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IFPS II EVALUATION: ANNEXES

September 2007

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INNOVATIONS IN FAMILY PLANNING SERVICES PROJECT II (IFPS II) MAY 31, 2007

BACKGROUND

The IFPS project was originally designed in 1992 to help the Government of India (GOI) revitalize family planning (FP) services using the state of Uttar Pradesh (UP) as the primary site and testing ground for program innovations. An independent society, the State Innovations in Family Planning Services Project Agency (SIFPSA), was created to oversee implementation of activities in UP.

The goal of the first IFPS project was to help UP reduce its rate of population growth to a level consistent with its social and economic objectives. Numeric goals were attached to those objectives in terms of the total fertility rate (TFR) and contraceptive prevalence rate (CPR). While these goals were not fully met, the project demonstrated a number of successful implementation systems and innovations that made substantial contributions to advancing FP in the large geographic areas in which it worked.

Originally, IFPS focused solely on FP. Later, the project was broadened to include maternal health, child survival, and HIV/AIDS, and geographically, the project was extended to the neighboring new states of Uttarakhand (UA) and Jharkhand (JH) to support development of high- quality health services delivery systems there.

The IFPS project has been funded by a performance-based disbursement (PBD) mechanism that links disbursements to achievement of specific performance objectives. In this system, the focus is on achieving results rather than tracking inputs.

IFPS I ACHIEVEMENTS

In Uttar Pradesh SIFPSA is now an organization with over 56 headquarters staff who have overseen more than 400 discrete projects and activities. It has focused its work in 38 of the state's 70 districts; these are home to 94 million of its 170 million people. As a result of SIFPSA efforts in IFPS I, CPR has increased nearly twice as fast since 1998/99 in the districts where SIFPSA was working than in the other UP districts. CPR rates achieved were 27.3% and 21.3% respectively. (In IFPS districts, there was a 1.2 annual percentage point increase vs. 0.6 percentage points in non-IFPS districts; in non-IFPS districts CPR increased from 18.2% to 22.7%). There was also a nearly 0.4 percentage point annual increase in spacing method use in IFPS I project areas.[1]

Much of this gain has been credited to SIFPSA's support in helping local institutions formulate and implement district action plans (DAPs). Moreover, where SIFPSA supported community- based distribution (CBD) of FP information and services by local NGOs and cooperatives, CPR increased by an annual average of two to three percentage

[1] Perform 1995 and RH Indicator Surveys 1998, 1999, 2000, 2001, 2002, and 2003.

points. (CPR increased from 18.2 to 30 in districts where CBD workers were present.) Statewide social marketing efforts contributed to a doubling of condom sales in rural areas throughout the state, to more than 100 million units each year. Importantly, some of these interventions and the management systems through which they were delivered have served as models for broader use across India.

NHFS 3 Findings

Recent NFHS 3 findings demonstrate that where USAID investments have been concentrated, positive trends have been notable. CPR in UP increased from 20.8% to 29.3% between National Family Health Surveys (NFHSs) 2 and 3. Use of modern spacing methods in UP increased from 6% to 12% with most of this attributed to condom use (at 8.7%). Sterilization continues to be the FP method desired by most couples, making up 17.3% of the method mix. In UK CPR has increased from 40% to 56% and use of spacing methods has shown strong gains, from 9% to 21%. JH has also shown improvements in CPR, increasing use, from 24.9% to 31%. Despite these gains, however, more than a fifth of the couples living in UP and nearly a quarter of women in JH have an unmet need for FP. Because more than half of all women in UP get married by age 18 and the median age at first birth is 19, young women and their children are at high risk for infant and maternal mortality during childbirth.

The status of women's reproductive health did not show much improvement between NFHS 2 and 3 in the USAID focus states of UP, JH, and UK. In UP only a quarter of births take place in an institution and just under a third are attended by a skilled provider. JH fares a little worse, with 19.2% of deliveries taking place in an institution and 28.7% attended by a skilled provider. Half of all pregnant women are anemic. In the UP, however, the number of women receiving 3 ANC visitshas improved, from 14.6% to 26.3%.

The most striking findings of NFHS 3 are in child health. Not only did the number of children who are underweight remain static between the two surveys at about 46%, but the number of children severely malnourished (wasted) actually increased from 16% to 19%. Anemia amongst children is nearly epidemic at 85%. Children who are fully immunized in UP has also remained nearly static at 23% (20.2% in NFHS 2). In areas where USAID has focused its efforts, however, the health of children has improved. Immunization rates increased from 9 to 36% in JH and VA coverage reached 23%.

IFPS II STRATEGY AND OBJECTIVES

The original objectives of the IFPS project were to increase access to and quality of FP services while promoting FP more generally. Over time the project was revised to incorporate reproductive health (RH), child survival and HIV/AIDS concerns and to expand its reach beyond UP to include UK and JH. These are also the objectives of IFPS II, but the strategies for addressing them have evolved. The following interests have been highlighted.

- **Increasing public-private partnerships.** The major theme of IFPS II has been on developing, demonstrating, documenting, and leveraging expansion of working models of public-private partnerships (PPPs) to deliver integrated reproductive health services in UP, UT, and JH.

- **Catalytic role for technical assistance.** In the past USAID-financed technical assistance (TA) supported direct implementation on a large scale. Under IFPS II it was planned that TA would be used catalytically to develop, demonstrate, document, and leverage expansion of PPAs.
- **Integrated client-centered services.** Services were to be client-centered using the lifecycle approach, to be integrated to the extent feasible with FP, RH, HIV/AIDS, and child survival concerns. Where epidemiologically appropriate, interventions addressing HIV/AIDS would be considered. But reducing family size is still the principal program focus, and the expansion of the choice of contraceptive methods, including injectables, has been a major area of emphasis of IFPS II.
- **Sustainability.** While USAID would use its resources to concentrate on innovation, the state governments would be responsible for financing larger-scale interventions. This includes both old IFPS interventions (e.g., DAPs, RCH camps, or CBD programs) and replication of new PPP (public-private partnership) models growing out of IFPS II.

IFPS II PROJECT OBJECTIVES

The performance targets of IFPS II as outlined in the initial project agreement are to

1. Increase demand for RCH services through behavior change communication (BCC) and marketing.
2. Increase delivery of integrated RCH services through PPPs.
3. Strengthen the capacity of the public sector to manage the provision of public and private RCH services through appropriate policies, monitoring and evaluation (M&E), quality assurance, and the like.
4. Strengthen the capacity of SIFPSA so it may more effectively promote collaborative partnerships with Indian and U.S. institutions to support delivery of integrated RCH services.
5. Utilize the resources of other development partners and the government to scale up and sustain innovations.

IFPS II IMPLEMENTATION: TECHNICAL ASSISTANCE MECHANISM

Experience in IFPS I demonstrated the need for significant investments in flexible TA and collaboration. For IFPS II, a new modality has been used to provide the TA needed to create and document high-quality working models of PPPs throughout the three states.

In designing the IFPS II, it was envisaged that the majority of TA for the three states would be provided through Indian partner institutions linked through formal subcontracts or grants to an overall technical collaboration contract awarded and managed by USAID/India. Additional project staff would be located in state offices in UP, UK, and JH to provide TA to the state societies.

In addition to TA at the state level, the technical collaboration contract supported establishment and operation of a cell within the GOI Department of Family Welfare that focuses on the needs of the Empowered Action Group (EAG) states.

To maintain links to international best practices, it was planned that targeted short-term international assistance would be provided for all components of the technical collaboration contract.

IFPS II ACTIVITIES FINANCED THROUGH PERFORMANCE-BASED DISBURSEMENTS

In addition to the support provided to IFPS II through TA, IFPS II activities have also been implemented through state societies using a system of performance-based disbursement (PBD). The following activities have been funded using PBD:

Operations research. Operations research plays a significant role in the formulation and demonstration of successful PPP models. In IFPS II, it was envisaged that TA would be used to build the capacity of the partner organizations in each state to conceptualize, oversee, and contract for operations research activities. Bilateral assistance for operations research involving aspects of the RCH II program would be available to assist the program in the three states.

Social franchising. Social franchising refers to the use of franchising methods to achieve social rather than financial goals. There are several different models of social franchising, including stand-alone networks and fractional franchises. Each franchising activity has three basic programmatic goals: assuring the availability of services, assuring the quality of services, and increasing awareness and use of services. As part of this activity in the three states IFPS II would draw on national and international experience to develop, demonstrate, and document a number of models to meet these goals.

Franchising models implemented through IFPS II were intended to expand the basket of contraceptive choices to include such methods as the standard days method, emergency contraception, and injectables. Also,, substantial efforts would be made to establish systems for quality assurance and M&E, incorporate gender and equity considerations, address HIV/AIDS (where epidemiologically appropriate), and to working models of social franchising that could be scaled up without substantial modification.

Increasing public-private partnerships. Developing, demonstrating, documenting, and leveraging expansion of working PPP models to provide more integrated RCH services has been the fundamental tenet of the IFPS II project. There are a number of examples of such partnerships within India and throughout the world. Incorporating international best practices, examples of these models would be tailored for the IFPS II project area.

IFPS II TECHNICAL ASSISTANCE AND COLLABORATION (NON-PBD) ACTIVITIES

A third mechanism for funding IFPS II activities was through support at the central level as well as in JH and UK for very defined and discrete activities to be addressed through

the TA contract. The following activities in the IFPS II design became part of the IFPS II project description:

- **Social marketing.** IFPS I proved that social marketing efforts increase sales and use of specific methods of modern contraception. Condom sales in rural areas of UP have more than doubled since 1999, and availability of both pills and condoms increased from 19% of rural villages in 1999 to 44% in 2003. Technical assistance funded by IFPS II was to continue to be made available to assist in designing and evaluating social marketing efforts. However, it was anticipated that starting in April 2005 funding for implementation would come from the GOI RCH II program, after which it was anticipated that the RCH II program would fund social marketing activities.
- **Assistance for the Empowered Action Group Cell Within MoHFW**. Under IFPS II, the primary focus of the EAG cell within the Ministry of Health and Family Welfare was to provide support to the EAG states in such areas as health planning, policy, and FP/RH technical guideline development. IFPS II TA could support central government efforts to liaise with EAG state RCH II implementers and synthesize state-level experience into more generally applicable guidelines.
- **Behavior change communication.** Experience in IPFS has shown that merely providing more services does not ensure that they will be used. Therefore, IFPS II was to provide significant TA to design and evaluate BCC efforts implemented through the national RCH II program. As with social marketing, it was anticipated that funds would begin to flow from the RCH II program in April 2005. Until then time, USAID would support BCC activities that had begun under IFPS.
- **Support for technical cells in Uttarakhand.** UK has established a Health Directorate. To build its capacity to implement, coordinate, and monitor health programs, the management and technical capacities of the Directorate would be augmented and specialized technical cells set up. These specialized cells would look after training, immunization, PPPs, M&E, logistics, civil registration, and information, education and communication (IEC) activities. IFPS II would support two to three key positions in each cell. Once the capabilities of the cells and staff are established, the positions would be shifted to the Government of Uttarakhand (GOUK) in a phased manner. TA to operationalize the cells would be provided under IFPS II.
- **Public sector training in Uttarakhand and Jharkhand.** A major thrust of IFPS I in UP was to enhance the skills of public sector providers and rehabilitate health facilities to meet established quality standards. During IFPS II, it was envisaged that UK and JH would benefit from the best practices established for training providers in FP counseling skills, clinical skills related to sterilization procedures and IUDs (intrauterine devices), and skills related to infection prevention and the upgrading of clinical sites. The emphasis would be on transferring knowledge, building capacity, and setting standards, rather than on full-scale implementation of specific training programs. It was envisaged that the trainings themselves (apart from training-of-trainers) would be done with RCH II funds.

PROJECT OUTCOMES

1. Modern method contraceptive prevalence rate in UP increased to 30.6% (an increase of 6.0 percentage points from its 2003 level of 24.6%)

2. Percentage of women receiving sufficient iron/folic acid tablets during their last pregnancy in UP increased to 43.2% (10 percentage points from the 2003 level of 33.2%)

3. Over 420 million condoms sold in rural areas of UP

4. Over 14 million cycles of oral pills sold in rural areas of UP

ACHIEVEMENTS OF THE IFPS II PROJECT

1. PPPs initiated in UP and Uttarakhand.
   a) Social franchising to be implemented statewide, with the objective of establishing 40 fully franchised clinics offering comprehensive RCH services; 400 fractional franchisees; and 6,000 referral networks by the end of the second year of the project.
   b) Social marketing of pills and condoms to be implemented statewide in UP
   c) Contracting out of all block health facilities to an NGO initiated in UK
   d) Voucher schemes implemented in three districts of UP and UK
   e) NGO projects providing clinical FP services and mobilizing use of FP services in 12 districts of UP
   f) Mobile health clinic (MHC) started in one district of UK

5. An alternative to the GOI ASHA (Accredited Social Health Activist) worker scheme piloted in six blocks in UA; experience to be evaluated to examine alternatives for ASHA recruitment, training, and payment

6. District Action plans developed for all districts in UP and UK, with district plans reflected in state Program Implementation Plans (PIP) for submission to GOI

7. TA provided for design of national BCC campaigns, including 25 television spots focused on RCH; GOI resources leveraged to broadcast RCH television spots nationwide

8. Establishment of the NHSRC (National Health Systems Resource Center) supported through recruitment of 23 technical staff and logistical support for office infrastructure

9. TA provided to GOUP on monitoring quality of RCH camps and piloting a quality assurance model in two districts

PROPOSED SCOPE OF WORK

The bilateral component of IFPS II will end in September 2008 and the TA portion will end in March 2008. There is an option for a two-year extension of the TA component

being implemented through ITAP (IFPS Technical Assistance Project). The evaluation will assess programmatic approaches and strategies and the effectiveness of project systems and processes, document lessons learned, and make recommendations for future directions. The contracting agency will identify a list of possible candidates for each position, and a short list of candidates (multiple candidates for each position) will then be forwarded to the Mission for its approval. The Mission will then approve a final team for the assignment. Stakeholders of the project will be involved in the planning and implementation of the evaluation as appropriate.

The objectives of the evaluation are:

- Review and analyze the ***program strategies*** and ***technical approaches*** adopted by IFPS II to achieving FP/RH results, including increasing contraceptive use, sales of oral pills and condoms, and the percentage of women receiving IFA.
- Review success of project in ***demonstrating innovations*** and effectively advocating for their ***adoption and scale up*** by government, other donors, etc.
- Review ***implementation mechanisms*** and assess the effectiveness of project management systems, including ***technical support, planning, monitoring, and finance***.
- Identify and document ***lessons learned*** in the project.
- Provide ***recommendations for technical approaches and strategies*** to may applied in a follow-on project for increasing contraceptive use, particularly spacing methods, through public and private sector approaches, as well as scaling up and leveraging resources to improving RH in India. Recommendations for how a new project might address ***adolescent reproductive health needs*** and ***capacity building of Indian institutions*** would be welcomed.
- The main audience for the evaluation consists of USAID/India, USAID/Washington, GOI, NHSRC, and the state governments of UP, UK, and JH.

PART I: REVIEW OF IFPS II

Program Analysis, Project Management, and Lessons Learned

The full team will participate in the first phase of the evaluation. The specific tasks for this phase will be as follows:

1. Program Analysis: The team of consultants will assess the overall strategy and effectiveness of the project and the quality of its activities. The team will analyze how appropriate the strategies and approaches are to achieve project objectives. The following are specific topic areas should be addressed in the evaluation, including draft questions for the team's consideration:

    a) Public Health Impact: What is the contribution of the IFPS II project and IFPS II activities to furthering the FP/RH goals defined in USAID/India's mission strategy? Do the strategies of the project seem appropriate to achieve project health objectives? In what way has the project provided leadership, e.g., by

facilitating favorable FP/RH policies, in improving family planning and reproductive health at the state or national level?

b) Innovations and PPPs: What are the successful outcomes in terms of introduction of innovations, demonstration of PPP models, innovations that have been adopted by government or other donors for replication or scale up, improved quality, access, use of the private sector, and improved collaboration and integration of the public and private sectors? What have been some of the challenges and facilitating and hindering factors in making demonstration, adoption, and scale-up of PPPs through this project successful or not? In what way has the project provided leadership in public private partnership, e.g., by facilitating a policy environment that is favorable to PPPs, at the state or national level? Has implementation of new models been adequately documented, through monitoring and operations research, to be used in advocacy for scale-up and adoption by government or other donors?

c) Behavior Change Communication: What role has the project played in increasing demand for RCH services, contributing to behavior change, and increasing awareness of RCH issues through behavior change communication? What factors have contributed to achievements and what have been some of the barriers?

d) Capacity Building: How has the project facilitated capacity building of state societies to deliver or manage FP/RH programs? How has the project contributed to the development of sustainable, quality societies able to implement NRHM programs at the state level? To what extent has the project been able to strengthen capacity of the public sector to manage the provision of public and private RCH services through appropriate policies, M&E, and quality assurance? What activities, interventions, or strategies have been most effective in helping improve public sector services?

e) National-Level Technical Assistance: Assess the project's success at working through NHSRC or otherwise to influence national level policy and programming? How effective has the project been in serving as a technical resource at the national level on RH/FP, PPPs, BCC, health systems, or other technical subjects? In what areas has the project been more successful and why?

f) Leveraging for Scale-up and Sustainability: How effective has the project been in working with other partners, such as donors, government, NGOs, or UN agencies, to take advantage of opportunities to build upon what others are doing? How effective has the project been in transferring funding for implementation of specific activities, e.g., social marketing, district action plans (DAPs), and BCC, to the RCH II/NRHM program? What has been the experience of the project in handing over implementation of IFPS I innovations—RCH camps, DAPs, CBD workers—to the government under RCH II/NRHM for long term sustainability of these interventions? What leveraging opportunities has the project taken advantage of, and how could the

project have further exploited these opportunities for GOI funding? How has this impacted the sustainability and scale-up of interventions introduced?

2. Project Management: The team will review implementation mechanisms and comment on the effectiveness of the management structure of the project and on the adequacy of management systems in improving the efficiency of implementation activities.

Overall themes related to project management as well as illustrative questions to be addressed follow.

- **IFPS II Management Structure:** How effective is the ***IFPS II management structure***, including the ***bilateral component*** implemented through state societies and the ***unilateral TA component*** implemented through Futures Group/ITAP, in achieving IFPS goals, that is, the dissemination and scale up of PPPs in FP/RH in India?
- **Technical Assistance Component:** What role has ***TA*** played in the IFPS II Project? Does the TA provided through Futures Group, JHU, QED, Bearing Point, and Sibley International meet IFPS program needs, i.e., provide high-quality TA to design and document high-quality working models of PPPs throughout the three states? Are there any gaps from the perspective of SIFPSA, UAHFWS, JHS, GOI, or USAID? How could TA have been made more effective and efficient? How effective has the prime, Futures Group, been in tapping into the skills and expertise of its subs, QED, Bearing Point, and Sibley, Int'l? How effective has this TA arrangement been in comparison to IFPS I TA implemented through six large cooperating agencies (Engender Health, CEDPA, CMS, JHU/CCP, Intrahealth, and Futures/ Policy Group)?
- **Bilateral Mechanism:** What advantage has the project gained as part of a ***bilateral agreement between GOI and USAID***? How has this improved implementation of the project or enhanced outcomes now or in the future of the project? How have GOI contributions helped or hindered the project?
- **Internal IFPS Management:** Is ***IFPS project implementation within USAID/India PHN Office*** effective and adequate? How has it been coordinated with other USAID/PHN activities to maximize opportunities for impact on MCH/RH? How has it been coordinated with other USAID/India technical offices to take advantage of synergies and similar mandates? How has it coordinated on management with support offices, namely PS (Program Support), RFMO (Regional Financial Management Office) and RCO (Regional Contracting Office)?
- **Management of geographic scope:** How effective has the project been in management of work across three states, UP, UA and JH, and at the national level for achieving program impact? How has the ***experience differed*** in each state and the national level?

3. Performance-Based Disbursement System

a) How has the PBD system contributed to achievement of IFPS II results? How has the PBD system helped or been seen as a barrier to achieving results? What have been some of the trade-offs in implementing such a system?

b) What has the project gained through implementation of the PBD system? What recommendations can be made about PBD in the follow-on design?

c) How has the PBD system, and the bilateral funding system, been able to control fund misappropriations in the current state environment?

4. Lessons Learned: The team will assess and document key lessons learned from implementation of various components of the project. It will also recommend how lessons learned from IFPS II can be used to further design and implement PPPs and innovations for furthering the FP/RH agenda in India, namely, to inform the next year and a half of the current IFPS project and the design of the follow-on project?

Thematic areas, with a list of suggested questions, that should be addressed include:

- What are the ***strengths*** of the project and what lessons can be drawn from its activities for future programs (in terms of public health impact; success of the strategy of demonstration of innovations for eventual scale-up; government buy-in and support; policy, advocacy; capacity, and institutional strengthening; leveraging; sustainability; etc.)
- What were some of the ***pitfalls*** encountered in implementing the program, and what lessons can be drawn for future programs?
- What can be learned about ***overall IFPS management***, including bilateral, unilateral TA, and PBD components, and how has IFPS worked with other divisions and offices in USAID/India to maximize synergies and increase impact?
- How effective has the project been in ***leveraging resources*** from other development partners and the government to ***scale up innovations***? What has been learned about the project's ability to leverage and scale-up?
- In what way has the project contributed to ***USAID's legacy***?

PART II: RECOMMENDATIONS ON FUTURE DIRECTIONS

The team will also review the findings, conclusions, and recommendations and provide brief suggestions and options for future directions for the project. One of the primary questions for which the Mission would seek recommendations is whether, when the current phase of the project ends in September 2008, the Mission should seek an ***extension of the TA and bilateral*** agreements or engage in a ***redesign*** and ***procurement*** of a new project. A redesign team, contracted from September 24–October 2, will incorporate the recommendations from the evaluation team and will have be responsible for providing direction and vision for the redesign or extension of IFPS II. The redesign team will include at least one expert who also participated in the evaluation.

Questions that should be addressed by the evaluation team include:

- **Mid-Term Corrections:** What ***corrections or revisions*** might be made between now and the end of the project in September 2008?
- **Priority technical areas, approaches, and target groups:** What ***priorities***, such as private sector, public sector, capacity or institution building, policy or /advocacy, should be included in the follow-on project? ***What public health areas*** and ***target groups*** should be the focus of the follow-on? What ***general approaches and technical strategies*** should be considered? How should the follow-on incorporate new strategies of adolescent RH and capacity building of Indian institutions?
- **NRHM and Partners:** How should the follow-on relate to the ***National Rural Health Mission*** (including RCH-2) at ***state and national levels***? Which focus areas seem to have achieved their full potential and may now need to be handed over to other stakeholders? How can project activities be integrated with other initiatives supported by other ***donors, government, and private sector*** to maximize synergies? Recommend ways to further ***leverage resources*** from government, donors, and private entities.
- **Management:** What recommendations does the team have for the future management structure of the project, specifically with regard to the ***PBD*** system, the ***TA*** component, and the ***bilateral vs. unilateral*** aspect of the project?

