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FROM POLICY TO ACTION

Using a Capacity-Building and Mentoring Program to Implement a Family Planning Strategy in Jharkhand, India

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The Health Policy Project worked closely with experts in the Department of Health and Family Welfare, Government of Jharkhand (India), to develop and implement a capacity-building program. The program's goal was to strengthen the management skills of departmental, district and block staff to implement Jharkand's family planning strategy. The capacity-building program involved developing a comprehensive management training curriculum, using the curriculum to train department, district and block staff, providing mentoring and supportive supervision during field visits, and strengthening linkages and partnerships for better multisectoral coordination. This body of work, along with the collection of considerable input from stakeholders, was designed to ensure effective implementation of the family planning strategy in three pilot districts and subsequent scale-up by the state government.

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EXECUTIVE SUMMARY

Background

Jharkhand is one of eight states in the "Empowered Action Group" designated by the Indian government to receive special development assistance. When Jharkhand was formed, in 2000, it suffered from high levels of malnutrition and poverty, low levels of literacy and per capita income, and severe income inequality. In the years since, the state has made encouraging progress on key development indicators, including health. Rates of skilled delivery and immunization have increased, the treatment success rate for communicable diseases such as tuberculosis has improved, and the prevalence of leprosy has declined.

Family planning (FP) and reproductive health (RH) are priorities as Jharkhand seeks to meet the United Nations Millennium Development Goals for maternal and child health. In 2004, the state formulated its Population and Reproductive and Child Health Policy, aiming to achieve a total fertility rate (TFR) of 2.1 by 2020. (As of 2011, the TFR was 2.9.) To strengthen the health system, under the National Health Mission (NHM), Jharkhand placed managers responsible for planning, implementation, and monitoring at the state, district, and block administrative levels.

Despite these efforts, demand for and use of RH services did not increase. Thus in 2010, the state, with assistance from the Health Policy Initiative of the U.S. Agency for International Development (USAID), designed a strategy consisting of nine interventions to reduce unmet need for spacing and permanent FP methods:

- Increase the age at marriage and delay first pregnancy.
- Promote use of spacing methods.
- Promote long-acting permanent methods, to meet the demand for limiting births.
- Integrate FP and maternal, newborn, and child health.
- Foster male engagement.
- Reach out to the rural and urban poor and marginalized populations.
- Increase involvement by the private sector, nongovernmental organizations, and public-sector undertakings.
- Coordinate with other departments.
- Adopt an effective communication strategy.

A year later, the state asked the USAID-funded Health Policy Project (HPP) to design and implement a capacity-building initiative for the FP program's state-level oversight team (the Family Planning Cell) and for the district- and block-level managers responsible for carrying out the FP program.

From September 2011 to September 2013, HPP conducted a needs assessment of the capacity of the FP Cell and district- and block-level staff to carry out the FP strategy and developed and implemented a plan to address gaps. The plan had four components:

- Develop a comprehensive curriculum—a training resource—especially for FP.
- Build skills and competencies through training workshops.
- Provide mentoring and supportive supervision in places of service delivery.
- Strengthen linkages and partnerships for greater multisectoral coordination.

In collaboration with the state's Department of Health and Family Welfare (DOHFW), HPP implemented the training and mentoring program in Simdega, Giridih, and Chaibasa—districts of special concern. HPP worked with two civil society partners: Child in Need Institute (CINI), a local civil society organization (CSO) with extensive experience in the public health sector, and Public Health Resource Society (PHRS), a network of public health professionals.

Key Points

HPP's capacity-building plan assumed that the state leadership in Jharkhand would continue to support the mandate of the FP Cell, to make FP a high priority, and to invest in improving institutional and systems capacity after one year of HPP support. The plan attempted to minimize the risk that technical support would lapse, by establishing partnerships with state organizations, which could carry out individual and institutional capacity building as needed.

The core of HPP's program and approach was to institutionalize capacities and foster partnerships and linkages at the state and district level to achieve sustainable improvements. HPP conducted a state assessment to identify key government offices and CSOs as potential partners to implement the program. Institutionalizing capacities depended on selecting the right mix of experts to serve as master trainers: the "state resource group." Based on the results of the assessment and in discussion with the DOHFW, 16 people were identified, representing

- Staff of the FP Cell
- Medical officers in-charge from district facilities (to strengthen capacities at the district level)
- Representatives of state- and district-level CSOs (chosen for their proven track records in implementing health and family welfare programs at the community level and experience in working with the government health systems)

HPP, together with national- and state-level experts, facilitated a four-day workshop to train the master trainers. There, the participants also developed a measurable action plan to improve the FP Cell's management capacity.

In turn, the master trainers conducted training workshops in the three districts for a total of 65 district- and block-level health employees. The workshops followed a team-building model, bringing district managers together for planning and allowing block-level staff to discuss programmatic barriers with district staff and identify solutions.

The most important component of the capacity-building plan was mentoring and supportive supervision. The objective was to help the district team to carry out the action plans developed at the district workshops, focusing on the following health system needs:

- Improving the quality of FP services
- Improving data quality of the health management information system
- Improving community monitoring mechanisms
- Increasing demand-generation efforts for FP
- Managing human resources effectively to improve service delivery
- Fostering collaboration with other departments

Just as mentoring and supportive supervision were necessary measures to bring about positive systemic changes, dialogue and advocacy with the state and district leadership were necessary to create an enabling environment for policy implementation. To that end, HPP worked with the FP Cell to convene a "Caucus on Health Systems Strengthening and Effective Management," to bring state-level decisionmakers together with state- and district-level implementers to review improvements, discuss operational barriers, and consider policy changes.

