other programs (such as GOI's Empowered Action Group and RCH, and the World Bank funded Health Systems Development Project). Developing capacity to access these resources will expand the pool of available resources. Due focus on this area could lead to optimal synergies between various projects.

- **Competition among states useful.** Initially, UP did not show much interest in developing a population policy for the state. However, USAID assistance to several other states in the country drew the attention of UP policymakers who essentially did not want to be perceived as being left behind. As a result, USAID supported a comprehensive population policy for UP, providing an opportunity to place family planning and population issues on the table in the state.

- **Closer engagement with state government is key.** Broad program oversight is provided to the IFPS project through a committee structure in which the GOUP is represented. However, the GOUP has never taken full ownership of the IFPS project. As a result, while a majority of IFPS assistance has gone to public sector interventions, GOUP staff view SIFPSA as a parallel structure. Another example is the fact that SIFPSA—not GOUP—has scaled up numerous innovations. Cases in point include multiple year support for RCH camps, provider training, TT campaigns, CBD projects, upgradation of sites, etc., when these costs could have been gradually assumed by the GOUP and the RCH project.

- **The focus on results has proved beneficial.** Through the performance-based funding mechanism, the project has focused on results instead of inputs. Such a focus has been beneficial for three reasons. First, other donor programs often measure their success in terms of the percentage of allocations that have been expended. In contrast, the success of the IFPS project has been measured in terms of people-level impacts, which have been substantial in the areas in which it has worked. Second, the results focus has allowed for organizational flexibility to make management and implementation changes as required. In contrast, centrally-sponsored schemes often specify with exacting detail the number and salary of personnel managing activities and implementation arrangements. Such specifications may not be appropriate for every situation, yet are difficult to change or waive. IFPS's focus on results has allowed implementers to determine the right mix and nature of interventions, as long as results are achieved. Third, the focus on results has provided leverage for ensuring implementation. Project implementers have found it useful to state that payments for activities can only be made if results are achieved.

- **The focus on results is not a panacea.** Despite the beneficial aspects of a focus on results, the system is not perfect. Without careful attention to benchmark design—the most tangible manifestation of the results-based focus—it is possible that the quality of interventions can be subordinated to numbers of a given result that make up the benchmark. Short term pursuit of numbers at the expense of quality may be detrimental to long term project goals.

- **Decentralization with accountability works.** Initial trends within the project districts indicate that the original six DAP districts performed better than non-DAP project and non-project districts. Therefore, the DAP approach was scaled up to cover 38 districts throughout UP. PMUs in each district have proven vital to the success of the DAP approach. With the inevitable and frequent changes in the technical and administrative leadership at the district level (Chief Medical Officer and District Magistrate), it is important to have a stable group of personnel in the districts to ensure that population and reproductive health issues remain on the agenda. The IFPS DAP guidelines have been sent to every state in the country along with the instruction to use them when formulating district-specific plans as part of state activities in conjunction with the national RCH II program. This decision of the GOI to implement DAPs in all districts of India has resulted in USAID's investments in a single state affecting health programming throughout the entire country.

- **Innovations can be tested on a scale that is replicable.** In the IFPS project, several innovations have been tested and replicated successfully to cover vast project areas. Examples include the DAP approach, RCH camps, the TT campaign, social marketing activities, and CBD approaches using NGOs, dairy cooperatives and the employer sector.

- **Improved supply alone is necessary but not sufficient for results.** IFPS provided substantial inputs for strengthening clinical and counseling skills of service providers and upgrading service delivery sites. These interventions are not having the desired impact because actual service provision has not increased dramatically. Demand creation has been identified as the missing link to increased service provision in both the public and private sector.

- **Rural marketing efforts have improved access.** One of the major criticisms of the social marketing programs around the world has been that they focus on urban and easier to reach populations. To ensure that the social marketing efforts were directed at areas within minimal access to contraceptives, SIFPSA designed a social marketing effort that focused on reaching 60% of the 112 million rural people residing in mid-sized villages. SIFPSA has demonstrated that through concerted efforts the availability of pills and condoms can be significantly improved in rural UP. However, in order to improve utilization, the expansion of distribution needs to be coupled with strong demand creation efforts, which has been a gap. Thus until recently, the full potential of the social marketing effort has not been tapped fully. Further, the contraceptive social marketing component and GkH communication effort have shown the power of the market to reach to a larger audience within a short period of time to achieve public health goals.

- **Behavior change efforts are critical for significant impact.** Behavior change efforts have been limited in both scope and intensity in IFPS. Adequate emphasis was not provided on promoting trained providers and upgraded sites. Further, method-specific misconceptions were not addressed adequately.

- **The CBD approach has worked.** NGO and other community-based distribution projects have yielded good results in terms of increasing CPR, child immunization rates and maternal health indices.