Methodology Proposed

We propose to engage the services of a team of local and international consultants/ resource people in this effort. The team will include five to six specialists in the following areas: public health impact, FP/RH expertise, PPP experience, BCC, and health systems and policy. Team members should be familiar with the Indian public health system, have experience in analyzing strategies and conducting evaluations, and possess project management experience.

To examine the issues thoroughly, the following methodology is suggested:

1. Team Planning Meeting: A two-day in-country team planning meeting will be held to
    a) share background, experience, and expectations for the assignment;
    b) formulate a common understanding of the assignment and how it fits into USAID's broader program and objectives;
    c) review the background of the IFPS I and II project and its current status;
    d) identify clients involved in the task, develop a common understanding of their relationships and interests, and agree on an approach to working with them;
    e) define and agree on the roles and responsibilities of the team leader and team members;
    f) agree on the objectives and desired outcomes of the assignment;,
    g) draw up a realistic work plan;
    h) orient the team to the report guidelines and financial forms; and

i) discuss administrative procedures.

2. Data Collection: The evaluation team will review project documents and reports, including work plans, benchmark achievement documents, the IFPS II 18th ProAg Amendment and amplified project description, the IFPS I Mid-term and Final evaluation, IFPS PILs, and FP/RH Division Strategy. The team will also review the financial records maintained by RFMO. (See Annex C for a list of key documents)
3. Interviews and Consultation Meetings: The team will also conduct interviews and consultation meetings with stakeholders and informants, including but not limited to USAID mission staff, the ITAP team, SIFPSA, UAHFWS, JHS, GOI representatives, NHSRC, NGOs working with SIFPSA, and private sector partners (KPMG, HLFPPT, PSI, DKT).
4. Field Visits: The team will undertake visits to SIFPSA, ITAP, GOUP, UAHFWS, JHS, NHSRC and GOI/Director Donor Coordination. The team may consider dividing into two groups for field visits to UP and to UK and JH.

The first two days will be very important for laying the groundwork for the evaluation. The team will be briefed by USAID and ITAP staff at the beginning of the assignment to prepare them for site visits, clarify issues, review the proposed approach, and solidify the plan for completion of the evaluation.

Time Frame

The Phase I assessment will begin **August 13** and the draft report will be made available at the end of the three-week assessment period. The team leader will be responsible for planning, design, and implementation of the evaluation and coordination of work among team members. It will be the team leader's responsibility to submit a satisfactory report to USAID within the agreed timelines. The team leader is responsible for report writing and organization of the debriefing presentations. The final report should be made available within two weeks of the receipt of comments on the draft report from USAID and ITAP. Program schedules for field visits shall be provided before or on arrival in India.

Deliverables

The following deliverables will be required from the evaluation team:

1. An assessment instrument drafted by the team before field visits are made. The design may be modified after discussions with USAID.
2. A report of the findings and recommendations that is concise, actionable, and solution-oriented will be drafted by the team leader by the end of the three-week assessment.
3. Two debriefing presentations will be made to USAID staff within four days of completion of field visits, one for the PHN office and the other for the front office and the SO14 team.
4. Copies of all PowerPoint presentations and briefings will be made for the use of the Office of Population, Health and Nutrition.

5. The team leader will be responsible for reviewing USAID comments on the draft report and correcting any factual inaccuracies or omissions, while recognizing that this is an independent evaluation and that the findings and recommendations may not necessarily reflect USAID suggestions for revisions or comments. An electronic and a hard copy should be sent to USAID within two weeks of the receipt of the comments. The draft format for the evaluation report is as follows:

   a) Executive summary (4-5 pages)

   b) Introduction

   c) Program background

   d) Methodology

   e) Observations and findings for each analytical area

   f) Lessons learned

   g) Recommendations for the future

   h) Midcourse corrections

   i) Annexes (including but not limited to lists of persons and organizations met, and any questionnaires drafted)

Reporting

The team will report to the Reproductive Health Division Chief.

Logistical Support

USAID and ITAP will organize meetings and provide assistance for making travel and lodging arrangements. The team members will be required to make their own payments.

Qualifications of the Consultants/Team Members

See Annex 1

Proposed Level of Effort

Area of Expertise	Member	Person Days (LOE)	Travel (LOE)	Total (LOE)
Team Leader	1	**28**	**4**	**32**
Public Health Evaluation Expert	1	**22**	**4**	**26**
FP/RH Technical expert	1	**22**	**4**	**26**
Public Private Sector Partnership Expert	**1**	**22**	**4**	**26**
Communication/Behavior Change Expert	1	**22**	**4**	**26**
Health Systems and Policy Expert	1	**22**	**4**	**26**
Total		**138**	**24**	**162**

Included in the LOE are **18** days for in-country work (six day work week), **4** days for prep and report writing for general team members, and **10** days for prep and report writing for Team Leader. This does not include travel time or weekends.

ANNEX 1

Qualifications of the Team Members

We propose a **5-6 member team** with the following range of skills:

1. Team leader, an expert in project management
2. Public health evaluation expert
3. Technical expert in family planning/reproductive health
4. Expert in public-private partnerships
5. Communication and behavior change expert
6. Health systems and policy expert

1. Team Leader

The team leader will be responsible for looking at the big picture of the project, including coordinating and packaging the deliverables in consultation with other members of the team. The leader, in consultation with other team members, will develop tools for the assessment and a design plan and share it with USAID/India and incorporate comments, if any. S/he will be required to ensure quality of work and provide direction and coordination for the rest of the team. S/he will be responsible for completion of the assessment and reporting on areas not covered by other members of the team. The team leader will draw up the outline for the draft report, present the report, and, after incorporating the comments, submit the final report to USAID/India within the prescribed timeline. The team leader is also expected to be the lead in assessing overall project management issues. S/he will also lead in summarizing lessons learned and providing recommendations for future directions.

Skills/Experience: The team leader will be a senior person having more than 15 years experience working in the field of FP and RH and with the private sector and be considered a leader in this field. S/he should have knowledge of FP and RCH issues in India. S/he should have a good understanding of project administration and financing and management skills, including an understanding of how USAID functions. S/he should have excellent writing and communication skills. S/he should have past experience of leading a team for evaluation/assessment or related assignments.

2. Public Health Evaluation Expert

The public health evaluation expert will be responsible for reviewing the public health impact of the Project. S/he will assist in developing tools and a design plan for the assessment. S/he would document the lessons learned and provide recommendations for future directions with respect to the public health impact of project activities. S/he will work closely with the private sector partnership consultant to determine if the private sector approach of IFPS was effective in achieving public health impact. S/he will also have responsibility for drawing conclusions about effectiveness of the overall IFPS design in achieving public health impact.

Skills/Experience: The public health expert will be a senior person with at least 10 years of experience working in the field of RCH. S/He will have expertise in evaluation of public health programs, and should have knowledge of FP and RCH issues in India. S/he should also have a good understanding of the relevant national programs, be familiar with the public and private actors in health, and have a good grasp of issues related to the private sector. S/he should have excellent writing and communication skills.

3. Technical Expert in FP and RH

The FP/RH technical expert will be responsible for assessing the ability of the project to achieve outcomes in FP/RH, provide technical leadership in FP/RH, and effectively advocate for favorable FP/RH policies. The FP/RH technical expert will also assess the technical quality of IFPS II FP/RH interventions. S/he will document the lessons learnt and provide recommendations for future directions.

Skills/ Experience: The FP/RH technical expert will have at least 7 to 10 years of experience in management or consulting on FP/RH programs. This person should have proven background and experience in FP/RH and a strong understanding of the challenges facing FP/RH programs in India. S/he should also have good understanding of the relevant national programs in FP/RH, both public and private sector.

4. Public Private Partnership Expert

The PPP expert will be responsible for assessing all aspects related to the private sector in IFPS II. S/he will provide key insights into the ability of the project to achieve public health results by emphasizing the PPPs outlined in the design. S/he will comment on ability to advocate for and introduce private sector models into a public sector system, as well as comment on sustainability of IFPS II innovations through the public sector or otherwise. S/he will also provide lessons learned; recommendations for strengthening the project, ensuring higher private sector participation, and assessing the needs of the private sector; and suggestions for new directions.

Skills/ Experience: The PPP expert will have at least 7 to 10 years of experience working to integrate the public and private sector in the health field. Prior working experience in India is preferred.

5. Communication and Behavior Change Expert

The CBC expert will be responsible for assessing the effectiveness of IFPS II BCC and demand-generation activities for FP/RH products to improve awareness and use of FP/RH products and services. S/he will provide recommendations for strengthening these interventions and creating linkages with other activities and suggestions for new directions.

Skills/Experience: The specialist will have at least 10 years experience working in the area of BCC. S/he should have a good understanding of health communication programs for providers as well as clients.

6. Health Systems and Policy Expert

The health systems and policy expert will have responsibility for examining the project's ability to advocate and influence policy and decision making at the state and national level, particularly to affect a policy environment that is favorable to PPPs. This person will also look at the sustainability of IFPS II innovations and the ability of the project to leverage and influence NRHM and RCH II programming, including adoption by GOI of IFPS II innovations.

Skills/Experience: The specialist will have at least 7–10 years experience working in the policy and advocacy arena. S/he should have a good understanding of the Indian health system, particularly NRHM and RCH II.

ANNEX B:

IFPS II EVALUATION
TEAM ITINERARY
(AUG. 12–SEPT. 7, 2007)

Sunday, Aug 12 (GH Tech Team at hotel)

4:00 – 5:00 pm	Introductions and brief review of team skills and background Distribution of preliminary report outline for team review

Monday, Aug 13 (GH Tech Team and USAID staff)

9:00 – 11:00 am	Overview USAID strategy, health portfolio, and background and history of IFPS I and II
11:00 – 12:00 noon	Meeting with USAID Mission Director
12:00 – 1:00 pm	Lunch break
1:00 – 2:00 pm	Overview of Health System, NRHM, discussion of context, environment, health system challenges, other questions from team about environment, data sources, resource people, etc.
2:00 – 3:00 pm	USAID Program Support Office
3:00 – 4:00 pm	Overview continued
4:00 – 5:00 pm	Evaluation methodology, analytic framework, assessment instruments, components, and content
5:00 - 5:30 pm	Review of travel itinerary and meetings, logistics

Tuesday Aug 14 (GH Tech Team and USAID staff)

9:00 – 10:00 am	USAID Finance Office
10:00 – 11:00 am	Overview of IFPS II (continued), USAID's view of challenges and project issues, questions from the team

11:00 – 12:00 noon	Review of draft report outline with USAID; reach agreement on any modifications; finalize schedule of deliverables
12:00 – 1:00 pm	Lunch break
1:00 – 3:00 pm	ITAP overview, Dr. Narayana, director, ITAP
3:00 – 5:00 pm	NHSRC overview, Dr. T. Sundaraman, executive director

Wednesday Aug 15 (**GH Tech Team at hotel**)

9:00 – 10:00 am	Review of SOW and expectations and deliverables; finalize assessment instruments
10:00 – 11:30 am	Teamwork expectations, content responsibilities of each team member, team responsibility on field trips, sharing reading materials, deadlines of deliverables from each team member, report writing tasks and assignments
11:30 – 12:30 pm	Administrative questions, issues, processes, questions for GH Tech headquarters
1:00 pm	Team leader send report outline and assessment instruments to Monique, USAID
1:00 – 4:00 pm	Individual reading time, prepare for field trips
4:00 – 5:00 pm	Final consultation with Mission prior to site visits; team reviews plan for conducting evaluation, roles, responsibilities
August 16-17	**Travel to Uttarakhand and Jharkhand (See below)**

Monday Aug 20 (GH Tech and USAID staff)

9:00 – 10:00 am	Mission meetings: Debrief and clarifications
10:00 – 11:00 am	Robert Clay, USAID
11:00 – 12:00 noon	HS team meeting
12:00 – 1:00 pm	MCH/UH team meeting
3:00 – 4:00 pm	Donor coordination: Sanjeev Gupta

4:00 – 5:00 pm	RSS: Dr. Jayalakshmi
August 21-24	**Travel to UP** **(See Appendix)**
Monday Aug 27	**(GH Tech and USAID staff)**
9:15 – 10:30 am	Dr Maiti, MOHFW
10:30 – 11:30 am	Chaitinya, MOHFW
11:30 – 12:30 pm	Mr. Chowdhury, social marketing, MOHFW
12:30 – 1:30 pm	Lunch
2:00 – 3:00 pm	UNFPA
3:00 – 4:00 pm	Tarun Seem, MOHFW
2:30 – 3:30 pm	Peter Berman and Vikram Rajan, World Bank
4:00 – 5:00 pm	DFID
Tuesday Aug 28	HOLIDAY (Raksha Bandhan)
9:00 – 1:00 pm	Team meeting
1:00 – 1:30 pm	Aradhna Johri, director, RCH II (former executive director, SIFPSA)
Wednesday Aug 29	**(GH Tech and USAID staff)**
8:00 – 9:00 am	Meeting with Robert Clay (at mission)
9:00 – 11:00 am	PHN presentation and discussions
4:00 – 5:30 pm	Front Office and Mission-wide debrief
Thursday Aug 30	**(GH Tech and USAID staff)**
10:30 – 11:30 am	IRH, Priya Jha
2:00 – 3:00 pm	NIHFW, Dr. Nandan
3:30 – 4:30 pm	Population Council
4:30 – 5:30 pm	Monique/Loveleen, USAID

Friday Aug 31	**(GH Tech and USAID staff)**
10:00 am	Laurie Parker, IntraHealth International, Inc Loveleen Johri, USAID
11:00 am	Robert Clay, USAID
12:00 noon	Sheena, USAID
3:00 pm	Manoj HLFPPT, ITAP Office
4:00 pm	PHN office reception
September 1–7	Report Writing
Thursday Sept 6	
3:00 pm	HIV/AIDS Division
Friday, Sept 7	**SUBMIT REPORT TO USAID**

UTTARAKHAND TEAM I
HARIDWAR VOUCHER SCHEME, ASHA +, GOUK

Team : **Venkat Raman, Sarah Harbison, Moni**

August 16:	**Roorke**
6:50 am	Depart Delhi for Roorke (New Delhi train station)
11:00 am	Arrive Roorke (ITAP/UK to meet team in Roorke)
11:30 am	Visit PHC MOs, nursing homes, ASHAs, DM/Haridwar district (PPP, PH impact, innovations, FP/RH impact)
4:00 pm	Depart Roorke/Haridwar for Dehradun
6:00 pm	Arrive Dehradun; check in Pacific Hotel
August 17:	**Dehradun**
10:00 am	Overview, ITAP (PH impact, M&E, innovations, capacity building, TA mechanism, PBD)
12:00 noon	Meet with Secretary, Directorate, ED/UAHFWS (TA mechanism, capacity building, scaling up, replicability)
1:30 pm	Lunch
2:30 pm	Overview: ASHA +scheme (PH impact, M&E, OR, scale-up, replicability)
4:15 pm	Depart for train station
5:00 pm	Depart for Delhi

UTTARAKHAND TEAM II
MOBILE HEALTH CLINIC, ASHA +, GOUK

Team : **Joy Riggs Perla, Anuradha Bhatterjee, Monique**

August 15:	**Nainital**
10:00 pm	Depart Delhi for Khashgodam (New Delhi train station)
5:00 am	Arrive Khashgodam (ITAP/UK to meet team); drive 2 hours to Nainital
8:00 am	Visit Mobile Health Clinic : Inaugural run of van, site map, services provided, van management, meet with BISR (PPP, PH impact, innovations, scale-up, replicability)
4:30 pm	Depart Nainital for Kashgodam (Drive 2 hours to Kashgodam)
7:40 pm	Depart Kashgodam for Dehradun
4:20 am	Arrive Dehradun; check in Pacific Hotel

August 17:	**Dehradun**
10:00 am	Overview, ITAP (ITAP Office) (PH impact, M&E, innovations, capacity building, TA mechanism, PBD)
12:00 noon	Meet with Secretary, Directorate, ED/UAHFWS (Ministry), ITAP to accompany (TA mechanism, capacity building, scale-up, replicability)
1:30 pm	Lunch
2:30 pm	Overview: ASHA + scheme (ITAP office) (PH impact, M&E, OR, scale-up, replicability)
4:15 pm	Depart for train station
5:00 pm	Depart for Delhi

JHARKHAND TEAM
GOJ, IMR/MMR DEATH AUDIT

Team : **Mihira Karra, Paula Quigley, Loveleen, Lokesh**

August 16:	**Ranchi**
11:00 am	Depart New Delhi for JH
12:30 pm	Arrive Jharkhand (ITAP/JH to meet team at airport)
1:30 pm	Overview: ITAP (ITAP office), working lunch (BCC, capacity/institution building, PBD, TA to government)
3:00 pm	Meet with GOJ: Secretary, Sp [?] Secretary; visit JHS campus (capacity/institution building, TA to government, BCC)
4:30 pm	Visit SDM sites (Ranchi); check in Capitol Hotel
August 17:	**Gumla**
8:00 am	Travel to Gumla (car)
10:00 am	Overview of IMR/MMR death audit – CARE (TA to governmentt and NGOs)
1:00 pm	Depart (arrive Ranchi at 3:00)
4:15 pm	Flight to Delhi (OR depart on 7:10 flight to Delhi, via Orissa, arriving at 11:30 pm

UP TRAVEL: AUGUST 21 – 24
UP TEAM I, BCC

Team : **Moni, Anuradha, Mihira, SIFPSA HQ BCC expert, ITAP**

August 21:	**Lucknow**
8:50 am	Depart IC flight to Lucknow
11:30 am	Overview: SIFPSA (current/past/in pipeline activities under USAID, GOI, and through savings, achievements, new role as SHRC, PBD, challenges)

1:30 pm	Lunch
2:30 pm	SIFPSA overvew (cont'd)
3:30:pm	ITAP overview
5:30 pm	Check into Taj Hotel

August 22: Lucknow

10:00 am	Meeting with Directorate (flip books)
11:30 am	Overview of SIFPSA BCC activities (permanent methods campaign, Suvidha TV spots, posters, radio series, mass media spots, flip books)
1:30 pm	Lunch
2:30 pm	Overview (contd)
3:30 pm	Drive to Kanpur
5:30 pm	Arrive Kanpur; check into hotel

August 23: Kanpur

10:00 am	NGO project, Kanpur (BCC component of NGO projects, Suvidha wall paintings, folk performance)
12:00 noon	VHWSC training (OR market town activity ORr sensitization of political leaders)
1:00 pm	Lunch
2:00 pm	NGO project, Kanpur
4:45 pm	Depart Kanpur, Shatabdi, for Delhi
10:40 pm	Arrive Delhi, check into Taj Ambassador

August 24: Ghaziabad

8:00 am	Depart for Ghaziabad by car (ITAP to accompany)
10:00 am	Overview of social marketing (DKT)
12:00 noon	Market town activity
1:30 pm	Lunch
2:30 pm	Return to Delhi

UP TEAM II - PPP

Team : Monique, Venkat Raman, Sarah Harbison, SIFPSA HQ PPP expert, ITAP

August 21: Lucknow

8:50 am	Depart on IC flight to Lucknow
11:30 am	SIFPSA overview (current/past/in pipeline activities under USAID, GOI, and through savings, achievements, new role as SHRC, PBD, challenges)
1:30 pm	Lunch
2:30 pm	SIFPSA Overview (cont'd)

3:30 pm	ITAP overview
5:30 pm	Check into Taj

August 22: Agra

6:00 am	Depart for Agra by train; SIFPSA to accompany
11:00 am	Check into hotel
11:30 am	Overview of Agra voucher scheme (DIFPSA)
1:00 pm	Working lunch
2:00 pm	Nursing homes, NGOs, ASHAs, CMO, DM
5:30 pm	Return to hotel

August 23: Agra

10:00 am	Social franchising – L0 hospital; SIFPSA to accompany
12:00 noon	NGO project I
1:00 pm	Lunch
2:00 pm	NGO project II (neighboring district)
4:00 pm	Return to Agra

August 24: Ghaziabad

8:00 am	Depart for Ghaziabad by car; ITAP to accompany
10:00 am	Overview of social marketing (DKT)
12:00 noon	Market town activity
1:30 pm	Lunch
2:30 pm	Return to Delhi

UP TEAM III - POLICY/PUBLIC SECTOR

Team : Loveleen, Paula Quigley, Joy Riggs Perla, SIFPSA HQ Public Sector expert, ITAP

August 21: Lucknow

8:50 am	Depart on IC flight to Lucknow
11:30 am	SIFPSA overview, Alok Tandon, executive director, SIFPSA, and mission director, NHRM (current/past/in pipeline activities under USAID, GOI, and through savings, achievements, new role as SHRC, PBD, challenges)
1:30 pm	Lunch
2:30 pm	SIFPSA overview (cont'd)
3:30 pm	Overview ITAP
5:30 pm	Check into Taj

August 22:	**Lucknow**
9:00 am	Meeting with Rajiv Gupta, DP general auditor, SIFPSA
10:00 am	Meeting with Principal Secretary
11:00 am	Meeting with Shailesh Krishna, secretary for family welfare
11:30 am	Meeting with Dr. Neera Jain, director, SIHFW
12:00 noon	Meeting with JS Deepak, Principal Secretary (former executive director, SIFPSA)
1:00 pm	Meeting with S.P. Goyal, PD UP SACS
2:00 pm	Meeting with L.B. Prasad, director, general health services
August 23:	**Lucknow**
11:00 am	Social franchising launch
1:30 pm	Follow-up meeting with Dr. Narayana, ITAP
2:00 pm	Depart Lucknow for nearby district
4:00 pm	QI circle Return to Lucknow
August 24:	**Nearby district**
10:00 am	RCH camp
12:00 noon	Sensitization of political leaders
4:00 pm	Return to Lucknow
5:50 pm	Depart, IC flight to Delhi

ANNEX C: LIST OF DOCUMENTS/MATERIALS REVIEWED

1. IFPS18th Amendatory Project Agreement 2004
2. PBD Policy Framework (Memo from AID A/General Council dated April 18, 2002)
3. IFPS Project Authorization
4. NAD IFPS II–The Second Phase of the Innovations in FP Services Project, October 1, 2004 to September 30, 2008
5. 10-year PBD Framework, Part I
6. 10-Year PBD Framework, Part II
7. IFPS Project Paper 1992
8. SIFPSA Organogram
9. IFPS Assessment Summary Report April 2003
10. National Family Health Surveys 92/93, 98/99, 05/06
11. Reproductive and Child Health Programme Joint Review Mission, Aides Memoire (Feb/Mar 2006, Oct 2006, Jan-Feb 2007, July 07 draft)
12. Performance Monitoring Plan for ITAP, May 2007 revision
13. IFPS II Project Benchmarks (10^{th} – 12^{th}) for UP and UK
14. USAID Family Planning/Reproductive Health Division Strategy, April 5, 2007
15. USAID India Country Strategic Plan (The Last Mile: Completing the Development Agenda), FY 2003-2007.
16. USAID Performance Management Plan for SO 14 2002–2007
17. Designing a Social Franchising Initiative in the Health Sector, Futures Group, November 2006
18. USAID-India Partners' Guide, July 2006
19. International Workshop on Social Franchising in the Health Sector, November 2006
20. ITAP Contract, April 2005
21. Performance Monitoring Plan for ITAP, May 2007
22. Ideas, Insights, and Innovations: Achievements and Lessons Learned from the Innovations in Family Planning Services (IFPS) Project, 1992–2004, December 2006, Constella Group
23. Making a Difference, Best Practices Leading to Impacts, SIFPSA, December 2003.
24. SIFPSA Restructuring Plan and Road Map, KPMG, January 2007
25. Social Franchising in UP: Request for Proposal and HLFPPT Technical Proposal
26. ITAP Work Plan, April–September 2007
27. Reproductive Health Indicators Survey for UP, 2005

28. USAID Country Health Statistical Report, India, May 2007
29. SOW: USAID/India's Next Steps—Adolescent Health in FP/RH, September 2007
30. SOW: USAID/India's Next Steps—Institutional Capacity Building for FP/RH, September 2007
31. Healthy Adolescents Empowered Adolescents, UNFPA 2005
32. Evaluation of Mobile Clinics in Uttaranchal, March 2006
33. SIFPSA: Request for Assistance: Agencies to Provide Clinic-Based Reproductive Health Services, 2006
34. Rapid Assessment of Clinic-Based NGO Projects in UP, August 2007
35. ASHA Training Module, SIFPSA
36. Strengthening RH/FP Services Among Industrial Workers and Adjoining Communities: End of Project Evaluation, IIHMR Jaipur, November 2004
37. Cooperative Dairy-Based Rural Family Welfare Project: Final Report, ORG-Marg, November 2004
38. Hardwar Voucher System Baseline Survey, Constella Futures, June 2007
39. District Action Plan, Dehradun, Uttarakhand
40. District Action Plan, Saharanpur, UP

BCC DOCUMENTS/MATERIALS

National

41. NRHM Communication Matrix
42. NRHM Tracking Study
43. NRHM TV Spots (CD)

Uttarakhand

44. ITAP RFP–Institutional Delivery
45. ITAP RFP–Immunization
46. ITAP Uttarakhand Workplan for Bridge Communication Intervention (Oct 2006–March 2007)
47. Reading materials for ASHA, Book 2 (NRHM Training Program)
48. Reading Materials for ASHA, Book 4 (NRHM Training Program)
49. Uttaranchal NRHM Report, Oct 2005
50. USAID India—Evaluation of Mobile Clinics in Uttaranchal
51. Birla Institute of Technology Report—Mobile Health Clinics in Ramnagar
52. ASHA Plus Training Materials—Charts, Leaflets, Interactive Pictorial Booklets:
    a. Grabh Nirodhak Saadhan
    b. Mahwari Hone Par Kya Karein
    c. Food Chart
    d. Apne Sharir Ko Jaano

e. Jaise Jaise Hum Badte Hain
f. Anemia
g. Jaaniye ASHA Ke Baarey Mein

53. Sambhav Logo and Flipbook for Voucher Scheme
54. Jug Jug Jiyo Campaign (Institutional Delivery) —Presentation and Materials Developed by RK Swamy (CD)

Jharkhand

55. Behavior Change Communication Strategy for Jharkhand
56. ITAP RFP for Institutional Delivery
57. ITAP RFP for Birth Spacing
58. Report: Assessing the Impact of Integrating SDM in India (Dissemination Meeting, April 2007, Ranchi)
59. IRH Folder on SDM—IEC Materials
60. Note on Intra-Communication (RK Swamy), CD and Chart

Uttar Pradesh

61. IUCD Campaign, Suvidha Poster/TV/Leaflet (CD)
62. Female Sterilization Campaign, IEC Materials, TV and Radio Spots (CD)
63. Radio Drama Series, Darpan, and Sunehere Sapne Sawarte Rahe
64. Wall Chart and Poster: Comprehensive Family Planning Methods – Kya Aaapne Apne Liye Upyukt Grabh Nirodhak Chuna Hai?
65. Report: Folk Media—The SIFPSA Experience
66. Brochure: Jan Chetana Abhiyaan (for sensitization of political leaders)
67. DKT IEC Materials for Social Marketing
68. USAID/ITAP Presentation at Partners' Workshop for Development of Communication, 2006.
69. UP—IFPS II Communications Strategy Document
70. UP—IFPS II Communication Work Plan
71. UP—IFPS II Communication Strategy, Child Health (Excel)
72. UP—IFPS II Communication Strategy, Family Planning (Excel)
73. USAID–India Report (PDF): Knowledge and Perceptions About Reproductive Health Issues and Media Reach Among Mothers-in-Law, 2006 (Constella)
74. USAID–India Report (PDF): Knowledge about RCH Services Provided and Media Exposure—A Study of Grassroot Level Workers, 2006
75. USAID–India Report: Reproductive Health Indicator Survey, IP, 2005
76. SDM IEC Materials: Comic, Poster, Wall Chart

PUBLIC-PRIVATE PARTNERSHIP

Power Point Presentations:

77. Presentation by Dr. Anil Mishra, ITAP office, Uttarakhand, August 17, 2007
78. *Agra Voucher System*, presentation by Ms. J.S. Srilata, SIFPSA office, August 22, 2007
79. *Social Franchising for Bettering Health of Working Poor in UP*, resentation by Mr. G. Manoj, CEO, HLFPPT, August 31, 2007
80. *Taking Diagnostics to People: Towards a Collaborative Experiment in Uttarakhand and a Dossier,* Presentation by Mr. G.D. Palaria, BISR, August 16, 2007
81. *DKT India, Project Saksham: Social Marketing of Condoms and Oral Pills in Rural Uttar Pradesh*, presentation by DKT Team (Ms. Sandra Gass), August 24, 2007
82. *ITAP–IFPS II Technical Assistance Project*, presentation by G.D.Narayana, August 14, 2007
83. *Overview of SIFPSA*, presentation by Mr. Krishnaswamy, August 21, 2007
84. Presentations by Mr. Robert Clay, Ms. Sheena Chhabra, Ms. Loveleen Johri, Mr. Bob Massey, and Ms. Monique Mosolf at USAID; and ITAP presentation notes from Lucknow (various dates in August 2007)

Concept Notes and Research Reports

85. Futures Group, *Public-Private Partnerships in Health Care: Guidelines for Contracting out Public Health Services to Private Organizations*, undated
86. IFPS Health Voucher System, Agra District, UP (draft), undated

USAID Publications

87. *Ideas, Insights, and Innovations: Achievements and Lessons Learned from Innovations in Family Planning Services (IFPS) Project, 1992–2004*, December 2006
88. *Formulation of Population and Health Policies in Indian States, 1997–2004*, November 2006
89. *Evaluation of Mobile Clinics in Uttaranchal*, March 2006
90. *International Workshop on Social Franchising in the Health Sector: Workshop Proceedings*, November 2006
91. *Designing a Social Franchising Initiative in the Health Sector*, November 2006

RFP Documents

92. SCOVA, *Proposal for Implementing of Voucher System for Improving RCH Outcomes in 2 blocks of Haridwar District, Uttaranchal, India,* submitted to Uttaranchal health and family welfare society, December 2006.

93. HLFPPT, *A Proposal to Set up a Sustainable Network of Social Franchised Clinics for Working Poor in Uttar Pradesh: Technical and Financial Proposal* (revised proposal incorporating suggestions of PAC of SIFPSA) submitted to SIFPSA, March 8, 2007
94. SIFPSA, *Request for Proposal: Social Franchising in Uttar Pradesh, SIFPSA-IFPS-II Technical Assistance Project,* undated
95. BISR, *Proposal for Mobile Health Clinic in Nainital District,* submitted to Department of Health and Family Welfare, Uttaranchal, December 2006
96. SCOVA, *Request for Proposal for Operationalising Mobile Health Van in Ramnagar,* undated
97. ITAP, *Social Marketing of Condoms and Oral Pills in Rural Uttar Pradesh,* undated
98. ITAP, RFP from Marketing Agencies for Marketing of Nirodh Deluxe Condoms and Mala D Oral Pills in Uttar Pradesh, undated

Contracts

99. Agreement between SIFPSA and NIRPHAD, dated September 30, 2006. for managing voucher scheme and ASHA scheme, and for outreach activities with CHACS in three blocks (Akola, Bichpuri, and Baroli Aheer) of Agra district
100. MOU between CMO, Agra, and SN medical college, Agra, for implementing voucher scheme in Agra district (accreditation, empanelment, quality control, training, and monitoring of the private partners in the voucher scheme), dated December 18, 2006
101. Agreement between CMO, Agra, and Agra Hospital for implementation of voucher scheme in Agra district, dated December 27, 2006
102. Firm fixed-price subcontract between Futures Group International LLC and DKT India under IFPS II technical assistance project (USAID contract number GPO-1-00-04-00015-00), dated April 1, 2007

OTHER

103. *Accreditation for Hospitals and Health Care Providers: Standards for Hospitals Providing RCH services Under Public-Private Partnership in Uttar Pradesh,* undated

ANNEX D: EVALUATION ANALYTIC FRAMEWORK AND ASSESSMENT TOOLS

1. Expected End of Project Outcomes

Current status and likelihood of meeting targets by September 2008

Assessment of progress toward achieving outcomes stated in "Revised Amplified Project Description," Attachment A to Grant Agreement Amendment dated Aug 24, 2004

People-level results	UP	UA	JH
1. Modern method CPR in UP increased to 30.6% (6% points above the 2003 level of 24.6%)	x		
2. Percentage of women receiving a sufficient quantity of iron/folic acid tablets during last pregnancy in UP increased to 43.2% (10% points above it's the 2003 level of 33.2%)	x		
3. Over 420 million condoms sold in rural areas of UP	x		
4. Over 14 million cycles of oral pills sold in rural areas of UP	x		
Additional results			
5. Three state proposals for RCHII developed and funded with local resources	x	x	x
6. Over $60 million leveraged over the life of the project from GOI and other development partners	x	x	x
7. Uttaranchal Public Health Directorate staffed, five-year plan in place, and staff paid by the state government.		x	
8. By the end of the project, at least one working model of a public-private partnership funded by other agencies for wider implementation	x	x	x

2. The revised Project Objectives for IFPS II are as follows:

1. Increase demand for RCH services through BCC and marketing.
2. Increase delivery of integrated RCH services through public-private partnerships.
3. Strengthen the capacity of the public sector to manage the provision of public and private RCH services (policies, monitoring and evaluation, quality assurance, etc.).
4. Enhance the transformation of SIFPSA and promote collaborative partnerships with Indian and U.S. institutions to support the delivery of integrated RCH services.
5. Realize sustainability by support from other development partners and the government for scaling up innovations.

Note from May 04 NAD extension the following "sub-results" (same as objectives listed above)

SR1: Demand for RCH services increased.

Illustrative Indicators

- condom / oral pill sales, and
- percent of population who think it is very important to adopt specific healthy RCH practices

SR2: Delivery of integrated RCH services increased through public-private partnerships

Illustrative indicators

- number of RCH service delivery points incorporating PPPs, and
- quality of RCH services incorporating PPPs (this could be an index of several indicators).

SR3: Public sector capacity to manage the provision of private sector RCH services strengthened

Illustrative Indicators

- the number of state government contracts for private sector RCH services; and,
- the establishment and implementation of mechanisms and standards to monitor quality and provision of private sector services

SR4: Transformation of SIFPSA enhanced and collaborative partnerships with Indian and US institutions strengthened

Illustrative Indicators

- percent of non-USAID funding that is used to finance SIFPSA operations; and
- proportion of technical assistance that is provided under the project by local Indian entities

SR5: Sustainability realized by support from other donors and government for scaling up innovations

Illustrative Indicators

- amount of funding leveraged from GOI and/or the donor community; and
- utilization of such funding in the target states to finance RCH activities

3. Program Component Analyses (looking at how they are contributing to the outcomes, objectives, and sub-results listed above)

a. Progress toward achievement of other milestones as identified in ITAP Contract and Work Plans
   i. Social marketing
   ii. Assistance to EAG cell
   iii. BCC
   iv. Technical support to cells in Uttarakhand (public sector support)
   v. Public sector training in UK and JH (public sector support)

b. Progress on performance-based disbursement benchmarks, assessment of accomplishments and challenges
   i. Operations research
   ii. Social franchising
   iii. Increasing PPPs

4. Management and Financial Assessment

a. Management structure and mechanisms
b. Geographic scope and state differences
c. Management issues for all IFPS II partners (USAID, ITAP, GOI, societies, etc.)
d. Analysis of project funding drawn-down
e. Performance based disbursement financial issues

5. Conclusions of analysis and implications for future

ASSESSMENT TOOLS

1. Interview/Question Guide – Key stakeholders
2. Analysis of project data, other surveys (public health impact), financial information
3. Review of descriptive and analytical documents related to the project
4. Evidence gathered from field visits

Interview/Question Guide (Aug 13-14)

Note: The "interview/question guide" is intended to ensure that no key areas of inquiry are overlooked. Some issues and questions may be addressed adequately during briefings or in the written materials. The team will use the guide as a reference to ensure that topics of importance to the SOW are covered and that there is some consistency to the topics covered by different teams or individuals during interviews and site visits.

Aug 13-14

USAID Director

- What proportion of the Mission's OYB are the PHN activities?
- Given that the Indian economy and health budget is so large, and USAID health resources relatively small in comparison, what role do you feel USAID is playing in the health sector?
- What is USAID's comparative advantage as a donor in India?
- What are your concerns about IFPS? Are there areas to which you want the team to pay special attention?
- Has IFPS II benefited from being part of the bilateral agreement? In what ways has it been helpful? Is there a downside?
- From your point of view, has IFPS II been too management-intensive for the Mission as a whole, or is that not an issue?

- How do you feel about performance-based disbursements as now structured? What are your concerns about this system?
- Do you see USAID's program in India changing over time? How?

USAID PHN Staff

Environment of IFPS II

- What are your views about the role of USAID, and IFPS II in particular, within the health system nationally and in the three states? Do you believe that the MoHFW shares that view, or do they have a different perspective?
- Position and relationship of IFPS II in the Health Portfolio: What's the vision in terms of how the pieces of the portfolio fit together?

Management Issues

- How management-intensive are the two major components? What does it take from the Mission in terms of personnel to adequately oversee this activity?
- What are the mechanisms in place to oversee the work of the Futures Group (steering committees, etc)?
- How effectively, in your view, is the ITAP consortium of organizations working? Is each partner contributing as envisioned? Have there been problems from your point of view?
- Does the TA component provide results reporting as needed by the Mission? Have there been problems associated with that function, especially in relation to the OP?
- How complicated is the system to verify achievements under the PBD component? How is that managed? What changes would you like to see?
- Do you have any specific evidence at this point that there is increased "ownership" of the IFPS II project by state governments or the national government as a result of the bilateral agreement? How different is it from IFPS I?

Technical and Programmatic Issues:

- Have there been any changes in thinking about the results framework outlined in the NAD May 04? Is that still current in terms of expectations for project results and achievements?
- What are the IFPS II relevant indicators in the Mission's PMP? In the OP?
- In reviewing the five objectives of the project, discuss the PHN Office's view on the progress and challenges in each area. Where has progress been the strongest and why? Where has it been the most challenging or weakest?
- In your view, how likely is it that the NHSRC will be able to continue funding the 23 staff currently supported by IFPS II? What about the staff support to the state cells?

- In your view, how well has SIFPSA been able to transform itself into an innovator and developer of best practice models as envisioned in the NAD?
- How confident are you that ITAP is producing high-quality, evidence-based models of PPPs in the three states?
- How much buy-in do you believe exists at the state level for the concept of PPPs? Is there any specific evidence of this buy-in?
- What mechanisms do you have in place to help facilitate cross-project coordination and sharing of information within the USAID PHN portfolio of projects? Are there regular meetings? How does that work?
- What mechanisms are in place for donor coordination in the health sector at the national or state level?
- Has USAID played a role in "selling" IFPS I or II innovations (RCH camps, DAPs, etc) to other programs like RCH II or NRHM? Does USAID promote this at the state level in any way?

Program Support Office

- Is there a Mission team structure that supports the PHN office with management of the IFPS II project? How does that function?
- What are your views about how well the PBD system has worked? The NAD states that it is not the same system and procedure used during IFPS I—how does it differ?
- Are there any issues or problems with the current PDB plus TA contract in terms of generating the results required by the Mission's Operational Plan, since the OP came into existence after the IFPS II was operational? Have any adjustments been made?
- Do you believe that USAID-India should continue to use PBD systems in the future?
- Is the ITAP technical assistance mechanism better than the IFPS I system of multiple individual CAs? What are the shortcomings? What is the evidence of success from your perspective?
- What are your views about the advantages or shortcomings of the IFPS II being part of the bilateral agreement?

Finance Office

- What are your views about how well the PBD system has worked? The NAD states that it is not the same system and procedure used during IFPS I? How does it differ?
- Are there currently concerns about financial management issues in the state government? Have any of these concerns affected implementation of the PBD mechanism?
- Do you believe that USAID-India should continue to have a PBD element to future activities?
- Are there pipeline problems with IFPS II? Is the project spending at a satisfactory rate from the Mission's perspective?
- How does the audit function work for IFPS II? Are local grantees under the ITAP mechanism audited annually? Have there been major problems? How is the PBD system audited, and by whom?

ITAP

- Since the primary mechanism for providing short-term TA through ITAP is through subagreements with Indian institutions, how is that working? What are the constraints and challenges?
- How do you relate to SIFPSA in UP? Is TA provided on demand, or are ITAP partner institutions more proactive in suggesting areas of collaborative work?
- In all three states, what is ITAP's relationship with state health officials? What are the coordinating or approval mechanisms for project activities? How is that working?
- Since ITAP's role is primarily technical support, in what way are you building sustainability, since that is a major thrust of the IFPS II?
- How do you track impact vis-à-vis ITAP's contribution to overall achievements in IFPS II?
- In what way is IFPS II more client-centered than IFPS I? Illustrate using concrete, real-life examples.
- What is the role of each subcontractor? Does everyone function as a fully integrated ITAP team, or does each group have a distinct role and independent operating procedures?
- How do you feel about the national component to support the EAG group? Has that work been effective? How could it be strengthened? Will the staff positions be sustained?
- How would you characterize the success (or lack of success) related to developing and documenting PPP models in all three states? What have been the biggest lessons? How supportive are state governments of the PPP strategy?

- Does ITAP contribute to achieving specific performance-based disbursement benchmarks, such as those related to social franchising or increasing PPPs? If so, how? What have been the lessons learned from that effort?
- In what specific ways are you using lessons learned from IFPS I to do things differently in IFPS II?
- What are your biggest challenges and constraints? Where has progress been faster or easier?
- If you were proposing a design for IFPS II all over again, what specific changes would you make based on experience to date?
- What is USAID's role with ITAP activities, and have they performed their role in ways that facilitates implementation? What could they do differently? Has it been an effective partnership?

National Health System Resource Center

- Please tell the IFPS II evaluation team about the mandate of NHSRC and how you are organized to provide support services to the EAG states.
- How many State Health System Resource Centers have been established, and are they performing effectively? How do you support the state-level ones?
- In what ways do you collaborate with the IFPS II project beyond the 23 staff positions it supports? How, specifically, has the project contributed to your efforts to improve the availability of technical consultants and to develop state capacity in the areas of health planning, policy, research, training, etc.?
- What organizations are supporting your work other than the MOHFW, USAID, and UNFPA? What is the nature of that support?
- Are you involved in the operations research capacity-building that IFPS II is supporting through the bilateral element of the project in the three states? Does NHSRC also fund research?
- How could IFPS II improve its support for NHSRC? With IFPS II ending in September 2008, what are your plans for continuing the staff that they have been supporting?

FIELD TRIP QUESTIONS

Voucher Scheme

A. *PHC, Nursing Home staff*
    a. When did it start?
    b. How were you selected?
    c. How does it function?
        i. How does it flow from where to where?
        ii. Who distributes?
        iii. Where used?
        iv. How do sites get reimbursed?

v. What services are covered?
vi. What FP methods are covered?
vii. How much supply is given the first time?
viii. How is resupply done?
ix. Who is approved to receive vouchers?
x. How is this verified?
xi. How are staff trained, by whom, and on what topics and issues?
xii. What FP materials do you have?*
xiii. How are voucher statistics reported?*
xiv. What services are they mostly used for and how much (volume)?
xv. Do ASHAs get incentives to distribute?
xvi. How is the whole scheme working?
xvii. Who qualifies?
xviii. How do they know they qualify?
xix. From where do they get vouchers?
xx. How is qualification verified?
xxi. What FP methods do clients get?

B. DM/MO

a. What's your opinion of the voucher scheme?
b. Are there any problems?
c. Will you replicate?
d. How? Where?

C. ASHAs (whether Plus or not)

a. How were you selected?
b. When did you start?
c. How were you trained, and by whom?
d. What services do you provide?
e. What materials did you receive to help with your work?*
f. What supplies do you carry?
g. What FP methods do you provide?
h. Do you refer, and to whom, for other methods? (which ones)
i. Do you carry vouchers?
j. Who do you give vouchers to?
k. What kind of payments do you get, and for what?
l. What NGO are you linked to?
m. What reporting do you do, and how?

n. How many families do you cover?
o. How many clients do you have in a week or a month?

D. ITAP Office (Team One and Two)

ASHA Plus Questions:

a. Whom did you train?
b. Who developed the curriculum?* (look for FP methods and IFA)
c. Are there plans for refresher or inservice training?
d. How to you supervise and whom? (whole supervision structure)
    i. How are NGOs supervised?
    ii. How are ASHAs supervised?
e. How is reporting done? (who , when , etc)
f. What materials were developed, and by whom, for providers and clients? (check for FP and IFA)
g. What methods do ASHAs provide?
h. How do ASHAs report?
i. How is the program working?

Questions About Vouchers for ITAP

a. Who did you select and how?
b. Who did you train?
c. Who developed the curriculum? (look for FP and IFA)
d. Are there plans for refresher and inservice training?
e. Supervision structure: how are sites supervised and monitored?
f. How is reporting done? (look for M&E forms)*
g. What materials were developed, and by whom, for providers and clients? (check for FP and IFA)
h. What methods are covered by vouchers?
i. How do you track vouchers?
j. What are vouchers used for? (look at service use type)
k. What is your involvement with UA/HFSW/SCOVA?
l. How is PPD done for UK, and for what?
m. How is the whole scheme working?

Questions About the Mobile Health Clinic at ITAP

a. Who did you train for the mobile unit?
b. How did you select the organization?

c. What curriculum was used?*
d. What materials do providers have in the van?
e. What services are provided (FP and IFA)?
f. What client materials do vans have?
g. How is it working?

ED / UA HFWS (SCOVA?)

a. What is the linkage with ITAP?
b. What is your opinion on the voucher scheme and ASHA +?
c. What is your opinion on replication and scale up?
d. What other TA is received from ITAP?
e. What are your future needs?