- **CBD training in itself empowers women.** Through IFPS, over 15,000 female community based distribution workers have been trained. On site visits and in success stories that have been reported, the IFPS implementation team has heard how as a result of their position in the village, they have become empowered agents for change on a broad agenda. At least 12 women who were CBD workers have gone on to be elected as village pradhans after their association with the project activities.

- **Opportunities for stronger linkages between HIV/AIDS, family planning and child survival not fully tapped.** Since 2002, efforts have been made to further strengthen RH components and better integrate key child survival and HIV/AIDS interventions into the IFPS project. For example, the social marketing efforts have been expanded to include Oral Rehydration Salts, IFA and safe delivery kits. However, efforts to link HIV/AIDS prevention, family planning and social marketing were not that successful.

- **Key research is essential to program expansion.** The project could have benefited from a systematic tracking of client perspectives and an enhanced understanding of factors leading to utilization of services. This would have helped in orienting the strategic focus of the project to the client rather than the provider. Furthermore, assessments of interventions effectiveness and impact have not been undertaken to the extent necessary, and where these have been undertaken the findings have been utilized selectively.

- **Diversity needs to be adequately recognized.** UP is the most populous state of India with over 166 million people. Only five other countries in the world have larger populations. UP represents four broad socio-cultural regions and a rich cultural, religious, social and economic diversity. Though to a large extent the UP population policy recognizes this diversity, it posed a challenge to the IFPS program response, particularly with regard to client segmentation.

- **Technical Assistance is crucial for success**. The role of TA in enhancing public sector readiness was clearly demonstrated through quality improvements in skills of trained providers, infection prevention practices, supportive supervision and facilities improvement in IFPS-funded districts. GOUP and neighboring states are taking advantage of resources developed under the IFPS project and learning from these experiences to enhance the quality of their services.

- **Dissemination is important.** The documentation and dissemination of program efforts has been limited largely due to issues of control and openness of the implementing partner during a substantial part of the IFPS project. This has led to considerable misconceptions about IFPS both within India and USAID/W. Wider dissemination would have resulted in building greater ownership of the efforts and support for the project.

These lessons and others have been taken into consideration during the design of the proposed activities (IFPS-II, the follow-on IFPS project) to improve the RCH situation in UP, Uttaranchal and Jharkhand.

APPENDICES

Appendix 1

(A list of evaluations and special studies conducted during the life of the SO, including Annual Reports)

1. National Family health Survey (Uttar Pradesh), 1992-93;
2. Family Planning Programs in Uttar Pradesh: Issues for Strategy Development, 1994;
3. 1995 PERFORM Survey in Uttar Pradesh;
4. Uttar Pradesh: Male Reproductive Health Survey, 1995-1996;
5. IFPS Project management Review, 1996;
6. IFPS Mid-term Assessment, 1997;
7. Annual Indicator Surveys, 1998, 1999, 2000, 2001, 2003;
8. IFPS Project Aide Memoire, 2001 and, 2002;
9. IFPS Project Impact Analysis, 2001;
10. IFPS Lessons Learned, 2002;
11. Alternative Projections for Contraceptive Use, and Intentions to Use a Method : An analysis for the Project Areas of the IFPS, 2003; and
12. Assessment of the Innovations in Family Planning Services Project, 2003

Appendix 2

(A list of instrument close out reports prepared for contracts, grants, and cooperative agreements)

Close-out reports are maintained by Regional Contracting Office, USAID/India. For any information, please contact Mr. Marcus Johnson, Regional Contracting Officer at e-mail: mjohnson@usaid.gov

Appendix 3

(Names and contact point of individuals who were directly involved in various phases of the SO (planning, achieving, and assessing and learning), and who would be good sources of additional information)

1. Linda Morse (USAID)
2. John Rogosch(USAID)
3. Bill Goldman (USAID)
4. Jerry Tarter (USAID)
5. Jinny Sewell (USAID)
6. Kris Loken (USAID)
7. Jim Bever (USAID)
8. Randy Kolstad (USAID)
9. Sheena Chhabra (USAID)
10. Samaresh Sengupta (USAID)
11. Anjana Singh (USAID)
12. Meenakshi (USAID)
13. Jyoti Shankar Tewari (USAID)
14. Robert Clay (USAID)
15. G. Narayana (Futures Group)
16. Rita Leavell (Futures Group)
17. Uma Pillai (Government of India)
18. Aradhana Johri (Government of India)
19. J. S. Deepak (Government of India)
20. Kalpana Awasthi (Government of India)

If you wish to contact any of the above individuals or if you would like any additional information about this SO please contact Mr. Jyoti Tewari at Tel# 2419-8428 or e-mail: jtewari@usaid.gov.