At the Mobile Health Center (Nainital)

a. When is it starting?
b. Who is managing it? Who is paying for the recurrent costs?
c. What services are provided?
d. Who are the providers?
e. What FP methods are provided?
f. Who trained the providers?
g. What is the catchment area and route?
h. How many clients do you expect to see in a day?
i. Is there any outreach connection, and by whom?
j. When someone needs a service you don't have, what is the plan?
k. What materials do you have for providers? (Look for FP methods and IFA)
l. What materials do you have for clients? (FP & IFA)

Jharkhand Visit

a. In each of the following areas, specific content on FP and IFA needs that should be checked:

BCC? Capacity building? TA for GoJ? PBD?

b. Is JHS going to be the route for bilateral in future?
c. What will be the role of ITAP for the next year?
d. What are the future needs for TA to the public and private sectors?

CHECKLIST FOR THE PPP COMPONENT

STAKEHOLDERS TO BE INTERVIEWED:

PUBLIC SECTOR: Staff, facility managers, program administrators
PRIVATE SECTOR: Staff, project managers, facility managers
PRI: Community leaders (?)
POLICY MAKERS (Section bureaucrats)
BENEFICIARIES

Questions for PPP Components

- How did the private partner come to know about the project?
- Who and what is the background of the private partner? Can you give a brief on their involvement in the health sector, especially FP services? Their owners, funding, beneficiary groups, other projects they handle, etc.?
- What population and beneficiary groups are the project supposed to cover? (total population, number of enlisted beneficiaries, how beneficiaries are identified or excluded)
- State perceived objectives of the project.
- What are the partner commitments (stated and actual)? Are there any deficiencies in the commitments not being fulfilled? What is the role of the public sector managers and public health facilities in the project?
- How was the private partner identified? Shortlisted? Selected? Contracted? Was it through open tender or by prior consultation?
- What is the duration of the partnership?
- What are the performance indicators? How were the indicators identified and finalized? How are the performance indicators being monitored? By whom?
- What are the user fees (if any) for services provided under the scheme? What about other services provided beyond the scheme?
- Explain about reimbursement to the private agency. Are there any bottlenecks in the timely release of funds? What are the procedural difficulties? If there have been delays in the past, how did they manage?
- Are there any incentives to the private partners—performance-based or otherwise?
- What is your opinion about sustainability and scalability, with or without project funding?
- Is there an exit opportunity for the public or private partner? What are the penalties?

BCC Assessment

Topics: Campaigns, IEC materials, IPC initiatives:

- Messages/activities
- Creative execution:

  Thomson Social: what was their brief?

  What were the campaigns?

  What behavior change was expected and achieved from the campaigns?

  Were any KABP studies done?
- Outcome of the campaigns/initiatives

  Were there any impact assessments?

  Is there any evidence to link greater uptake of FP services with the communication?
- Information requirements:

  All documents related to the above questions.

  Materials related to all communication campaigns: mass media, materials, IPC activities, folk media

  Social mobilization and community-led engagements and activities

This document also mentions that the communication strategy to support service delivery in IFPS I was "weak."

What was done to correct this?

Does IFPS II communication strategy address the need to support OCP?

What about] support for the CSM and ANM –IUCD initiatives?

Analysis - Continuation of Communication Strategy of IFPS I in IFPS II

- How much of continuity maintained?
- Based on what evidence that earlier strategy/initiatives have been successful?
- How much of deviation – based on what evidence that this was necessary*?*

Review - New Communication Strategy in IFPS II

- Was there a Communication Strategy Paper?
- Was there a Communication Needs Assessment study before the paper was drafted?
- What about any rapid assessments, such as dipstick studies, running with campaigns of IFPS II?

Review (Per Region -UP/UK/JH): All communication campaigns/materials.

- Meetings with IEC officers, functionaries, advertising agencies, filmmakers?
- Analysis per campaign: creative execution, key messages, cultural/religious sensitivities in communication messages/IPC?
- Was there one overarching message with multiple means of execution? Or multiple messages for different target audiences?
- Was mass media used with mid-media support?
- What about IPC through ASHA? How much of Enter-educate campaigns? Like Taru in Bihar?
- What about other forms of IPC for behavior change? Community involvement? Youth peer education? Something like CHARCA?
- What is the impact of Goli ke Hamjoli?
- What about the impact of commercial sector campaigns for condoms?

Meeting the Objectives:

Did project authorization directives like those iterated below, which clearly indicate the importance of communication, actually provide the underpinnings for IFPS I and II?

> "India Family Planning Practices Survey (1989) provides evidence of the need in UP for public education and efforts to fill knowledge gaps and correct misconceptions about FP methods. Given the importance of reaching the general public, IFPS will develop and support such a public education program (PEP)…"
>
> "A multi-faceted IEC program can increase the demand for and quality of services and improve overall effectiveness of family planning service and delivery**."**

ANNEX E: BEHAVIOR CHANGE COMMUNICATION

National

1. Communication Matrix for NRHM Spots Produced During IFPS II

"*Swasthya Bharat ki shuruat hoti hai swasthya parivar se….aap se!"* is the USP for the NRHM spots. The USP squarely places the responsibility for action on each individual in the country for a healthy family leading to a healthy nation. Different spots have been produced as part of the NRHM dealing with such issues as age at marriage, HIV/ AIDS, ante natal care, family planning, immunization, and oral rehydration therapy. The single USP provides the necessary link between all issues. Further details of the spots are provided in the table below:

Spot No.	Spot	Issue/ Behavior topic	Duration	Current Behavior	Desired Behavior	Barriers/ Gaps	Audience	Benefit/ Motivation	Message/s
1	Girl - Black and white with red ribbons	Age at Marriage	60 and 50 secs	Low age at marriage especially in rural areas leading to significant MMR and IMR	Marriage of a girl child only after legal age of marriage	Social values and attitude toward girls	Parents in rural areas of North India	- Your daughter is the link to future generations. Take care of her health.	- Give your daughter enough time to nurture her dreams - For the health of your daughter, marry her only after 18 years of age
2	Raveena Tandon	Age at Marriage Route – Celebrity Endorsement	50 secs	Low age at marriage especially in rural areas leading to significant MMR and IMR	Marriage of a girl child only after legal age of marriage	Social values and attitude toward girls child	Parents in rural areas of North India	- Healthy mother means a happy family - Age at marriage determines the health of future of generations	- Marriage only after a girl is mentally ready to be a wife and physically ready to be a mother - Nurture the dreams of a young girl
3	Bhairavi Bhaichura	AIDS Route – Celebrity Endorsement	25 secs	- HIV/AIDS is a taboo topic - Parents do not talk with their children about possible routes of transmission of HIV and about its prevention - Most young people gain information about sexual health from peers or unreliable sources	- Encourage parents to openly talk about sexual health issues and about routes of transmission of HIV and its prevention	- Sex and sexual health are taboo topics	Parents of young people in urban as well as rural areas	Parents have to guide their children to the right path	- Talk to your children about HIV/ AIDS - Knowledge about AIDS is the first step to prevention

Spot No.	Spot	Issue/ Behavior topic	Duration	Current Behavior	Desired Behavior	Barriers/ Gaps	Audience	Benefit/ Motivation	Message/s
4	Rajpal Yadav	AIDS Route – Celebrity Endorsement	40, 30, and 22 secs	- Poor self and risk perception - Unprotected sexual acts	- Each non-reproductive sexual act should be protected	- Sexually active young people do not know that even a single unsafe sexual act can lead to HIV	Sexually active young people	- Even one irresponsible sexual act can lead to HIV - Be courageous and behave responsibly	- Be aware, take precautions, and save yourself from HIV - Be safe
5	Afternoon Gossip	Antenatal care (ANC) Route – Celebrity Endorsement	60 secs	- Because women do not register their pregnancies and do not get their ANC check-up, they do not get their TT injections and do not consume IFA tablets - Most deliveries take place at home without a trained birth attendant	- Women register their pregnancies and get their ANC check-ups done by qualified medical practitioners - Adequate rest and nutrition for each pregnancy - Delivery should take place in a hospital	- Little or no information about ANC - Myths and misconceptions about pregnancy - Older women in the household reinforce the myths and resist change	- Women of reproductive age in rural areas in North India - Key influencers like mothers-in-law who are decision makers on pregnancy issues	- Do's of ANC	- ANC is important for the health of both the mother and the child
6	Juhi Chawla	Antenatal care Route – Celebrity Endorsement	54 secs	- Because women do not register their pregnancies and do not get their ANC check–up, .they do not get their TT injections and do not consume IFA tablets - Most deliveries take place at home without a trained birth attendant	- Women register their pregnancies and get their ANC check-ups done by qualified medical practitioners - Adequate rest and nutrition for each pregnancy - Delivery should take place in a hospital	- Little or no information about ANC - Myths and misconceptions about pregnancy - Older women in the household reinforce the myths and resist change	Women of reproductive age in rural areas in North India	- Healthy children are important in this era of increasing population and decreasing resources	- Do's of ANC - A healthy mother is important for healthy children and for a healthy nation
7	Pallavi Joshi	Antenatal care Route – Celebrity	30 secs	- The pregnant woman is responsible for staying healthy	- Involvement of the household in the pregnancy	- Little or no information about ANC - Myths and	Families of pregnant women in both rural	- Motherhood is the most beautiful phase for a woman.	- ANC is the responsibility of the whole family - 3 check ups, IFA, TT,

Spot No.	Spot	Issue/ Behavior topic	Duration	Current Behavior	Desired Behavior	Barriers/ Gaps	Audience	Benefit/ Motivation	Message/s
		Endorsement		during pregnancy - Because women do not register their pregnancies and do not get their ANC check–up, they do not get their TT injections and do not consume IFA tablets - Most deliveries take place at home without a trained birth attendant	- Women register their pregnancies and get their ANC check-ups done by qualified medical practitioners - Adequate rest and nutrition for each pregnancy - Delivery should take place in a hospital	misconceptions about pregnancy - Older women in the household reinforce the myths and resist change	and urban areas in North India	Take care of her during her pregnancy. - Encourage pregnant women around you to get their ANC check-ups	rest and nutrition are important aspects of ANC - Institutional delivery is safer
8	Supriya	Antenatal care Route – Celebrity Endorsement	40 secs	- The pregnant woman is responsible for staying healthy during pregnancy - Because women do not register their pregnancies and do not get their ANC check–ups, .they do not get their TT injections and do not consume IFA tablets	- Involvement of the husband in the pregnancy - Women register their pregnancies and get their ANC check-ups done by qualified medical practitioners - Adequate rest and nutrition is necessary for each pregnancy	- Little or no information about ANC - Myths and misconceptions around pregnancy	Husbands of pregnant women in both rural and urban areas in North India	- ANC is important to the health of a mother in later years	- Husbands also have a role in pregnancy, by taking care of the wife and ensuring regular check ups - 3 check ups, IFA, TT, rest and nutrition important aspects of ANC
9	Acrobat – oral pills (OCs)	Family planning Recognize that women are constantly worried that they may become pregnant and that OCs are a	40 secs	-Many women do not use any contraceptive method even though they do not plan to become pregnant - Therefore they are worried every month when they expect their menstrual	- That a woman should take control of her fertility by using OCs. - That it is a safe and effective method endorsed by	- Existing rumours and myths about OCs - A readiness to take the risk of an unplanned pregnancy	Women in SECs A-D in the age group of 20-35 in urban areas of North India	- To be free of the monthly tension that they miss their menstrual periods because they are pregnant	- That OC are a safe and effective method - That they are easy to use - That your doctor endorses this method and that they should contact the doctor for further information and advice.

Spot No.	Spot	Issue/ Behavior topic	Duration	Current Behavior	Desired Behavior	Barriers/ Gaps	Audience	Benefit/ Motivation	Message/s
		safe way to be free of this tension		periods - They consider OCs, but have heard many rumors about adverse effects	their doctor - That they understand that it is a safe and simple method to use				- That over 80 million women around the world use OCs.
10	Varun and Rajeshwari	Family Planning Normalizing the image of condoms and condom users to increase consistent use of condoms by sexually active men	20 secs	- Do not use condoms consistently because of perception they are only to be used if one has multiple sex partners and also due to embarrassment associated with asking for, buying ,and using condoms	Use condoms with regular and occasional sex partners and use them consistently	- Condoms are not for me - If I love my partner, I don't need to use a condom - They are for people with illicit sexual relationships	Sexually active single and married men aged 20-45 in urban areas	I should use a condom if I love and care for my partner	- Show her how much you care. Use a condom, always
11	Juhi Chawla	Family planning Route – Celebrity endorsement	53 secs	- High fertility rate - Poor adoption of FP methods after reaching the desired family size	- Adopting a temporary method of FP for spacing between children - Choosing between temporary or permanent methods of FP planning on reaching the desired family size	- Desire for the male child - More children considered additional bread winners for the family - Myths and misconceptions about different methods of contraception	Eligible couples in both rural and urban areas of North India	- A healthy family is a prosperous family - Spacing is important for health of the mother and child - Different methods of spacing are available and a convenient one can be found	- Importance of spacing for health of mother and child - Small family is a happy family irrespective of the genders of children - Different methods of temporary and permanent FP methods are available that can be adopted after consultation with your doctor
12	Kite	Family planning Using OCs will help a woman have control over her multiple roles	40 secs	- Married women have to play multiple roles that compete for their time and attention - Family members may not cooperate	A woman who adopts OCs will be in a better position to play all her roles at home because she does not	- Husbands and other family members may not support this and may be overly demanding	Women in SECs A-D in the aged 20-35 in urban areas of North India	- A woman who uses OCs and has control over her fertility can successfully play all of her demanding roles	- An OC user has control over her life and household roles - A husband's cooperation is needed for this - There are many OC

Spot No.	Spot	Issue/ Behavior topic	Duration	Current Behavior	Desired Behavior	Barriers/ Gaps	Audience	Benefit/ Motivation	Message/s
				or support these	have to worry about unplanned pregnancies			in a household	brands on the market
13	Pallavi Joshi	Family planning Spacing is important for the health of a woman and there are many contraceptive means available for this	25 secs	- High fertility rate - Poor adoption of FP methods after reaching the desired family size	Adopting FP methods for spacing and limiting family size	- Desire for a male child - More children are additional bread winners for the family - Myths and misconceptions about different methods of contraception	Eligible couples in both rural and urban areas of North India	- Spacing is important for the health of the mother and child	- Limit the size of your family so that you can provide good upbringing, health ,and education to them - A variety of FP methods are available today. Choose the one you like
14	Raveena Tandon	Family planning	50 secs	- No discussion about FP methods	- Couples discuss among themselves and then adopt an FP method	- Myths and misconceptions about different methods of contraception	Eligible couples in both rural and urban areas of North India	- Marriage at the right age, delaying the first child, and spacing between children lead to a healthy body and healthy mind	- Consult your spouse and adopt an FP method
15	Rohit and Mansi Condom 'Yahi Hai Sahi' Celebrity TVCs	Family planning Normalizing the image of condoms and the condom user to increase consistent use of condoms by sexually active men	20 secs	Do not use condoms consistently because of perception that they are only to be used if one has multiple sex partners and also due to embarrassment associated to asking for, buying, and using condoms	Use condoms with regular and occasional sex partners and use them consistently	- Condoms are not for me - If I love my partner, I don't need to use a condom - They are for people with illicit sexual relationships	Sexually active single and married men aged 20-45 in urban areas	I should use a condom if I love and care for my partner	- Show her how much you care; use condoms always
16	Sachin	Family planning	45 secs	- High fertility rate - Poor adoption of FP methods after reaching the desired family size	Adopt FP methods for spacing and limiting the size of families	- Desire for a male child - More children are additional bread winners for the family - Myths and	Eligible couples in both rural and urban areas of North India	- A healthy family is a prosperous family - Spacing is important for health of the mother and child	- Spacing is important for the health of mother and child - Limit the size of your family so that you can provide good upbringing, health, and

Spot No.	Spot	Issue/ Behavior topic	Duration	Current Behavior	Desired Behavior	Barriers/ Gaps	Audience	Benefit/ Motivation	Message/s
						misconceptions about different methods of contraception		- Different methods of spacing are available, and a convenient one can be adopted	education to them - Different temporary and permanent FP methods are available, which can be adopted after consultation with your doctor
17	Suhaag Raat	Family planning	40 secs and 20 secs	Do not use condoms consistently because of perception that they are only to be used if one has multiple sex partners and also due to embarrassment associated to asking for, buying, and using condoms	Use condoms with regular and occasional sex partners and use them consistently	- Condoms are not for me. - If I love my partner I don't need to use a condom - They are for people with illicit sexual relationships	Sexually active single and married men aged 20-45 in urban areas	I should use a condom if I love and care for my partner	Show her how much you care; use condoms always
18	Train – oral pills	Family planning Increase knowledge that OCs are a safe and convenient method of contraception	40 and 20 secs	- Perception that OCs have many harmful side effects - Concern that it is difficult to use, especially when doing nonroutine activities like travelling	- Appreciate that OCs are a safe method endorsed by doctors - a user does not need to make any major changes to her usage cycles even when away from home	- OCs have many side effects and they should only be used on doctors advice - When travelling a user will forget to take her pills regularly	- Women in SECs A-D in the aged 20-35 in urban areas of North India	- Even doctors use OCs and so they must be a safe and convenient method	- OCs do not have any harmful side effects - They can be easily used - They are a good spacing method
19	Pallavi Joshi	Immunization	25 secs	- Children are not immunized against all diseases	- All children are immunized for all diseases	- Myths and misconceptions about immunization	Primarily caregivers in households in North India	- Health is the best gift to a child	- Be responsible; get your children immunized against all diseases
20	ORS Teachers TVC	WHO ORS New low osmolarity	40 and 20 secs	- Inconsistent use of ORS in diarrhea - Low awareness of benefits of new	Make low osmolarity WHO ORS the first line of treatment	Caregivers often do not think of diarrhea as a serious	Primarily caregivers of children under 5	The new WHO ORS with reduced osmolarity	With new ORS the child recovers faster from diarrhea, which allows caregivers to carry on

Spot No.	Spot	Issue/ Behavior topic	Duration	Current Behavior	Desired Behavior	Barriers/ Gaps	Audience	Benefit/ Motivation	Message/s
		WHO ORS as the first line of treatment for infant and childhood diarrhea, as the new ORS provides faster relief		ORS - Regular food is stopped during diarrhea because child refuses to accept food	in every episode of infant and childhood diarrhea - Give WHO ORS immediately when diarrhea strikes - Appreciate benefits of new ORS - Continue feeding the child	disorder and try to manage it with home remedies - Diarrhea is at best seen as an irritant and disruption from regular activities, not a life- threatening illness - Widespread and irrational use of drugs	(includes young mothers and also mothers-in-law, fathers and elder siblings) residing in urban areas of North India Also healthcare providers such as doctors, chemists, aanganwadi workers, etc.	provides quicker relief from diarrhea than the earlier standard ORS	with their normal routine - Give WHO formula ORS immediately when diarrhea strikes - Continue regular food of the child during diarrhea; do not stop it
21	Raju-Nandu complete home diarrhea manage-ment TVC	WHO ORS Curative and preventive behaviors for home management of diarrhea Explain that malnourish-ment resulting from diarrhea is a major barrier to growth of a child		- Low awareness & use of ORS and other available fluids for rehydration - Low rates of exclusive breast feeding up to six months because caregivers believe that mothers milk should be stopped during diarrhea - Reduced feeding during diarrhea and lack of energy-dense diet after recovery - Caregivers do not wash their and the child's hands with soap - Caregivers do not recognize critical	ORS as the first line of treatment for diarrhea along with appropriate available fluids such as rice or water, coconut water - Breast feed exclusively up to six months - Continue feeding during diarrhea and give extra energy-dense food after recovery - Wash mother's and child's hands at critical points with soap	- Diarrhea perceived as routine minor illness - Lack of awareness of ORT as an essential and effective solution for diarrhea. - Perceptions that breastfeeding weakens the mother; that mother's milk may pass on infection to the child; and that mother's milk is difficult for a child to digest	Primarily caregivers in SEC D & E households in urban areas	Empowers caregivers to better manage infant diarrhea at home and ensure the normal growth of the child	- Follow simple messages to manage infant and childhood diarrhea at home and ensure proper and consistent growth of the child, because diarrhea can be a serious disorder and frequent episodes of diarrhea can result in malnutrition - ORS and home-based solutions are available for preventing and curing dehydration during diarrhea

Spot No.	Spot	Issue/ Behavior topic	Duration	Current Behavior	Desired Behavior	Barriers/ Gaps	Audience	Benefit/ Motivation	Message/s
				signs of danger, do not take the child to a doctor ,and indulge in self-medication	- Recognize critical signs of illness and take the child to a doctor	during diarrhea - Caregivers reduce child's food intake because child rejects food - Lack of recognition that visibly clean hands may still be unclean unless washed with soap - Recognition of critical signs of diarrhea illness			

2. Excerpts from Tracking Study on NRHM Spots

" …Sample and Study Design

The study followed a two-stage stratified systematic random sampling design. In the first stage, 213 primary sampling units (PSUs), , which were villages and urban-wards, in eight EAG states, were selected through the population proportion to size (PPS) technique. In the second stage, 3,200 households were selected in these PSUs using a systematic random sampling procedure, and interviews were conducted.

To identify target respondents, a household listing exercise was carried out in all the PSUs. Since the objective of the study was to assess the impact of TV spots, during the listing exercise ownership of a functional TV was ascertained for each household. Three structured questionnaires were used to elicit the required information: (i) Household questionnaire; (ii) Questionnaire for married men and women (20–45 years); and (iii) Questionnaire for unmarried adolescents (15–19 years).

The number of people interviewed were:

- 1,496 currently married men aged 20–45
- 1,588 currently married women aged 20–45
- 779 adolescent boys aged 15–19
- 791 adolescent girls aged 15–19

Key Findings

1. Access and Viewership

A well-planned and executed TV campaign could potentially reach about one-fourth of the rural and over half the urban target audience. TV viewership by target segments in the eight EAG states is discussed below.

1.1 Access to TV

- Only 23% of rural households own a functional TV, but over half the urban households (57%) have one.

1.2 Rural TV Viewership

- **Currently married women:** Only one in seven women (16%) in rural areas of EAG states watch TV daily. Another 7% watch TV at least once a week and 4% watch at least once a month. A well-planned TV campaign could at best reach a little more than one-fourth of rural women in EAG states.
- **Currently married men:** A lower proportion of men than women watch TV regularly. Only 11% of men in rural areas of EAG states watch TV daily. Another 5% watch at least once a week and 9% watch at least once a month. A TV campaign could at best reach about one-fifth of rural men in EAG states
- **Adolescent girls:** In rural areas of EAG states 23% of girls watch TV daily, another 5% watch at least once a week, and 4% watch at least once a month. A TV campaign could at best reach about one-third of the rural girls in EAG states.
- **Adolescent boys:** A lower proportion of rural boys watch TV regularly than girls. Only 14% of boys in rural areas of EAG states watch TV regularly, another 11% watch at least once a week, and 6% watch at least once a month. A TV campaign could at best reach about one-third of the rural boys in EAG states.

1.3 Urban TV Viewership:

- **Currently married women:** The urban situation is quite different from the rural. As many as 45% women in urban areas of EAG states watch TV daily, another 6% watch at least once a week, and 2% watch at least once a month. A well-planned TV campaign could reach more than half of the urban women in EAG states.

- **Currently married men:** Like their rural counterparts, urban men watch less TV than women. Only 31% of men in rural areas of EAG state watch TV daily, another 8% watch at least once in a week, and 3% watch at least once in a month. A TV campaign could therefore reach about 40% of men in EAG states.
- **Adolescent girls:** In urban areas 42% girls watch TV daily, another 8% watch at least once a week, and 3% watch at least once a month. A well-planned TV campaign could reach at least half the urban girls in EAG states.
- **Adolescent boys:** The viewership pattern of urban boys in EAG states is similar to that of girls: 39% watch TV daily, another 6% watch at least once a week, and 6% watch at least once a month, so a well-planned TV campaign could reach half the urban boys in EAG states.

2. Visibility/Recall of TV Spots

All percentages in this section have been calculated for the subset of the target population having access to TV.[2] Recall of the TV spots was checked at three levels: one spontaneously, the second after some prompting, and the third after helping the respondent by narrating key aspects of the TV spot.

2.1 Age at Marriage

The NRHM spots supported by USAID include three spots on age at marriage, one by the film actress Raveena Tandon, the second a black and white spot, and the third by Amitabh Bachchan. These spots had limited spontaneous or probed recall in rural areas, but did better in urban areas. The black and white spot in particular appears to be registering a decent spontaneous/probed recall in urban areas. Recall of these spots by target segments by rural and urban areas is given in Table 1. It is evident that the proportion spontaneously mentioning the TV spot is rather low but increases marginally with probing and significantly with aiding. This pattern holds good in both rural and urban areas for all three types of advertisements on age at marriage.

[2] Access to TV has been defined by ownership of functional TV within the household.

Table 1: Percent of Respondents Who Have Seen AGE AT MARRIAGE Spots				
Type of ad	Yes–Spontaneous	Yes–Probed	Yes–Aided	Total
Rural Areas				
Raveena Tandon				
Currently married women	1.7	2.3	11.9	15.9
Currently married men	2.5	5.0	9.3	16.8
Adolescent girls	1.1	3.6	13.2	17.9
Adolescent boys	4.4	5.2	17.0	26.6
Amitabh Bachchan				
Currently married women	2.0	6.2	13.6	21.8
Currently married men	3.0	8.3	19.5	30.8
Adolescent girls	4.5	6.0	25.0	35.5
Adolescent boys	5.2	11.9	21.3	38.4
Black & White				
Currently married women	2.2	5.4	35.7	43.3
Currently married men	2.7	6.1	21.9	30.7
Adolescent girls	5.2	5.1	39.7	50.0
Adolescent boys	1.7	12.0	23.3	37.0
Urban Areas				
Raveena Tandon				
Currently married women	3.9	9.0	16.0	28.9
Currently married men	6.6	7.1	16.2	29.9
Adolescent girls	6.3	7.8	15.3	29.4
Adolescent boys	7.3	6.9	16.8	31.0
Amitabh Bachchan				
Currently married women	7.3	9.8	9.8	26.9
Currently married men	10.5	9.7	14.7	34.9
Adolescent girls	7.5	9.0	14.2	30.7
Adolescent boys	10.5	10.1	12.4	33.0
Black & White				
Currently married women	10.3	10.3	29.1	49.7
Currently married men	9.2	13.2	24.0	46.4
Adolescent girls	10.7	9.6	29.7	50.0
Adolescent boys	10.0	8.1	21.5	39.6

Of the three TV spots on age at marriage, the Black & White has much greater recall compared with the Raveena Tandon or Amitabh Bachchan ads. This is true of both rural and urban areas and all four segments of the target populations. Thisshows that the innovative treatment of the message very effectively broke through the clutter.

ANC spots

In the NRHM TV campaign, USAID supported five spots on antenatal care. Spontaneous recall of these ads was very low in both rural and urban areas (Table 2). Recall increased marginally after probing and significantly with aiding. Among currently married women, the ad by Pallavi Joshi has the highest overall recall, 33% in rural areas and 46% in urban area with Afternoon Gossip coming second (25% in rural and 41% in urban areas The three other spots have recall of less than 20% among married women in rural and about 25% in urban areas. Among currently married men, however, the Amitabh ad topped the list in rural areas (24%) and Afternoon Gossip in urban areas (30%), with the Amitabh one a close second.

As with currently married women, among both adolescent girls and adolescent boys, Pallavi Joshi had best recall, followed by Afternoon Gossip.

Table 2: Percent of Respondents Who Have Seen ANC Spots

Type of advertisement	Yes–Spontaneous		Yes–Probed		Yes–Aided		Total	
	R	U	R	U	R	U	R	U
Afternoon Gossip								
Currently married women	2.0	10.9	3.0	11.2	19.8	19.1	24.8	41.2
Currently married men	4.4	8.9	2.7	7.8	9.6	13.2	16.7	29.9
Adolescent girls	3.0	8.6	3.2	6.6	16.3	11.9	22.5	27.1
Adolescent boys	2.8	8.2	4.9	4.0	11.6	10.8	19.3	23.0
Juhi Chawla								
Currently married women	0.6	3.3	2.7	6.9	7.9	14.5	11.2	24.7
Currently married men	2.6	7.1	3.9	7.3	10.6	13.5	17.1	27.9
Adolescent girls	1.5	4.1	3.9	5.4	9.9	15.7	15.3	25.2
Adolescent boys	3.1	5.9	2.4	6.9	8.8	7.7	14.3	20.5
Pallavi Joshi								
Currently married women	1.6	4.9	8.9	15.6	22.5	25.1	33.0	45.6
Currently married men	0.6	2.5	4.9	10.8	8.0	15.6	13.5	28.9
Adolescent girls	3.5	5.9	6.5	13.9	17.8	23.8	27.8	43.6
Adolescent boys	1.9	4.4	2.7	8.0	9.7	11.5	14.3	23.9
Supriya								
Currently married women	0.8	1.6	2.0	5.5	9.8	18.0	12.6	25.1
Currently married men	1.3	2.5	1.5	6.7	8.5	13.0	11.3	22.2
Adolescent girls	0.1	1.9	2.4	4.9	7.8	16.3	10.3	23.1
Adolescent boys	0.6	1.9	1.9	3.8	9.2	8.8	11.7	14.5
Amitabh Bachchan								
Currently married women	1.8	6.1	4.9	8.5	12.5	10.5	19.2	25.1
Currently married men	5.4	10.8	3.3	7.9	15.7	10.6	24.4	29.3
Adolescent girls	1.4	6.9	6.2	5.0	14.6	10.7	22.2	22.6
Adolescent boys	4.9	8.6	4.1	4.9	13.4	8.4	22.4	21.9

2.2 Immunization and WHO-ORS

In the NRHM BCC campaign on television there are two ads on immunization and one on WHO-ORS (Tables 3 and 4).

The Amitabh Bachchan ad on immunization had a better spontaneous recall than the one by Pallavi Joshi: 7-8% of women and adolescent girls, 11% of men and 18% of adolescent boys reported having seen it. However, with probing and aided questioning, a higher proportion of women and adolescent girls reported having seen the Pallavi Joshi ad compared to Amitabh. With the men and adolescent boys, with aiding the Amitabh Bachchan ad continued to have top recall.

Table 3: Percent of Respondents Who Have Seen IMMUNIZATION Spots

Type of advertisement	Yes–Spontaneous		Yes–Probed		Yes–Aided		Total	
	R	U	R	U	R	U	R	U
Pallavi Joshi								
Currently married women	3.2	8.6	7.7	14.5	19.6	22.2	30.5	45.3
Currently married men	2.7	8.7	4.8	10.3	15.4	19.9	22.9	38.9
Adolescent girls	1.8	9.7	11.8	13.4	14.4	21.8	28.0	44.9
Adolescent boys	3.6	11.2	2.2	10.7	17.6	19.2	23.4	41.1
Amitabh Bachchan								
Currently married women	7.5	16.1	8.3	11.5	15.4	10.0	31.2	37.6
Currently married men	11.2	23.3	12.3	8.9	18.8	14.7	42.3	46.9
Adolescent girls	7.4	15.8	12.2	8.7	15.1	16.6	34.7	41.1
Adolescent boys	17.9	21.1	7.8	11.0	23.2	15.2	48.9	47.3

The WHO-ORS spot had better reach among women and adolescent girls than the immunization ads. Among currently married women in rural areas, 56 percent reported seeing the WHO-ORS ad, and the proportion increases to 66% in urban areas. In rural areas 48% of adolescent girls reported seeing this ad is 48% in rural, and again the proportion increases in urban areas, to 70%. The pattern is similar for both currently married men and adolescent boys.

Table 4: Percent of Respondents Who Have Seen the WHO-ORS Spot

	Yes–Spontaneous		Yes–Probed		Yes–Aided		Total	
	R	U	R	U	R	U	R	U
Currently married women	13.0	22.9	16.5	24.8	26.5	18.5	56.0	66.2
Currently married men	6.7	17.8	10.9	17.1	19.2	18.7	36.8	53.6
Adolescent girls	13.3	26.8	16.1	24.5	18.5	19.1	47.9	70.4
Adolescent boys	8.5	22.5	10.6	13.5	25.4	23.0	44.5	59.0

2.3 Family Planning

There are 11 TV spots on family planning in the NRHM BCC TV campaign, and their reach among different target populations is shown in Table 5. These spots ranged from addressing issues related to benefits of family planning in general to specific benefits of spacing and limiting. Several also addressed concerns related to the use of pills and condoms. The proportion of target respondents spontaneously recalling the family planning advertisements is low in rural areas, except for the Amitabh Bachchan ad, which was spontaneously reported by 5-8% of married women and men. The three spots on oral contraceptives (train, two women on rickshaw, and kite flying) and the Amitabh Bachchan spot on the benefits of FP had good overall recall. For the others, even after probing and aided questioning, in both rural and urban areas less than a quarter of the respondents were able to recall most of them.

Table 5: Percent of Respondents Who Have Seen FAMILY PLANNING Spots

Type of advertisement	Yes–Spontaneous		Yes–Probed		Yes–Aided		Total	
	R	U	R	U	R	U	R	U
Raveena Tandon								
Currently married women	1.2	3.9	3.8	8.7	10.4	15.2	15.4	27.8
Currently married men	5.0	10.4	5.7	8.6	9.0	14.1	19.7	33.1
Adolescent girls	0.7	4.1	4.5	5.6	12.3	13.3	17.5	23.0
Adolescent boys	3.0	13.0	5.9	6.3	16.0	9.0	24.9	28.3
Juhi Chawla								
Currently married women	0.5	2.0	4.2	7.5	9.4	11.7	14.1	21.2
Currently married men	2.3	7.4	5.6	9.3	8.3	10.6	16.2	27.3
Adolescent girls	0.5	4.9	5.8	3.2	8.6	14.6	14.9	22.7
Adolescent boys	0.7	7.0	7.8	9.6	7.7	9.0	16.2	25.6
Sachin Tendulkar								
Currently married women	0.2	2.1	2.4	5.8	9.2	16.2	11.8	24.1
Currently married men	3.0	5.4	0.9	7.6	7.2	11.4	11.1	24.4
Adolescent girls	0.3	1.2	2.8	4.1	12.1	14.7	15.2	20.0
Adolescent boys	1.8	6.1	3.9	7.5	7.1	6.6	12.8	20.2
Varun and Rajeswari								
Currently married women	0.4	0.9	1.2	5.4	8.0	15.1	9.6	21.4
Currently married men	1.1	1.8	1.2	5.6	4.7	9.5	7.0	16.9
Adolescent girls	0.1	1.4	0.9	4.6	6.7	14.6	7.7	20.6
Adolescent boys	0.1	1.9	3.7	6.0	5.5	10.5	9.3	18.4
Rohit and Mansi	0.2	0.8	0.9	5.0	10.6	18.6	11.7	24.4
Currently married	2.1	2.1	0.8	6.5	4.1	11.3	7.0	19.9
women	0.4	2.0	1.1	6.8	6.2	13.4	7.7	22.2

Table 5: Percent of Respondents Who Have Seen FAMILY PLANNING Spots

Type of advertisement	Yes–Spontaneous		Yes–Probed		Yes–Aided		Total	
	R	U	R	U	R	U	R	U
Currently married men	0.3	0.9	2.3	7.0	3.5	11.5	6.1	19.4
Adolescent girls								
Adolescent boys								
Pallavi Joshi								
Currently married women	1.2	7.7	6.4	11.2	17.2	18.2	24.8	37.1
Currently married men	1.0	4.8	3.1	8.7	5.3	10.8	9.4	24.3
Adolescent girls	0.9	4.2	7.7	12.5	16.5	24.2	25.1	40.9
Adolescent boys	0.5	5.5	3.0	8.0	9.1	9.8	12.6	23.3
Kite Flying								
Currently married women	1.9	6.3	9.1	15.3	26.6	27.5	37.6	49.1
Currently married men	1.2	5.3	4.1	11.3	15.1	18.1	20.4	34.7
Adolescent girls	1.2	4.8	7.7	15.9	24.2	24.2	33.1	44.9
Adolescent boys	1.9	4.6	7.2	12.9	12.1	20.0	21.2	37.5
Suhaag Raat								
Currently married women	1.8	4.7	4.5	12.8	19.5	23.0	25.8	40.5
Currently married men	1.6	9.2	6.2	10.7	18.0	18.4	25.8	38.3
Adolescent girls	0.4	4.5	3.3	9.7	17.9	19.2	21.6	33.4
Adolescent boys	2.1	8.4	6.4	9.7	23.4	17.8	31.9	35.9
Train								
Currently married women	1.6	9.7	13.5	20.6	32.1	28.0	47.2	58.3
Currently married men	4.5	7.7	6.2	12.2	20.4	17.3	31.1	37.2
Adolescent girls	1.8	9.0	13.1	17.6	27.6	28.8	42.5	55.4
Adolescent boys	2.3	9.2	11.4	10.3	18.8	18.4	32.5	37.9
Two Women on Rickshaw								
Currently married women	2.5	13.9	13.4	18.7	29.2	26.8	45.1	59.4
Currently married men	2.1	8.7	6.8	15.1	17.4	18.9	26.3	42.7
Adolescent girls	1.9	9.1	12.6	17.3	29.1	27.1	43.6	53.5
Adolescent boys	2.3	11.4	5.5	11.9	21.9	16.3	29.7	39.6
Amitabh Bachchan								
Currently married women	4.8	8.4	5.5	10.3	9.7	9.1	45.1	59.4
Currently married men	8.3	16.2	12.2	11.4	15.0	14.0	26.3	42.7
Adolescent girls	1.4	7.7	9.9	8.8	11.1	9.3	43.6	53.5
Adolescent boys	4.8	14.0	12.4	8.7	20.3	15.1	29.7	39.6

Action/Initiative Taken

- In general, a higher proportion of males in both categories than females attempted to take some type of action after seeing the TV spots on different topics. This is not surprising; numerous studies have shown that women often are not empowered to make decisions about their own health and the health of their children.
- Again, a higher proportion of male respondents than female respondents took the initiative to gather more information on the issues after seeing ads on different topics.
- In every case, the main initiative taken by the majority of the respondents was "Encouraging friends/ relatives/ others" or "by following the messages given through ad on themselves/spouse, their family member or children."
- The impact of the FP ad could be seen by the action taken by the currently married respondents: 58% of the currently married males and 46% of currently married females said they had started using a family planning method after viewing the ads.

Self-confidence and Attitude

- **Age at Marriage, ANC, immunization, and WHO-ORS**: The majority of the currently married men and women felt confident in discussing the issue and convincing the family member/ spouse on this issue. A similar trend was observed for adolescent respondents.
- **Family Planning:** Most of the adolescent boys felt confident about using a method to maintain the spacing between children after marriage (60%) and in convincing friend/brother/brother-in law to adopt FP methods (59%). The girls were also confident about initiating discussion of family planning (49%) and about convincing sister/sister-in-law of the importance of using family planning (47%).
- After seeing the FP spots, the majority of married men expressed confidence about initiating a discussion (86%) and were confident about convincing someone of the importance of FP (82%). Though the proportion was lower for married women, still, three-fourths of them were confident of convincing their spouse (76%) and anyone else (75%).
- Age at marriage: A higher proportion of respondents exposed to TV than those not exposed to TV were of the opinion that "**A girl/ boy should get married after attaining the legal age at marriage" or "Physically and mentally a girl becomes ready for marriage after completing 18 years."** Trends in perception were the same for all categories of respondents.
- In general, more respondents in each category recognized the importance of the messages disseminated through the ads on different topics. Most of them expressed a positive attitude toward seeking ANC services, proper immunization of child, and use of WHO-ORS and family planning methods.
- The responses showed that the majority of the respondents had a correct understanding of the issues, and also understood the importance of following the recommended practices for the betterment of themselves and their family members.

- The level of understanding, perceived importance of core topics, and positive attitude toward the messages conveyed through the ads was relatively higher among those exposed to the TV spots than those not exposed to them.

Effectiveness of the messages

Overall, it can be concluded that in each of the target groups nearly three-fifths of the respondents who were exposed to the ads found them to be effective and to convey the desired message.

Conclusions and Recommendations

Behavior change is a complex process that requires concerted effort over a sustained period. MOHFW identified six thematic areas on which television spots were aired. The selection of the themes was strategic and largely aligned with the three RCH-2 goals of reducing fertility, infant mortality, and maternal mortality and linked to the preparedness of the service delivery elements. As RCH-2 service delivery is strengthened, the themes for BCC will need to be expanded. However, this will need to be undertaken within an overarching evidence-based BCC strategic framework for RCH-2. Also, as noted in the RCH-2 National PIP, the BCC strategy will need to be phased in so that the efforts lead to the desired behavior change: "Too many messages aired less frequently can lead to dilution of BCC efforts…."

JHARKHAND:

The communication strategy for Jharkhand has the following objectives: *(Source – Behavior Change Communication Strategy for Jharkhand for RCH II and NRHM – See List of Reviewed Documents)*

- To enhance awareness, generate demand, and facilitate behavior change in specific target populations for health service-related FP, MH, CH and ARSH, thereby ultimately making a difference to IMR, MMR and TFR.
- To improve the image, trust, and perception of the health system and the providers by improving their attitude and performance through training and capacity building.
- To create an enabling and supporting environment by working with influencers and other stakeholders through capacity building, dialogue, networking, and advocacy.

Some of the recommendations in the strategy document that are now being implemented:

a. Behavior Change Impact Assessment Survey to develop baseline indicators and formative research across a broad range of health issues to help the creation of communication messages *(Source: RFP for Behavior Change Communication Baseline Survey for Jharkhand—In List of Documents reviewed);*

b. Media campaigns on birth spacing and on institutional deliveries.

TV Spots for Institutional Deliveries:

During the three years preceding NFHS-2, only 14 percent of births in Jharkhand were delivered in a medical facility. Among births delivered at home, only 4 percent were assisted by a health professional (76 percent were assisted by a traditional birth attendant). Only one of seven births outside a medical facility was followed by a postpartum check-up within two months of delivery. These results show that utilization of health services in Jharkhand during pregnancy, during delivery, and after childbirth is very low. Inadequate care during pregnancy, one of the primary factors associated with high maternal mortality, is reflected in the NFHS-2 findings for the state of Jharkhand, where the maternal mortality ratio at 371 is higher than the national average. The major cause of deaths is hemorrhage, sepsis, anemia, and obstructed labor.

ITAP and the Jharkhand Health Department will launch three TV spots to increase institutional deliveries among pregnant women:

- These spots will address the NRHM safe motherhood program through the Mukhya Mantri Janani Shishu Swasthya Abhiyan (MMJSS), also known as Janani Suraksha Yojana (JSY) in other states. This scheme focuses on the objective of reducing maternal and neonatal mortality by promoting institutional deliveries and making available quality care for mothers during pregnancy, delivery, and the post-natal period.
- The Request for Proposals (RFP) *(Request for Proposals: Television Commercials on Institutional Deliveries in Jharkhand – See list of documents reviewed)* from film production houses and advertising agencies circulated by ITAP bases the communication strategy on the need to make the target audience aware of the "three main delays which prevent timely access to health care during pregnancy and delivery along with birth preparedness and complication readiness":
  - Delays in deciding to seek care: families may not be able to recognize danger signs of complications during pregnancy or delivery, may not perceive the severity of illness experienced by the mother or the newborn, may face financial constraints, may have had a negative experience with the health care system before, or may not know how to transport the woman to a well-equipped hospital.
  - Delays in reaching care: This may be because of the distance between the woman's house and the nearest well-equipped health facility, the conditions of the roads, or the lack of emergency transportation.
  - Delays in receiving care: This may be due to unprofessional attitudes of service providers, a shortage of health equipment, a lack of personnel at the health facility, or poor technical and interpersonal skills of health professionals. Birth preparedness and complication readiness is the process of planning for normal birth well in advance and anticipating and preparing for action in case of an emergency. *
- The communication goal is to promote the benefit of institutional delivery and motivate birth preparedness with complete and correct information on the provisions and facilities for institutional delivery within the scope of the JSY scheme.

- The campaign focus is on creating awareness about birth preparedness; promoting institutional deliveries; identifying warning signs of problems in pregnancy; and improving utilization of JSY benefits.

TV Spots on Birth Spacing:

Knowledge of contraception is almost universal in Jharkhand: 99 percent of currently married women there know at least one modern FP method. They are most familiar with female sterilization (98%), followed by male sterilization (96%), the pill (68%), the condom (56%), and the IUD (48%). More than one-third of them (38%) have knowledge of at least one traditional method. However, only 31 percent of married women in Jharkhand are using any method of modern contraception—much lower than the national average of 49 percent, though contraceptive prevalence is considerably higher in urban areas (50%) than in rural areas (25%). Female sterilization is by far the most popular method: 23% of married women have been sterilized. Only 1% of women reported that their husbands are sterilized. Overall, both male and female sterilization accounts for 77% of total contraceptive use. Usage rates for pills (4%), IUD (0.6%), and condom (3%) are very low.

ITAP, together with the Jharkhand Health Department, will launch three TV spots to increase the use of modern, temporary contraceptive methods among married couples. The BCC Baseline Study found that the reasons for the low contraceptive prevalence rate (CPR) in the target audience are (1) the benefits associated with birth spacing are low; (2) product satisfaction is low; (3) products are not widely available and accessible; (4) negative perceptions about modern contraceptives (pills and IUDs) are high; (5) even though awareness is high, complete knowledge is low—there are many myths and misconceptions; and (6) people lack the confidence to try new methods.

- ITAP's Request for Proposals (RFP) *(Request for Proposals: Television Commercials on Birth Spacing in Jharkhand –see list of documents reviewed)* from film production houses and advertising agencies bases the communication strategy on the need to make the target audience aware of the health benefits associated with spacing births through increased use of modern temporary spacing methods; the different spacing methods available; where to get the methods and products; the need to negotiate the number and timing of children with their family members (specifically, husbands and mother-in-laws); motivate them to choose appropriate contraceptive methods to space birth.
- The core messages will be: "If you space births and the children are born at least 36 months apart, they will be born healthy and strong"(less risk of infant mortality, low birth weight, and premature delivery; spaced pregnancies (at least three years) ensure better health for mothers—less anemia and malnutrition; couples who have smaller families are able to enjoy/provide better quality of life).
- The RFP also mentions the strategy to address a secondary target audience (healthcare providers) to enable them to provide and counsel couples on the benefits of birth spacing and help them prepare and plan; provide medical assistance to women; advise the couple to choose or continue a method; and ensure that the services are offered at convenient timings and locations.

UTTARAKHAND

The communication strategy for Uttarakhand identifies two health status indicators as priority themes on which to build communication campaigns and activities: high child mortality and morbidity, and high maternal mortality and morbidity (*Sources:*

Framework for Bridge Communication Intervention (Oct 2006–March 2007; and Activity Plan for the Bridge Communication Intervention (Oct 2006–March 2007, see list of documents reviewed). Health issues related to high child mortality and high maternal morbidity are high incidence of diarrhea, lack of care during pregnancy, high incidence of ARI, low immunization rates, undernourishment and anemia in children, high parity, and unplanned pregnancy. Other health issues are STI/RTI, HIV/AIDS, tuberculosis, and unsafe abortions.

Child Morbidity: In Uttarakhand, almost one out of five children under 5 has diarrhea at any given time; ARI affects one out of six, and the situation is worse in the Terai region. More than two-thirds of children are anemic, and 75% of these have the condition in moderate to severe form. Over 40% of children are between two and three deviation standards below expected height and weight. Only one-third of the state's children have received complete immunization. Only one-fourth of newborns are fed during the first hour after delivery; almost three-fourths are not fed until the day after delivery.

Maternal Morbidity: Almost one in two women has anemia; during pregnancy, only half of pregnant women receive iron supplements. Just over 40% receive any form of ANC. Only one in five women delivers in a health facility or institution.

Family Planning: While contraceptive prevalence is moderately high, there are gaps between urban and rural populations. One in five women expresses the need to limit or space her pregnancies. The method mix favors permanent over temporary methods. The choices seem to be limited as only three methods are registered by the NFHS. Almost 40% of women have some form of RTI.

BCC on Immunization (Source – RFP forCcommunication Campaign to Improve Routine Immunization in Uttarakhand – In List of documents reviewed): ITAP, on behalf of the Uttarakhand Health and Family Welfare Society (UHFWS), selected the services of an advertising agency through RFP to design a campaign to increase immunization in Uttarakhand. This campaign is now in the pre-testing stage. The advertising agency is BEI Confluence. The campaign is to provide complete immunization services to all children in their first year. According to the NFHS III, coverage for initial schedules (BCG and polio) was as high as 80%,; but full immunization against the six preventable diseases was only 60%. This situation seems to have largely resulted from lack of knowledge about immunization schedules, confusion about where to access immunization services, poor attitudes toward immunization among caretakers, and missed opportunities for providing information and services by health workers.

The communication strategy focuses on reducing high drop-out rates and achieving 100% routine immunization in Uttarakhand, by promoting "full immunization" for children before their first birthday; encouraging parents to "finish a series of visits" to the health centre or a place where immunization services are provided before the first birthday; and improving the image of the health workers who administer vaccines among the parents and the community.

The target audience:

- Primary: Caregivers (fathers and mothers) of children under 12 months, aged 18-30 years, living in both rural and urban areas, who have not fully immunized their children.
- Secondary: Elders in the family; village influencers, including religious leaders; and ANMs, AWWs, and ASHAs.

There is a proposed mix of below-the-line activities and IPC to support the TV spots to increasing motivation and participation of healthcare providers and in the community; leveraging social networks, festivals, and events to attract more participation to immunization sites during Routine Immunization Days; and offering incentives to parents and community outreach workers (ASHA) who will help complete full immunization of children before their first birthday.

BCC on Institutional Delivery *(Source – RFP for Communication Campaign to Improve Institutional Deliveries in Uttarakhand,* and *Presentation on Institutional Delivery Campaign by selected agency, RK Swamy BBDO, August 29, 2007—see list of documents reviewed).* ITAP, on behalf of UHFWS, selected the services of an advertising agency through an RFP to design a campaign to increase institutional deliveries in Uttarakhand. This campaign has been pre-tested and was presented to the GOUK on August 29, 2007. The advertising agency is R.K.Swamy BBDO**.** The campaign is designed to promote the NRHM's JSY scheme with the objective of reducing maternal and neonatal mortality by promoting institutional deliveries and making quality care available for mothers during pregnancy and delivery and in the post- natal period. The JSY scheme ensures referral, reimbursement, and transport assistance for all pregnant women for services provided at PHC or district hospitals.

The integrated communication campaign introduces the theme of Jug Jug Jiyo (a term with emotive appeal, which is a blessing from elders to younger family members: a prayer and blessing for a long life). The communication approach is from the well-wishers' point of view and intended to remove barriers to institutional deliveries set by community and family elders; give a communication platform for ANM/ASHA workers to further their work; and motivate pregnant women to associate institutional deliveries with health and longevity for themselves and their babies. The campaign includes TV and radio spots, posters, illuminated signs, bus panels, stickers, and leaflets.

Institutional Delivery leaflet: Front

प्रसव अस्पताल में ही क्यों?

घर पर प्रसव मां व शिशु के लिए जानलेवा हो सकता है।

प्रसव के दौरान कभी भी आपात् स्थिति आ सकती है, जिसके लिए घर पर न साधन उपलब्ध होते है न दाई सक्षम होती है।

80 प्रतिशत गर्भवती स्त्रियाँ की मृत्यु आपात स्थिति में उपयुक्त चिकित्सा सहायता न मिलने के कारण होती है।

अस्पताल व स्वास्थ्य–केंद्रो पर ऐसी स्थितियों से निपटने के साधन व डॉक्टर उपलब्ध होते हैं।

जुग जुग जीयो

अस्पताल में प्रसव, यानी जीवन का वरदान

मां-बच्चे का जीवन न डालें जंजाल में, कराएं प्रसव अस्पताल में

VOUCHER SCHEME AND SAMBHAV BRANDING

ITAP has designed a logo for the voucher scheme with the brand name "Sambhav." The name is appropriate—"Sambhav " means "possible," and the Voucher Scheme (essentially a reimbursed healthcare plan) makes quality healthcare possible for poor women who would not have been able to dream of it before. The vouchers allow women to use private clinics for certain procedures (ANC, TT, IFA, FP – sterilization + IUD, deliveries, PNC, immunization). There is no payment burden on them and the private healthcare providers are reimbursed by the government.

The creative execution is cheerful, friendly, and reassuring, since the target beneficiaries of the voucher scheme are BPL women who are being motivated to use accessible and accredited private healthcare facilities for maternal, child, and reproductive health. The branding will be a communication aid for the ASHA and ANM, enabling them to refer their clients to the private clinics with the vouchers for the procedures. A flipbook has been published as an IPC tool for ASHAs and ANM; it explains the scheme, the different categories of procedures available, and the range of services.

ASHA/ASHA PLUS TRAINING MATERIALS (HINDI)

ITAP, through professional design and training agencies, has produced attractive and pictorial IPC materials for ASHA and ASHA+ workers. These cover subjects such as:

- The five "cleans" of home delivery
- The five signs of pregnancy
- The need to immunize babies
- The need for husbands to be prepared for fatherhood
- (financial responsibility and preparedness)
- The need for institutional delivery
- The need to weigh LBW babies

- The need for pregnant women to get rest and good food
- A food chart demonstrating a balanced, nutritious diet
- Physical differences between boys and girls/growing up and the reproductive system
- Menstruation and hygiene (also demonstration of how to make a sanitary napkin at home)

UTTAR PRADESH

BCC Strategy in IFPS II: The strategy was developed after a consultative workshop with JHU CCP; and the evidence base for the strategy was the Reproductive Health Indicator Survey (RHIS) undertaken by ITAP in 2005 and published in December 2005. Key findings from the RHIS *(Source – RHIS – In List of Documents Reviewed):*

- 30 percent increase in contraceptive prevalence over eight years
- Use of modern contraceptives among married women of reproductive age up from 20.9 percent in 1995 to 27.3 percent in 2003
- Nearly half (47%) of the increase in the modern CPR a result of spacing methods
- 51 percent increase in use of condoms and oral contraceptive for birth spacing
- Major shifts toward deliveries in health institutions and births attended by trained providers—both health professionals and trained traditional birth attendants
- Dramatic increase in the number of men and women who reported being exposed to a FP/RH message in the previous month

Table 6. UP, Currently Married Women (15-49)

Indicators	Urban	Rural	Total
Women married by age 18	67.6%	83.8%	80.7%
Currently using any modern contraceptives	38.8%	23.9%	26.7%
Unmet need for spacing	11.0%	16.2%	15.3%
Unmet need for limiting	15.6%	16.2%	16.1%
2 or more TT injections	72.7%	62.4%	63.7%
Full antenatal care	14.0%	7.9%	8.7%
Institutional deliveries	41.1%	15.5%	18.9%
Deliveries assisted by health professional	57.2%	21.6%	26.3%
Listens to radio at least once a week	21.9%	20.0%	20.4%
Watches TV at least once a week	56.2%	16.1%	23.6%
Exposed to any media	65.9%	29.3%	36.1%

(Source, SIFPSA Communication Plan, Draft Report- In List of Document Reviewed)

The BCC strategy has two primary objectives that address persistently complex social and economic situations in UP:

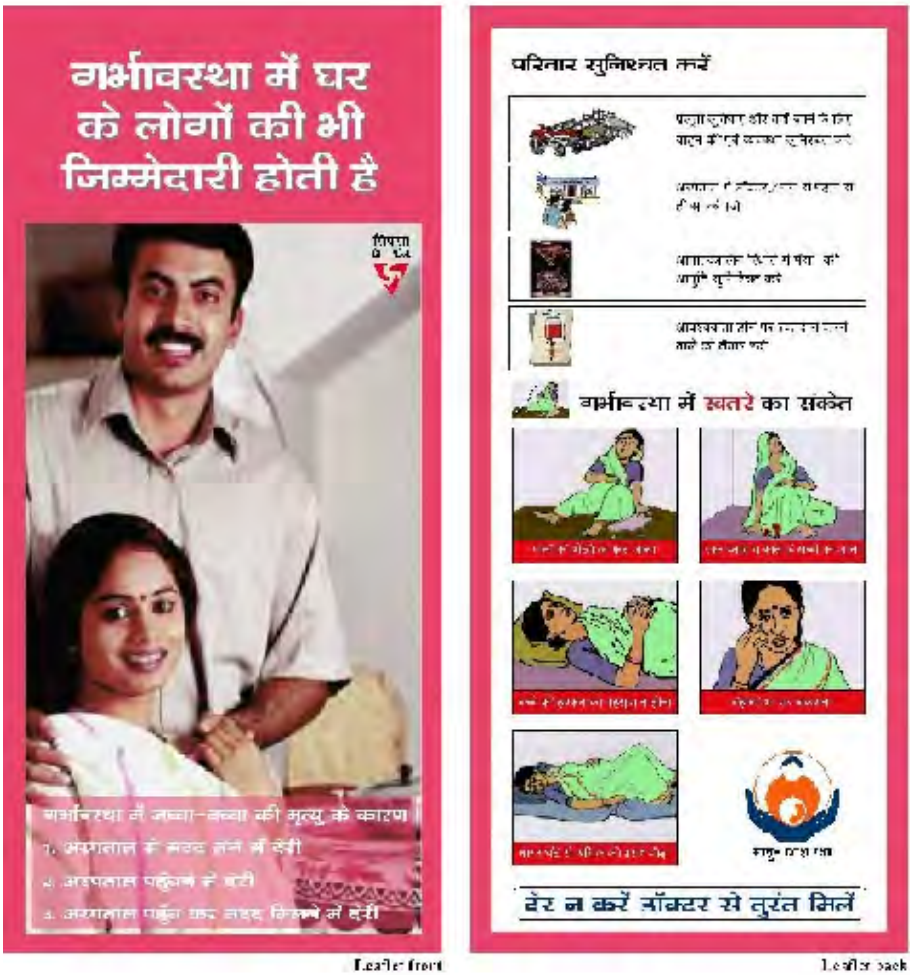
- To increase use of RH/FP services
- To increase use of child survival interventions

SOME MATERIALS FROM CAMPAIGNS IN UP:

Emergency Obstetric Care (EMOC): (Materials available on CD)

The Emergency Obstetric Care Campaign is aimed at rural and urban couples and at healthcare providers. The IEC materials are leaflets and posters. The key communication messages provide information about:

- Danger signs that signal the need to be prepared for an immediate or emergency delivery
- Signs that presage this condition
- Danger signs of a difficult birth
- The need to opt for institutional delivery
- The requirements for hygienic birthing conditions at home
- Care for the newborn (touch, warmth, breast-feeding, skin-to-skin contact)



Leaflet front Leaflet back

Leaflet (EMOC)

)

Poster (EMOC

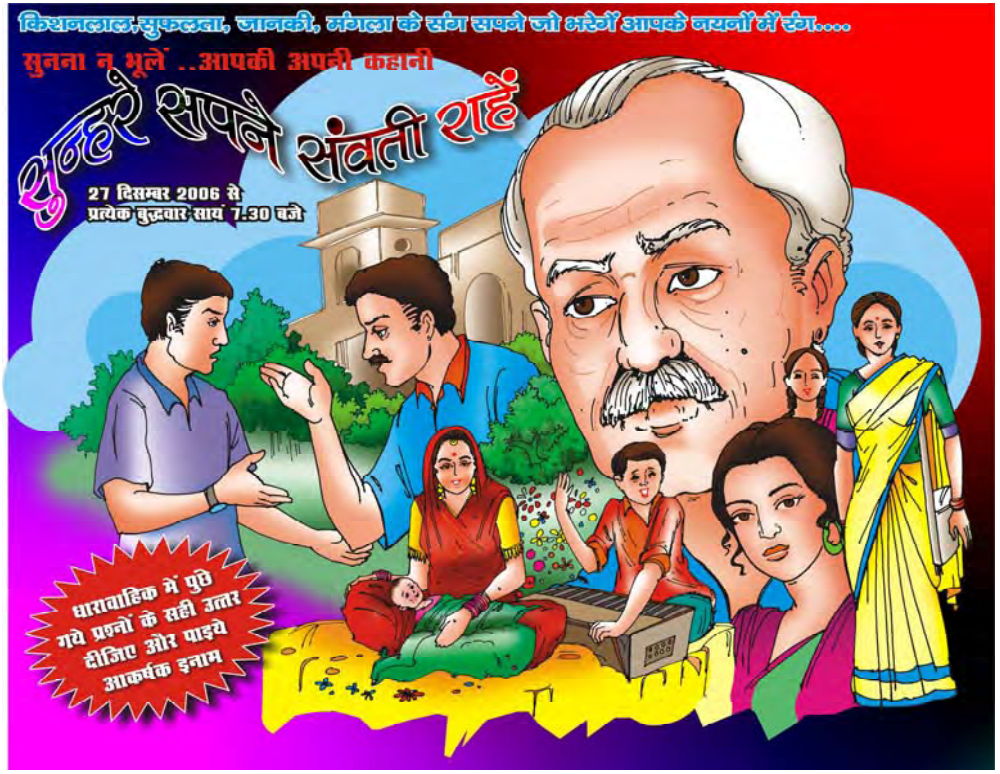
Female Sterilization (Available on CD)

The Female Sterilization campaign uses the mnemonic and logo from the earlier *Ao Baatein Karein* campaign, which had high recall among the target audience. The campaign addresses sensitive cultural issues and family dynamics between mothers-in-law and daughters-in-law, and removes fears that the sterilization procedure may be painful and debilitating. All communication materials (films and radio spots) have been professionally executed, with good production values. The themes are Teej (festival), Kamala (endorser), RCH Camp, Mother-in-Law, Daughter-in-Law, and ANM. First launched in 2006, this campaign is now being relaunched. Key messages:

- Sehat Sahi, Chinta Nahi (A healthy life is one without worries)—this line is an add-on to the Ao Baatein Karein Logo
- Bas Ek Hi Tanka—Baaki Jeevan Sukh se Kata (Just one stitch—live happily ever after)
- Chota-sa Operation—Minuton Mein Khatam (Very small operation—over in minutes)
- Na Koi Dard, Na Koi Kamjori (No pain, no weakness)
- RCH Camp—reinforcement of the multiple services available: immunization, care for pregnant women, sterilization and family planning (including IUDs)

Poster on Female Sterilization

Radio Dramas


किशनलाल,सुफलता, जानकी, मंगला के संग सपने जो भरेंगें आपके नयनों में रंग....
सुनना न भूलें ..आपकी अपनी कहानी
सुनहरे सपने संवती राहें
27 दिसम्बर 2006 से
प्रत्येक बुद्धवार सायं 7.30 बजे
धारावाहिक में पूछे गये प्रश्नों के सही उत्तर दीजिए और पाइये आकर्षक इनाम

Two radio dramas in an enter-educate serialized format of 26 episodes aired on All India Radio once a week from
January through June 2007.

- For the general public (Wednesday): *"Sunehere Sapne Sawarti Rahe."* The objective was to increase the use of spacing and permanent methods of family planning; increase the number of family members and women adopting appropriate maternal and child health practices—ANC, institutional delivery, PNC, immunization, breastfeeding, etc.; increase the number of men who are supportive and involved in FP; safe pregnancy; increase the number of people who know about the prevention of RTI/STI and HIV/AIDS. Target audience: Local influencers (teachers, political and religious leaders, community, women's groups); beneficiaries (men and women) and their families.
- For healthcare providers, ANM (Sunday): *"Darpan."* This is a distance learning program centered on the personality of the ANM with the objective of increasing her familiarity with different health issues and becoming more capable of communicating and providing health services/ counselling; and giving her confidence, an improved self–image, and a more valued position in the community.

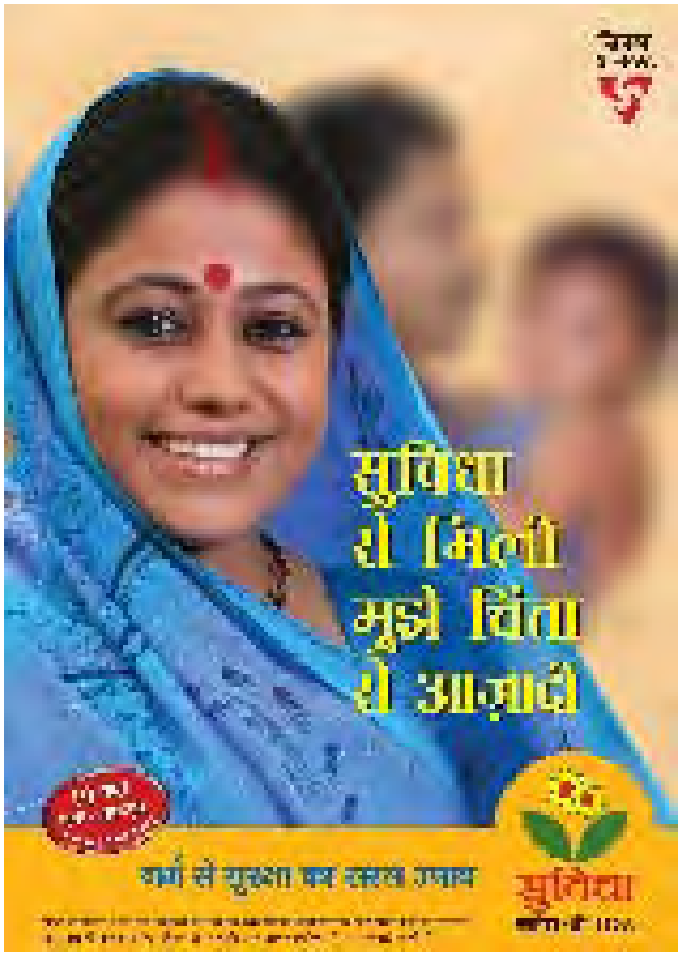
These radio dramas will now be aired for a second round. Response mechanisms have resulted in a satisfactory number of letters from listeners and a study has been undertaken for impact evaluation.

The Suvidha Campaign (Materials Available on CD)

The IUCD branding, brand positioning, and logo for the copper T IUD is backed by a sound rationale: there are target audience insights that point to the "inconvenience and bother" associated with IUD insertions in general, although no actual research or FGD studies on the insights were available for review.

- The brand name, Suvidha, denotes "Convenience."
- The happy woman on posters and films who seems to endorse the comfort and convenience of using Suvidha Copper T has a positive message to offer women in the target audience.
- Films, posters, packaging design, billboards, wall paintings, and information brochures are the components of the total communication campaign.

Suvidha Urban Poster



Suvidha Rural Poster

Suvidha Wall Chart

Flipbook for ASHAs—IPC Material

The flipbook addresses all the HRHM issues the ASHA needs to communicate to the community. These are:

- General health: safe drinking water, sanitation and waste disposal, nutrition
- FP methods: OCP, condoms, IUDs, male and female sterilization
- MCH: ANC, PNC, institutional delivery, newborn care, basic infant care
- RTI, STI
- HIV/AIDS
- Adolescent health and age at marriage
- Others: TB, malaria, blindness control, iodine deficiency, ayush

Flipbook Cover

HLFPPT Social Franchising Model

The social franchising PPP innovation of IFPS II was launched in UP on August 23, 2007. HLFPPT has developed the brands—MerryGold, MerrySilver, and MerryTarang (with a logo) for its multi-tiered network of clinics. Further communication plans are being drafted to attract patients to the clinics. These will be backed by signs, billboards, posters, and radio and TV spots to sustain the brand-building and marketing exercise.

HLFPPT Social Franchising Logo and Name—MerryGold.

Standard Days Method (SDM) & Lactational Amenorrhea Method (LAM)

These natural methods of spacing births offer a choice to people who are uncomfortable with or have never tried any other method; IFPS II has introduced them in UP because they are effective, scientific, and easy to use. Currently, efforts are being made to enhance knowledge about the methods through:

- Advocacy with government and SIFPSA officials, NGO partners, ASHAs, and others
- Training, adapting existing materials and flipbooks/job aids; CTU Training of Master Trainers (project coordinators and assistant project coordinators of NGO partners)
- New training manual in comic form
- Service provisioning: ASHAs to provide counselling and products in the community

The communication materials already published.are:

- Training tool and IPC material (pictorial format): Mala Chakra Vidhi (SDM)
- Poster: Bacche Mein Antar Rakhne Ka Ek Asaan Tareeka (SDM)
- Poster: Khushhaal Parivaar Ke Liye Aaap Apna Man Pasand Garbh Nirodhak Tareeka Apnaye (SDM)
- Brochure : Aisi Suraksha Aur Kahaan – Mala Chakra Hai Jahaan (SDM)
- Wall chart (SDM and LAM)

- Brochure on LAM

DKT International Social Marketing IEC Materials (Available on CD)

DKT International has run social marketing programs in UP before; in May 2007 it launched a new initiative for IFPS II. The objectives of the program are to increase awareness of trials and usage of condoms and oral contraceptive pills (OCP); increase availability and accessibility of condoms and OCP; and increase the number of condom and OCP brands available to the target audience to promote choice.

The social marketing campaign IEC /IPC materials are:

- TV and radio spots
- Bus panels
- Brochures and posters
- Events and market town activities
- Street plays and magic shows
- Gram panchayat meetings/community meetings
- Regular sales representative meetings with chemists, pharmacists, other condom depots (grocery stores, tea shops, cigarette shops), outreach workers, and ASHAs

ANNEX F: PUBLIC-PRIVATE PARTNERSHIP MODELS IFPS II

IFPS II PUBLIC-PRIVATE PARTNERSHIP PILOTS

One of the main objectives of IFPS II is to design, implement, and document models of public-private partnerships to improve access to integrated RCH and FP services. A comprehensive package would include antenatal services, safe motherhood, institutional deliveries, newborn care, treatment of sexually transmitted diseases, promotion of contraceptives, sterilization, emergency care, referral linkages, and behavioral change through IEC/ BCC. Six PPP models have been initiated by the IFPS-II:

- Provision of RH/FP services through a *mobile health clinic* (Ramnagar, Uttarakhand)
- Access to services in private hospitals through a *voucher system* (Hardwar, Uttarakhand, and Agra and Kanpur city, Uttar Pradesh);
- Access to services in designated *social franchise clinics* (Uttar Pradesh)
- Creating awareness and increasing access to contraceptives through *commercial social marketing* (Uttar Pradesh)
- Access to RH/FP services in remote villages through *comprehensive health and counseling sessions (CHACS)* organized by NGOs (Uttar Pradesh)
- *Contracting out* government health facilities to the private sector (Uttarkhand)

While some of these PPP initiatives are being implemented, others have yet to start. The following is a brief description and evaluation of the projects.

MODEL 1: MOBILE HEALTH CLINIC, RAMNAGAR, NAINITAL (UTTARAKHAND)

Background: With 93 percent of the terrain being hilly and sparsely populated, access to even basic health services for the people in UK is a major challenge. More than 70 percent of the population in the state are below poverty line and depend on public health services. Access to public health facilities is problematic due to distance and poor transport facilities. The problems are compounded by staff shortages; lack of equipment, drugs, and supplies; and inadequate infrastructure within the facilities. Diagnostic facilities are virtually absent in the hilly districts. Due to these complexities, the proportion of pregnant women receiving complete antenatal check up is estimated to be less than 20 percent, and about 80 percent of deliveries are at conducted at home. Only 14 percent of newborns receive any postpartum health checkups. Anemia, low birth weight, undernourishment, low immunization levels, and a high incidence of urinary tract infections (UTI) and reproductive tract infections (RTI) are major health concerns in the state. The objective and the utility of mobile health clinic need to be understood in the above context of complexities faced by the people in the region.

Project Description: The mobile health clinic (MHC) is being launched to improve access to primary care services, diagnostic services, and RCH services for people living

in two blocks of Nainital district, Ramnagar and Haldwani. The van, bought through the area development fund by the former state chief minister and fitted with diagnostic equipment in April 2006, was put under the control of the community health center (CHC) at Ramnagar, but due to a shortage of staff, the inappropriate quality of some equipment, and other administrative limitations, the van functioned for only a few months after it was put into service. After a hiatus of six months, in March 2007 the UK government, as part of the IFPS project, transferred the van to the Birla Institute of Scientific Research (BISR) to be used as a mobile health clinic under a PPP arrangement. BISR had successfully run a similar mobile health clinic for nearly five years. BISR was entrusted with the task of repairing and retrofitting the van with more appropriate equipment and obtaining necessary permission to commence providing mobile health services.

The MHC will be providing a basket of services, such as laboratory tests for blood and urine analysis; radiological diagnostics (ultrasound, X-ray, and ECG); obstetric and gynecological examinations; general physician consultation; ANC; FP services (condoms, pills, and IUD insertions), immunizations, TT injections and IFA for pregnant women, RTI/STI treatment, and IEC and counseling services. The MHC is expected to provide all these services during a one-day camp. Camps will be held at eight locations locations in the two blocks. Each month each location will host two camps at 15–day intervals. The MHC is staffed with a physician, a radiologist, a female medical officer, a health coordinator, a female health worker, an X-ray and ECG technician, a lab technician, a pharmacist, a male attendant, a supervisor-accountant, a driver, and a part time data-entry operator. The MHC will charge a registration fee of Rs. 10 for all the patients, including the BPL patients, which will be valid for two months. BPL cardholders will receive free medicines and consultations, and for other clients there are varied user charges, such as Rs. 150 for an ultrasound; Rs. 60 for x-ray; Rs. 50 for ECG; and Rs. 15 for a lab test. FP and immunization services are expected to be free, unless the products are marketed through social marketing channels. The MHC is likely to be operational soon, now that the retrofitting of the vehicle, installation of the equipment, and other formalities are being completed.

Observation: Provision of health services through MHCs has immense potential in this difficult terrain. Because UK has no medical facilities except for government primary health centers, to which physical access is not easy, MHCs offer the prospect of relief to the people in the region. The government-run PHC at Bhimtal does not have any radiological diagnostic equipment. The mobile health van (providing diagnostic services) operated by BISR for the past five years has therefore been highly popular among the people in the region, as local health officials acknowledge. Since 2002, the BISR has held nearly 900 health camps, benefiting more than 89,000 patients. The choice of BISR as the private service provider is a prudent one.

The launch of MHC has been considerably delayed for a number of reasons. Delay in the supply of upgraded equipment, retrofitting the van for diagnostic equipment and partitioning of space, acquiring a fitness certificate for the vehicle from road transport authorities, purchase of a generator and air-conditioner for the van, registration of diagnostic equipment under the PNDT act have all taken considerable time. The equipment installed earlier was of poor quality and needed to be upgraded. Another

reason for the delay may have been poor coordination between vendors, BISR, and local health officials. The MHC is a PPP initiative, but the partners do not seem to have interacted closely with one another. As a result local health officials were either unaware of or expressed serious concerns about several aspects of the project:

- Even the upgraded equipment (new specifications) to be installed was considered obsolete.
- The officials were of the opinion that the compensation package and the incentives for the medical officers and technical staff to be deployed in the MHC should be much higher than for government staff. A better compensation package, they said, would make it easier to recruit and retain motivated staff. However, this may not be possible, because the government may own the project once the IFPS involvement ends.
- Evidently there is as yet no mechanism for coordination between the local state health functionaries and the project managers.
- Concerns were expressed about the lack of training for the staff deployed in the project in community health, public health, RH, counseling, etc.
- The choice of location of the camp sites was another major concern expressed. It was suggested that the MHC camp sites should be closer to a government health facility (such as a sub-center or a PHC). Such an arrangement would not only make available the building premises (for privacy) for IUD procedures, but would also involve the ANMs or other outreach functionaries with the MHC.
- The absence of national health program component (TB, blindness control, etc.) in the range of services offered by the MHC, the absence of any formal referral mechanism between the MHC and the government or private health facilities, especially for follow up on diagnostics, and the lack of community-based outreach workers affiliated with the MHC are other issues that need to be carefully examined.

While the project document states that there will be referral linkage with government hospitals, in the past BISR had not optimized the opportunity for such referrals. Better communication between the partners will be critical for the success of the project. Attempts must be made to work with the chief medical officer (CMO) for getting medicines, contraceptives, pills, and IUD from government supplies to the MHC. At this juncture, it may not be possible for the project managers to review or revisit some of the concerns expressed about the project components, such as equipment specifications or the compensation package, But it would be highly appropriate to consider other concerns expressed by officials. Since most of the beneficiaries of MHC are likely to be using government health facilities for secondary and tertiary care services, cooperation with the district official and better coordination with local health officials will be critical.

Another major concern is the how prepared the BISR is to undertake a project on RCH and FP services. BISR is highly competent at providing diagnostic services and primary care, but the MHC project requires specialized orientation and training, including counseling and BCC skills, on RCH and FP. The project managers at BISR and the staff to be deployed in the MHC need to be reoriented toward the primary objective of the

MHC, which is providing RCH and family planning services, not just radiological services. Even the project proposal needs to clearly emphasize this core objective. RCH services would require more women staff, particularly the obstetrician/gynecologist and the paramedical staff. Such a staff composition is not clearly indicated. The staffing pattern indicated in the proposal is similar to the earlier mobile project of BISR.

Also, BISR is apparently not familiar with MIS, particularly in tracking and analyzing data on patients and types of services. The MIS format that captures RH/FP services from the MHC beneficiaries is not ready yet. The patient record slips or registration forms do not have any data fields for ANC, PNC, contraceptives, TT/IFA, immunization, etc. Without a well-defined MIS format, it may be difficult to monitor and evaluate the quality and performance of the project. The MHC does not carry any IEC materials on RH/FP. A significant opportunity for BCC will be missed if the MHC does not provide IEC on family planning.

It is not yet clear what systems are in place for supervision, monitoring, and quality control for the MHC. While the private partner's responsibilities and obligations are clearly laid out, the public partner's obligations (except for payment) are not spelled out. How operational bottlenecks or grievances, if any, are to be resolved through joint consultation is not clear either. It may be too early to consider these issues, but the project partners need to clarify these areas.

It was indicated in the proposal that, because the suspension in the van is not sturdy enough to be operational in the hilly terrain, it will be operated in easier terrain (meaning plains), so the camp sites will be in the plains. Whether this is what was originally envisioned also needs clarification. Equipment maintenance is an issue that requires attention from the project managers.

Recommendation: For any PPP model to succeed it is essential to have close coordination, trust-based relationships, and active communication channels between the partners. The MHC project presents an excellent opportunity to improve accessibility to health services in difficult geographical terrain like UK. The project is innovative and the choice of private partner has been prudent, but if the project is to realize its objectives, several shortcomings that have become evident must be overcome promptly. The following recommendations are based on our review and interaction with stakeholders:

- Create, or activate, a mechanism for closer coordination with block and district health functionaries, not just those at the state level). Hold a meeting of the co-ordination committee at the earliest opportunity. Invite key local stakeholders to the initial meetings.
- Clarify the project-related obligations of the public sector.
- Examine the suggestions about route plans and location of camp sites.
- Develop a strong communication channel with the CMO for leveraging supply of drugs, contraceptives, IFA tablets, and other requirements.
- Consider the possibility of holding some camps near PHCs or sub-centers. This may improve coordination with the public health system for referrals, outreach work, and integration with other health programs.

- Provide reorientation training to the BISR project managers and the MHC staff on RCH, FP, contraception, pre- and post-natal care, and IEC and BCC activities.
- Design a referral system between the MHC and public or private health facilities for follow-up on diagnosis, institutional delivery, sterilization, etc.
- Explore the possibility of linking with the voucher scheme for institutional deliveries in the private sector at Haldwani and Ramnagar.
- Provide immediate technical support to BISR on MIS and data management, including designing forms and formats for tracking RH/FP beneficiaries.
- Develop linkage with outreach health workers, such as ASHAs, ANMs, etc, so that the benefits of MHC camp activities are optimized.
- Design a flexible staffing pattern, especially among the women staff and clinical specialists. This may be difficult in this region where specialists are not readily available for a project like this. Better incentives could help attract and retain clinical staff.

MODEL 2: VOUCHER SCHEME (AT HARIDWAR, UK, AND AGRA, UP)

Background: Haridwar District in Uttarakhand is predominantly rural. Some of the social indicators (sex ratio, literacy rate) and health indicators for women and children (IMR, MMR, TFR, proportion of pregnant women receiving ANC, proportion of institutional deliveries, immunization of newborn) in the district are considerably worse than in the rest of the state. Nearly 78 percent of deliveries in rural areas occur at home. The lack of lady medical officers seems to influence the low institutional deliveries (6%) in public hospitals, particularly in two of the blocks of the district (Imlikheda and Bahadrabad). Though its presence is low in the state as a whole, the private sector dominates provision of services in this region.

The RH status of women in the Agra district in UP is not enviable. Despite having several public health facilities, institutional deliveries are low (33%). Key concerns in the district are the limited use of modern contraceptive methods (35%), the high proportion of women who do not get antenatal care (40%), the low proportion of fully immunized children (26%), and the very low awareness among women about STI/RTI (4.5%). Nearly 50% of women medical officer positions are vacant in public health institutions, further aggravating the problems. Most of the institutional deliveries are reportedly taking place in the private sector. That is why the voucher scheme has been chosen as a PPP mode, with the objective of improving access to RH services for pregnant women from poor families.

Project Description: Due to deficiencies in public health facilities, the poor are forced to seek services from an expensive and unregulated private sector, causing severe economic distress. The voucher scheme (modeled on similar schemes elsewhere in India), allows the government to reduce the financial burden of the poor (BPL beneficiaries) when they access services in the private sector. Through vouchers, the government can target the poor more effectively, involve the private sector in providing services to the poor without commercial loss, regulate the cost and quality of care in the private sector, avoid direct

monetary transactions, give the poor more choices, and improve access to services around the clock. The objectives of the voucher scheme project are to:

- Improve access to select RCH services among BPL families, and increase demand for institutional services in order to reduce IMR and MMR.
- Design a system of accreditation, regulation, and quality control in private health facilities involved in the scheme.
- Build public sector capacity to purchase health services from the private sector based on demand from the target groups, and create a system for identifying target groups.
- Increase the choices of service providers for patients.
- Document and disseminate the processes and the results.

The project objectives and intended outcomes are clearly stated in the proposal documents. The advantages of the voucher system are also clear. The roles and responsibilities of each partner is clearly defined. A voucher management agency (VMA), which functions under a project advisory committee (PAC) chaired by the district magistrate (DM) or CMO, controls management of the scheme, including identifying the beneficiaries, identifying and accrediting private nursing homes interested in participating in the voucher scheme, training staff of accredited institutes on quality standards, setting up a financial disbursement system for advancing funds and reimbursing private hospitals, managing project MIS, conducting periodic quality audits, and carrying out beneficiary feedback. In Agra, the state-run medical college has been entrusted with the task of accrediting, training, and monitoring the quality of services in the private nursing homes.

After accreditation, private hospitals are contracted to provide a package of RH/ FP services meeting the quality standards set out in the contract. They are also expected to conduct exit interviews of clients for their satisfaction level, maintain a system of flow of funds, maintain beneficiary information systems, submit periodic performance reports, and train their staff about the voucher scheme. The private hospitals are expected to adhere to the PNDT act.

ASHAs are the key functionaries in the voucher scheme. They are expected to disseminate information about it in the community; identify and register pregnant women from BPL families; plan for the health services the pregnant women need; distribute the vouchers; accompany the women (and their children) to the service point with the voucher; arrange for transport on the day of delivery; carryout beneficiary feedback; maintain beneficiary records; liaison with the ANMs, anganwadi workers, and other community-based functionaries; and counsel beneficiary. NGOs have been appointed as independent agencies, to coordinate between the public and the private sector and to supervise and monitor the quality of care. They are responsible for appointing, training, and supervising ASHAs in the scheme.

The voucher scheme covers a compressive package of services, including 3 ANC visits (check up, TT injection, IFA tablets, and nutritional counseling); deliveries (normal and caesarean); 2 PNC checkups; family planning (sterilization, IUD, condoms, and pills);

child immunization; RTI/STI checkup and treatment; partner counseling; and diagnostic tests. The cost of each service is clearly laid out in the project document.

The voucher scheme was launched in two blocks of Haridwar district (Imlikheda and Bahadrabad) in UK, on May 30, 2007, covering a total population of 451,743, about 151,000 of them being BPL. Seven private hospitals (including a missionary hospital) in the towns of Haridwar and Roorkee were accredited to provide services under the voucher scheme. They vary in size, structure, and type of services. So far, 48 ANMs and 447 ASHAs have been trained. Each of the private hospitals was given an initial advance of Rs. 30,000; funds will be replenished on the basis of submission of accounts. The voucher scheme at Haridwar requires exit interviews with 10 percent of the patients, semi- structured interviews with 20 percent, and quality and financial audits at six-month intervals.

The voucher scheme had already been launched on March 15, 2007, in seven blocks of Agra District, UP, which have a total population of 1.07 million, of which the 359,903 BPL are targeted). Ten private hospitals were accredited for service delivery after extensive consultations with the Agra Nursing Homes Association. The system for managing the voucher scheme is similar in both Agra and Haridwar. However, in Agra, SIFPSA (through its district project management unit, the DIFPSA) assists the CMO in managing the scheme.

In Agra, vouchers are distributed to pregnant women through ASHAs who have been selected and trained by two NGOs. SN Medical College, Agra, has been made the nodal agency for accrediting private hospitals and monitoring the quality of their service. They also conduct training programs for the staff of the facilities on quality standards. Complicated and emergency cases can be referred to SN Medical College. More than 1,500 ASHAs have been trained in the voucher scheme in Agra. The private hospitals receive supplies (contraceptives, IFA, and vaccines) from the government. When complications arise in a delivery, the patient is transported to the district hospital.

Observations:

AGRA: Ten private nursing homes have been accredited to provide voucher services. Two NGOs have been entrusted to coordinate the scheme in three blocks each, and the medical officer-in-charge of a primary health center has been asked to manage the scheme in one of the blocks (Shamshabad). It is not clear how the vouchers are distributed, collected, and reimbursed by the public hospital functionaries in this block.

Data on the number of patients targeted for ANCs and institutional deliveries for Years I and II are not easy to comprehend. It is projected that the number of ANCs to be conducted will be 3,239 in the first year and 4,860 in the second, but the number of expected institutional deliveries is 2,700 for year I and 3,780 for year II. If the average number of ANCs is likely to be three times the number of deliveries, these data need attention. PNC, on the other hand, is shown to be only 810 for year I.

From the launch of the voucher scheme on March 15 through July 31, 2007, the number of patients who used the vouchers for ANC services was 2,857 but only 351 institutional deliveries were recorded. More disconcerting is that of the 351 deliveries 154 (44%) were

shown as complicated or caesarean deliveries. The number of patients seeking for contraceptives is also very low.

It was reported that the private hospitals are enticing the ASHAs to enroll pregnant women under the voucher scheme in their own hospitals. There is an impression that if the ASHAs take the patient to the public hospital, their incentives will be influenced by the ANMs, whereas under the voucher scheme they need not worry.

Another serious concern at Agra is the lack of understanding about the voucher scheme among district officials. While the DM and the CMO expressed general appreciation for the scheme, it was apparent that they need more information. The CMO is new, and there is a need to bring him onboard through more frequent interaction and communication from DIFPSA/SIFPSA. The problem of verifying BPL status in the state is likely to be reviewed thoroughly soon.

Some of the problems in operating the voucher scheme at Agra are:

- insufficient inventory of vouchers, which seem to be always printed at the last minute
- lack of supplies of condoms, pills, and IFA tablets and vaccines from the government
- ASHAs who have been forced to issue vouchers to patients by panchayat members (up to 10% of vouchers are reportedly misused in this manner)
- some services not being covered, such as postpartum services, ICU, ventilator, and neonatal care
- no mechanism for augmenting blood supply in emergency cases
- the difficulty of ensuring uniform quality in all the participating private hospitals

The patient feedback system is not well evolved in Agra. The project management unit (PMU) at the CMO office is supposed to receive feedback from the pradhans and the NGO representative, who in turn receive it from the ASHAs. What specific mechanisms are used to compile information on deficiency in the quality of services or redress any complaints is not clear. Delays in services, unavailability of postoperative medicines, and early discharge from the hospital after caesarean delivery are among the complaints reported to the PMU. What corrective measures the PMU took is not known.

A major shortcoming has been an apparent lack of coordination between the public hospitals and the private hospitals in treating emergency patients in the voucher scheme. If the patient scheme develops complications admission to the private hospital, the public hospitals are reportedly refusing to admit, even if they are accompanied by ASHAs and ANMs.

There was patient overcrowding in the private hospital visited. The hospital receives a large number of voucher beneficiaries. It uses a separate time slot that segregates BPL patients from private patients. Long waiting time has been a particular cause for concern. There is only one gynecologist and the current workload is very high for a single doctor to manage. There is also limited waiting space. Even patients with newborn infants wait

for hours before service is provided. Nevertheless, the patients are highly appreciative of the services they receive.

The patient waiting area has tremendous potential for BCC activities, especially for display of audiovisual materials. The hospital is willing to invest in a television set, if the materials can be made available to them. This is an opportunity the project management team should seize.

At Nanglajar village in Agra district, women interviewed by the review team stated that before the voucher scheme most of the women delivered at home. But now there is clamor to go to the private hospital for deliveries. The women would rather go to the private hospital using the vouchers than to go to any other places, even if it meant losing cash incentives, i.e., they would rather go a private hospital and redeem the voucher than go to a public hospital and get paid Rs. 1400 under the JSY scheme.

In Haridwar**,** the ASHAs received complete training on the voucher scheme. They are highly enthusiastic, knowledgeable, and articulate, and show significant commitment to their work. However, their depth of understanding on FP is a different story. They also do not carry any contraceptives during field visits.

The role of the NGOs in the voucher scheme seems to be generally recognized as very effective. The NGO coordinator verifies the vouchers collected from the VMA in client homes and confirms the receipt of the service and the quality. NGOs and the private hospital reported that there are no administrative bottlenecks in working with the government.

Use of the voucher scheme in both Agra and Haridwar seem to be growing. However, there are differences in the costing of the services even between two contracts in Agra. The following table illustrates cost differences between the Agra and Haridwar voucher schemes.

Differences in the Cost of Voucher Services in Haridwar and in Agra

Service	Haridwar (Rs)	Agra (Rs)
ANC (3 visits)	40+30+30	25 Per visit
Normal delivery (including medicine and stay)	2,200	1,500*
Ultrasound	150	100
PNC (for each visit)	50	25
IUD	100	100
Caesarean delivery	8,000	5,000
Neonatal child respiratory distress	2,500	Not indicated
Sterilization	1,000	1,500*

*** These rates are different in the contract agreement with another hospital in Agra**

One component that is absent in the voucher scheme both in Agra and at Haridwar is greater attention to BCC and IEC. It would be useful to have a comprehensive plan for this and for the ASHAs to have materials to guide their counseling sessions.

In UK, universal health insurance is likely to be launched in four districts with coverage for up to Rs. 30,000 worth of services for each beneficiary. The scheme is likely to be

using the services of empanelled private providers. ASHAs are likely vehicles for the scheme, which would cover only the BPL patients. State and central government bear most of the costs; beneficiaries will pay a minimum premium. How this initiative affects the voucher scheme needs to be carefully tracked.

Recommendations:

- In Agra, there is a need for immediate attention to operational problems in the voucher scheme, among them being the high proportion of caesarean deliveries, long waiting period, segregation of BPL patients, low inventory of vouchers, and the need for a uniform quality measurement tool for all the private hospitals.
- DIFPSA and the state coordinator from SIFPSA need to invest more time in improving coordination and communication with district officials. Issues such as supply of IFA tablets, condoms, vaccines, and oral pills and referral linkages with public health facilities could be relieved with better coordination.
- The project management unit or VMA needs to more actively supervise and monitor private health facilities, patient feedback, and means of redressing grievances.
- There is also a need to review support services that may be missing from the ambit of voucher scheme based on systematic feedback from users. Newborn care is especially critical.
- In Haridwar the system of monitoring, quality control, and verification of services by the NGOs is very effective; this approach should continue to be assessed, and if successful made part of the scale-up. It may be worthwhile for the project staffs from Agra and Haridwar to meet to exchange their experiences and lessons.
- Since ASHAs are unsalaried and are paid for particular services, it is essential that these payments be prompt and reliable. Any unnecessary delay or interference from other government functionaries can quickly undermine their motivation. It is recommended that this issue be monitored carefully; the NGOs might be made responsible for this function.
- More efforts are needed to encourage the ASHAs to focus on outreach, FP, and IEC. They may need incentives to encourage people to move to modern methods of contraception, and to recruit IUD clients, in addition to the fee they currently get for sterilization. There is also a need to examine overlap in the roles of ASHAs, Anganwadi workers, and ANMs. There may be potential for complementarities.
- IEC materials, including audio and videos, should be provided for use at the private hospital.
- The voucher scheme possibly needs to be expanded to other regions in the state where the private sector is willing to be partners. However, information on the private sector, especially in UK, must be compiled before any expansion plans are considered. If the voucher scheme is to be sustained in the long term, help of mother NGOs (MNGO) would be imperative. SIFPSA may have to revisit their approach toward the MNGO scheme in UP.

- Systems for accrediting the private partners need to be institutionalized throughout the state with technical support from ITAP, local associations, and state government.

MODEL 3: SOCIAL FRANCHISING—LIFE SPRING HOSPITAL, UP

Background: Although UP has a large network of public health facilities, it is reported that only 9 percent of the population uses government health facilities for treatment of minor ailments. The economic cost of accessing health services in the private sector is enormous, with a large proportion of poor being indebted as a result. Others seek services from unqualified quacks and untrained rural medical practitioners (RMPs). Though the private sector is pervasive, its quality and cost are not regulated. A low-cost, self-sustaining network of health facilities (community based franchised clinics) as an alternative is what is envisioned as the objective of social franchise clinics.

Hindustan Latex Family Planning Promotion Trust (HLFPPT) is a non-profit subsidiary of Hindustan Latex Limited, a public undertaking. HLFPPT is an agency that is highly experienced in community-based social marketing, FP, and promotion of contraceptives; HIV/AIDS; delivery of RCH services; and providing technical expertise in public health. The agency in active in 10 different states in India. HLFPPT worked closely with SIFPSA from 1997 to 2006 in UP on a rural social marketing program to promote condoms. It also engaged as a community-based social marketing practitioner (Tarang partner), in collaborative social marketing with self-help women's groups and RMPs, and in generic social marketing. The agency also has the experience of running Vanitha clinics (57 social franchise clinics in the state of Andhra Pradesh) to provide RH services. Since its establishment in 1992, HLFPPT has grown into a large organization supported by grants of Rs. 1.3 billion. Based on the experience of running the Vanitha clinics, HLFPPT entered into a partnership with SIFPSA to create a similar model of social franchise clinics in UP.

Project Description: The project aims to create a sustainable model of health care facilities for low-income and poor people, by setting up a network of franchised hospitals offering quality RCH services at a fixed prenegotiated price. The social franchise clinics aim operate as a four-tier referral network of facilities and health posts through rural outreach—a "hub and spoke" model. At the the lowest level (L3) are the Tarang and Merry Tarang. Tarang are independent village-based rural medical practitioners (RMPs); Merry Tarang agents are Ayurveda, Unani, Siddha, and Homeopathy (AYUSH) practitioners. The Tarang who had been created by HLFPPT as part of the social marketing network in their earlier SIFPSA project.

It is proposed to appoint 10,500 Tarang or Merry Tarang agents. Tarang health posts are the first point of contact between the clients and the franchise facilities. They act as outreach workers. These community practitioners provide FP; counseling; social marketing of condoms, pills, and sanitary napkins; test kits for pregnancy and malaria; and DOTS. They are also provide IEC and act as counselors as well as referral agents for the higher-level franchised clinics.

At the next level (L2) is the Merry Silver Clinic. By the end of the project it is proposed to have 700 of these. Merry Silver clinics are fractional franchisees, run by private

allopathic doctors. HLFPPT would provide training, set the quality standards, and offer IT backup for these clinics. In addition to the services provided by the Tarangslevel, these clinics would have one or two beds and offer day care services, immunization, antiretroviral (ARV) drugs, and IUDs. They also handle ANC, PNC, and normal deliveries. They refer caesarean deliveries to the next level (L1) facilities, called Merry Gold hospitals.

It is proposed to have 70 Merry Gold hospital, one in each district of the state. Merry Gold hospitals would have 20 beds and be franchised to a field entrepreneur, with an initial investment of Rs. 3.5 millions. These hospitals are to be funded by the State Bank of India and ICICI Bank under an arrangement with HLFPPT and the entrepreneurs. HLFPPT ensures branding, marketing, quality assurance, training, and consistent pricing. In addition to what is offered by the Tarang and Merry Silver hospitals, the L1 hospitals would offer diagnostics, lab tests, deliveries (both normal and complicated), sterilization, pediatric services, well-baby clinics, and a 24-hour pharmacy. An ambulance attached to the hospital would transport emergency cases from L2 clinics.

In addition to this infrastructure, HLFPPT runs its own hospital, Life Spring Hospital (L0 hospitals). The L1 hospitals replicate Life Spring hospitals, with similar facilities and staffing patterns. To date there are two Life Spring hospitals in UP, one in Agra (commissioned in September, 2006) and Kanpur (commissioned in March 2006). These hospitals are built and owned by the HLFPPT.

The franchised clinics would provide a blend of curative and promotive services to optimally use their resources. The fee (charges) in these hospitals are 50 to 60 percent less than the market price, so that low-income patients can easily access the services. The breakeven for the franchised hospitals is expected to be 18 months, and the cash flow should be positive in four years. The L1 and L0 hospitals are expected to expand the scope of services by venturing into health insurance, telemedicine, and pharmacies. All the facilities are IT-enabled to share patient records, outcomes, costs, and benchmarks. A round-the-clock call center for emergency services is also envisaged.

The social franchising model was launched in of UP under the supervision of SIFPSA on August 23, 2007. In the first year of its operation, HLFPPT is expected to create 2 L0 hospitals, 6 L1 hospitals, 60 L2 clinics, and 900 tarang health posts in six districts. It is also expected that in year 1, the project will conduct 4,315 deliveries and 25,220 ANCs.

Observations: Since the project was been only two weeks old, it is too early to review and draw lessons. However, the review team did have some concerns.

Established in September 2006, Life Spring hospital in Agra is one of the L0 hospitals. The hospital has 20 beds and is capable of providing ANCs, delivery, FP, sterilization, radiological services, pathological services, immunization, and a range of other RCH services. The hospital employs more than 25 staff, including 7 medical officers and 2 outreach workers. The fee for a normal delivery is Rs. 1,499, the same as in the voucher scheme. Although the hospital does not distinguish between BPL and non-BPL patients, the BPL patients who self–declare receive a 10 percent discount. The hospital is supposed to have a minimum bed occupancy rate of 20 percent, and in best seasons up to 70%. So far, 90 percent of deliveries at the hospital have been normal ones. The hospital generates

a monthly income of Rs. 75,000; its monthly expenditure is Rs. 225,000. Staff members are hired on a yearly contract. Every day the hospital receives 10 to 15 outpatients and 1 or 2 inpatients. The hospital conducts free OPD on the 9th of every month.

The low use of such a large health facility with excellent infrastructure should be a major cause of concern. Despite having 20 beds in the hospital, both semi-private and private rooms, there was not a single inpatient when the review team visited the hospital. Even outpatients were not seen at that time of the day. The staff were not clear about the notion of social franchising or their future role in the project.

The social franchising model proposed by HLFPPT is extremely impressive, but the experience of Life Spring hospital at Agra needs to be carefully reviewed to identify lessons and scope for improving the performance of the business model. It is apparent that there has been no brand building or brand communication. It may be prudent to review the brand positioning and market segmentation for this L0 hospital at Agra.

It is not clear how the franchiser will handle the revenue (royalty/license fee or profit sharing). It was stated that the revenue from the first three years of the project would be earmarked in a corpus fund. The project will continue to operate from these funds through the fifth year (when cash flow would become positives); so far this is all is hypothetical and requires intense monitoring and follow up.

Overheads on staff salary could be another area of concern in the L0 and L1 hospitals, especially the support staff. It might be wise to rationalize rationalization by analyzing job profiles and the estimated workload of each staff member.

Recommendations:

- The project has enormous scope, but to succeed it requires brand building, marketing, linkage with other national health programs, and possibly other innovative mechanisms to attract larger numbers of patients. Location of the clinics and hospitals (accessibility for poor households), which is critical for the success of the project, needs to be based on a patient flow study. Whether to locate outside the town or city needs to be decided on sound analysis of the health services market rather than other considerations. This point need to be impressed upon the franchisees.
- For long-term sustainability of the hospital, it would be prudent for it to tie up with the voucher and JSY schemes, or joint with the employee state insurance (ESI) scheme or even public companies for their employees.
- The project will require intense supervision and monitoring and a flexible management structure in order to identify bottlenecks and implement solutions.
- Areas of cost control and optimal deployment of resources, including human resources, should be revisited.

MODEL 4: NGO-BASED CLINICS: CHACS (COMPREHENSIVE HEALTH AND COUNSELING SESSIONS), AGRA AND KANPUR

Background: One of the major challenges in providing health services in rural UP is to reach remote villages, where about 80 percent of the people live, and urban slums, where

another 5 percent live. The IFPS project recognized the importance of NGOs in reaching out to remote villages. In IFPS I, SIFPSA initiated involvement of an NGO to pilot community-based, RH services, and regular counseling through camps. This project validates the feasibility and impact of using volunteers to provide FP/RH services at the community level.

Project Description: The IFPS II NGO projects were started in October 2006; so far 24 NGOs have been contracted to cover 45 rural blocks and two urban slum areas in 11 districts of UP. In this phase the NGO projects were redesigned to offer a wider range of services, use innovative locality-specific approaches, and target larger populations. The NGOs organize and schedule Comprehensive Health and Counseling Session (CHACS). Each CHACS project area contains 20,000 people. The project engages a woman medical officer and a community health nurse or ANM.

CHACS are expected to provide counseling and IEC on RCH, ANC, TT vaccination, and IFA distribution; promote institutional deliveries and immunization for children; distribute pills, condoms (either free or under social marketing brands), and IUDs; make referrals for sterilization and offer screening and referral for STI/HIV, distribute ORS follow up on PNC/OCP/IUD and sterilization clients, offer basic curative and referral services; partner with private clinics for clinical services (using vouchers), and mobilize community support. A minimum of 10 CHACS are to be organized every month at predecided locations in each block.

As the NRHM instituted a new ASHA cadre, the NGO projects were revised to include linkages with the ASHAs. The NGOs train the ASHAs, who in turn register pregnant women and refer them to either accredited private institutes (using vouchers) or to a public health facility. The project coordinator links up with the CMO or local PHC/CHC for the supply of vaccines, IFA, ORS, IUD, and contraceptives. The NGO may charge a registration fee of Rs. 2 to 5 for its services. The NGOs hire community-based workers and other project staff. Staff from SIFPSA/ DIFPSA periodically evaluate how the project is functioning. Records to be maintained by the project staff, job descriptions and MIS forms and formats are clearly spelled out in the contract.

Observations: The projects are scheduled to end in September 2007. The evaluation team visited two NGOs in Kanpur (one slum-based and the other rural-based) and one in Agra (rural-based). Both the NGOs in Kanpur use either their own community ORVs in urban areas or ASHAs in rural areas for motivating clients, providing spacing methods, such as pills and condoms, and referring for clinical methods to the ANM or doctors in private and public clinics. The ORVs and ASHAs also provide ANC counseling and IFA. Where feasible they escort clients to clinics for institutional deliveries and for other clinical services, such as IUD insertions and sterilization. They also refer child clients for immunizations and TTs. ASHAs or ORVs also escort or refer clients to these CHACS for services. The ASHAs or ORVs are supervised by NGO supervisors, who are in turn supervised by the NGO APC and PC. SIFPSA offers the NGOs technical assistance in training, supervision, management systems, and M&E.

So far, ASHAs have been trained in only module 1 out of 5 by SIFHW. SIFPSA was allowed to use its own curriculum for ORVs and do only minimal additional training for ASHAs. Neither the SIFPSA nor the SIFHW training seems to be of the same quality as

the ITAP training of ASHA Plus in UK. ASHAs and ORVs have not received any IEC materials or tools to date. The flipbook published by SIFPSA is not yet in the program. Moreover, it needs some revision because of technical errors. For example, the pictorial depiction of all services provided by ASHAs on the first page does not have FP. The amenorrhea criterion, the most important one for LAM, is missing, and FP is not included in the pictures related to postpartum services.

Remuneration for IUDs and sterilization far outweigh the minimal margin the ORVs and ASHAs are allowed for pills and condom sales. This may distract from promotion of short-term spacing methods. There are also general problems with ASHAs getting reimbursed by the public sector. Another major issue for the ASHAs is lack of transportation for institutional deliveries for their clients. The relationship between the ANMs and ASHAs may also be a problem.

Building on lessons from IFPS I, SIFPSA has a good process for involving both new and experienced NGOs. NGO staff, ASHAs, and ORVs seem to be highly motivated, committed, and knowledgeable about the objectives of the project. CHACS are being held regularly in good locations, such as schools, and are drawing large crowds. Although only the PCs, APCs, and supervisors have been trained in the SDM, many of the ASHAs are already aware of the method and are eager to provide it.

In rural Agra NIRPHAD is the NGO entrusted with the task of organizing CHACS. It has been active in development field for more than 35 years, runs three hospitals in the district, and is also active in the Agra health project in 35 urban slums. The LMO is paid Rs. 800 per day, and the ANM gets Rs. 300 for each camp day. The camps are organized at the school in the village once a month. Government medical officials provide the list of places where the camps are to be held. Sometimes, the camps are held in two places in the same vicinity to give people better access.

The two camps held at Sikandarpur village is well–attended by an average 80 patients, of which 70 patients are reportedly women and children. Others visit the camps for general medical advice. The camps are meant for both BPL and non-BPL patients. The men interviewed by the review team were aware that the camp is primarily meant for women and children; they also complained that the camp provides only prescriptions, not medicines. The nearest medical facility for the village is 12 kilometers away. There is a subcenter in the village, and the ANM is reportedly providing immunizations. Water-borne diseases are most common in the village.

The women were well aware of the range of services provided in the camp. They were appreciative of the camp but wanted a broader scope of services that would also serve men. It was suggested that the frequency of the camps be increased. Several women agreed that the ASHAs are helping them to get ANCs and register for delivery through vouchers. The women, while praising the scheme, complained that the vouchers do not cover medicines in complicated situations (for example, it was recommended that one of the women with Rh-negative blood group get 10 folic injections costing up to Rs. 1,000).

The MIS reporting format given to the NGO for monthly reporting needs revision. Not only is the current format confusing, but several discrepancies were noted. Similarly, supervision of the project from SIFPSA office requires greater attention.

Recommendations:

- The quality and impact of ASHA training in all three states needs to be assessed once all the modules have been implemented.
- All projects identified a deep need for male volunteers. SIFPSA should help NGOs build on past experience with male volunteers and add them to any future program.
- ASHAs and ORVs should be given IEC materials and other tools. The flip book needs revision in the next phase.
- SDM and LAM should be added to the NGO projects in all three states.
- There need to be innovative ways for reimbursing ASHAs and ORVs and giving them credit for pill and condom clients.
- There are many opportunities to incorporate a broader spectrum of postpartum services, especially FP/RH, in the NGO programs. Postpartum FP should be a high priority.
- There need to be means for providing transport for institutional deliveries.
- There should be follow up of the serious issues and recommendations identified in ITAP's recent assessment of NGO projects and SIFPSA's management.

MODEL 5: CONTRACTING OUT A PUBLIC HEALTH FACILITY IN UK

Background: Contracting-out is one of the most predominant forms of PPPs throughout the world. In this model, a public health facility (either a PHC or a CHC) is completely handed over to a private partner (generally a not-for-profit agency), who runs the health facility and provides the local population with all the services the health facility can be expected to provide. The private partner is allocated a fund that is equivalent to the government budget for the health facility, covering staff salary, supplies, and maintenance costs. The government provides equipment, medicines, and fuel for an ambulance, if any. The private partner is expected to hire staff and deploy them according to health facility norms.

This model has been successful in several states in India, particularly Karnataka and Gujarat, but there are several complex issues associated with contracting. The choice of private partner; the perception of stakeholders in the local community that this may be an attempt at privatization; political commitment; the degree of trust and the relationship between the partners; the administrative autonomy of the private partner in running the facility, defining performance outcomes, and monitoring the quality of primary care services; the method for settling disputes between the partners; and the payment mechanism are critical issues that must be dealt with directly.

The state of UK decided to contract out all health institutions in Yamkeshwar Block in Pauri district, the constituency of the current health minister. ITAP had compiled an assessment of the facilities, including infrastructure, human resources, and level of facility performance, and a draft contract had been prepared. The minister is cautious about proceeding with the partnership initiative, fearing opposition, but the health

secretary is very keen to initiate this project and is looking for technical support from ITAP in choosing a right kind of contracting model.

Observation: Contracting out public health facilities is sensitive. Unlike in other states, in UK there is no popular or statewide NGO or private provider who could be approached to run government facilities. The government wishes to carefully study different models of contracting before choosing one. Though there are models of contracting operating in Karnataka, Gujarat, and Andhra Pradesh, it was agreed that a state team headed by the minister will visit one or more states to understand the dynamics of model. It is likely that this cause more delay. However, the state is positive about contracting.

Recommendation:

- The UK ITAP has several opportunities to provide technical assistance to the state government, which is keen and willing to pilot several innovations. The ITAP would be well advised to put together background materials quickly. For example, it could compile a database on private organizations (both profit and nonprofit) in the state, help the state choose the right contracting model, provide a rapid assessment of best practices and lessons from the voucher scheme, and draw up a model profile of ASHA Plus (in terms of skills, competencies, training, incentives, etc.) so that ASHA Plus is more widely accepted by the state. The ITAP could also build bridges so that the private sector and the government could recognize each other's needs and willingness to work together.

MODEL 6: COMMERCIAL SOCIAL MARKETING (CSM), UP

Background: High fertility rates, low contraceptive prevalence rate, low age at marriage, and absence of modern spacing methods are some of the major challenges for FP/RH services in UP. One of the main objectives of the IFPS II project is to increase demand for and improve access to RH products and services through innovative social marketing mechanisms using PPPs. In rural UP use of modern methods of contraception is very low. A large majority of contraceptive users rely on the private sector for supply of these products.

Another distressing trend has been a steady decline in the total sales of condoms and oral pills, especially in rural areas of UP, over the past three years. However, in category C and D villages, sales of oral pills and condoms have been increasing. To arrest the decline in the sale of contraceptives in rural UP and increase the proportion in C&D category villages, the IFPS II project sought the services of DKT India to promote social marketing of RH products. The objective at this stage of the project is to improve contraceptive prevalence.

To increase awareness of and demand for RH products, various communication strategies have been adopted sensitize, inform, and encourage the use of contraceptives and modern methods of FP. Mass media through radio spots, television spots, press releases, advertisements, billboards, bus panels, and wall paintings have been used extensively. Also common are market town activities, such as village road shows (with gifts and contests), street plays, magic shows, folk media puppet shows, community meetings, and

meetings with representatives of gram panchayats (village councils), shop keepers, anganwadi workers, rural medical practitioners, and local NGOs.

Project Description: DKT India (operational since 1992) is a subsidiary of an international agency well known for its social marketing projects in Africa, Asia, and Latin America. Approved as an authorized Social Marketing Organization by the GOI Ministry of Health and Family Welfare (MoHFW), DKT India has had extensive experience in social marketing of condoms and oral contraceptives in more than 18 states in India, reaching more than 600 million people. One-third of its sales are in rural areas of India. DKT India has two major brands, Zaroor condoms and Choice pills.

In IFPS II (Project Saksham), DKT has been entrusted with the task of reaching out between April 2007 and March 2008 to 69,000 category C and D villages in rural UP; achieve sales volume of 145 million condoms and 2.82 million cycles of contraceptive pills; and achieving a penetration of 50% of C and D category villages in rural UP. It has also agreed to conduct 350 market town activities, 234 TV spots, 1,350 radio spots, 1,200 community meetings, and 150 gram panchayat meetings by December 2007. DKT is also expected to conduct meetings with retailers, training of anganwadi workers, NGOs, doctors, and RMPs. In addition to commercially marketing its own brands, DKT also promotes free brands, such as Nirodh deluxe condoms and Mala D oral pills supplied by the MoHFW.

DKT's conducts activities at weekly markets and uses events like street plays, magic and puppet shows, contests, and gifts to attract the people. The entertainment programs are laced with serious messages on FP, RH, nutritional advices, general hygiene, and messages on safe sex; during the show pills and condoms are sold at stalls. Market town activities are held in cooperation with local retailers, medical practitioners, and health functionaries. Over 142 market town activities have been held so far, attracting more than 100,000 people. Another 558 market town activities are planned—well above the target set in the project. To sensitize local community leaders and elected representatives, 66 gram panchayat meetings have been held, with a total of nearly 800 panchyat members participating; another 284 are planned. More than 2,500 community meetings have been conducted, with an average of 15 participants each. DKT has also held 24 retailer meetings 15 meetings with anganwadi workers, and has contracted for bus panels on 32 buses, 1,278 radio spots, and 79 television spots.

Observations: DKT international uses multiple agents to promote use of condoms and oral pills, from ASHAs, anganwadi workers, outreach workers, medical practitioners (modern and village RMPs), and retailers on through their own sales representatives. Sales representatives and outreach workers are paid a monthly salary; anganwadi workers are given strips of oral pills in place of any travel allowance; RMP are paid a travel allowance; the retailers get an incentive of Rs.4 for a packet of oral pills and Rs. 2 for a packet of condoms. The agency also conducts lucky draws with prize coupons for audiences at village and road shows.

Because the social marketing strategy is a push campaign, it is not clear how the number of sales relate to the beneficiary count. While the number of condoms to be sold is easily targeted and achieved, it might be worthwhile to study the ratio of condoms sold vis-à-vis the number of beneficiaries reached.

Recommendation:

- Social marketing is achieving desirable targets, and DKT's strategies have been working well. However, information about the cost/benefit aspects of each of their strategies could be highly useful for optimizing benefits.