Findings

As part of their mentoring and supervisory visits to health facilities, the master trainers reported the gaps and barriers they observed, the solutions that were decided, and the actions that were taken. The data analyzed from the master trainers' reports showed improvements in the following areas:

- Quality of services at each facility with respect to improved supplies of FP products
- Human resources and training
- Fund utilization
- Community participation
- Behavior change communication to generate demand for FP
- Overall management

The biggest impacts of the mentoring and supportive supervision program were:

- Improved conditions and functioning of health facilities
- Better quality of service delivery and staff behavior
- A more open and enabling environment for collective problem solving by facility staff

As a result of these improvements, participants in the Caucus on Health Systems Strengthening and Effective Management decided to scale up the training and mentoring program to eight additional high-priority districts in Jharkhand. Between March and April 2014, 169 district and block level managers were trained in the scale up between March- April 2014.

The supportive supervision tool, Manager's Tool, has been adapted by the state and is being used in its review missions to identify gaps and best practices and provide on-the-job support to district and block functionaries.

Conclusions

The unique aspect of the capacity-building program is its focus on mentoring and supportive supervision, providing an opportunity not only to monitor the program but also to overcome barriers and challenges. The experience of HPP and its partners in Jharkhand points to the following tasks that should be part of any effort to take this approach to scale:

- Seek ownership at the highest level.
- In collaboration with participants, identify goals and expectations early in the project.
- Use existing institutional mechanisms to review progress.
- Build partnerships and linkages to institutionalize capacities.
- Create opportunities for dialogue to keep participants engaged and informed.

The most important lesson learned is that capacity building at the individual, organizational, and institutional levels is critical for the implementation of policies, and to ensure good governance including social participation. A health systems approach to implementation of the family planning strategy or any health program is critical and the six WHO building blocks (service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/governance) provide a good framework for projects to work with. There is an urgent need to strengthen the skills of program managers, data managers, and service providers (facility managers) to understand health systems and manage effective implementation of strategies and programs.

All capacity strengthening initiatives should include formal trainings and be supplemented with mentoring support, supportive supervision and on-the-job training to build on old and newly acquired knowledge, skills, and attitudes. Although the period of implementation was short, the Managers' Tool was effective as a checklist and discussion guide, a tool to record improvement, and to identify gaps, best practices, and solutions to local problems. The assessment also highlights the importance of instilling and encouraging a culture of supportive supervision rather than fault finding. Data use at all levels in the health system—community workers, hospital staff, program managers, and decision

makers—along with establishing platforms and systems to analyze data and use them for decision making, are critical to implementation of the strategy.

ABBREVIATIONS

ACMO	additional chief medical officer
AHS	annual health survey
ANM	auxiliary nurse midwife
BCC	behavior change communication
BPM	block program manager
CHC	community health center
CINI	Child in Need Institute
CSO	civil society organization
DOHFW	Department of Health and Family Welfare
DLHS	district level household survey
DPM	district program manager
DPMU	district program management unit
ECP	emergency contraceptive pill
FP	family planning
HMIS	health management information system
HPP	health policy project
HSS	health systems strengthening
IEC	information, education, and communication
IUCD	intrauterine contraceptive device
MOHFW	Ministry of Health and Family Welfare
MOIC	medical officer in-charge
MNCH	maternal, newborn, and child health
NGO	nongovernmental organization
NRHM	National Rural Health Mission
OCP	oral contraceptive pill
PHC	public health center
PHRS	public health resource network
PIP	program implementation plan
PPIUCD	postpartum intrauterine contraceptive device
QAC	quality assurance cell
RCH	reproductive and child health
RKS	*rogi kalyan samiti* (hospital management committee)
RH	reproductive health
RMNCH	reproductive, maternal, neonatal and child health
SC	subcenter
SPMU	state program management unit
SRG	state resource group
SRS	sample registration survey
TFR	total fertility rate
TOT	training of trainers
USAID	United States Agency for International Development
WHO	World Health Organization

1. INTRODUCTION

Jharkhand was formed just over a decade ago (2000) out of parts of south Bihar, combining the regions of Chotanagpur and Santhal Pargana. Given its provenance, the state began with an adverse legacy of high levels of malnutrition and poverty, low levels of literacy and per capita income, and high income inequality. Jharkhand's story is changing, and the state has made encouraging progress on key indicators, including health. Jharkhand has seen improvements in maternal and child health, as measured by increasing rates of skilled delivery and immunization from 2000 to 2012; in the expansion of services for communicable diseases such as tuberculosis, as measured by increases in the treatment success rate from 83% in 100 TB patients in 2007 to 86 in 2011; and in the prevalence of leprosy, which declined from 1.1 per 1000 population in 2007 to 0.59 in 2011 (Sample Registration Survey, or SRS, 2011).

Source: Health Policy Project

Among the factors accounting for Jharkhand's success have been a) the state's budget allocations for health, which have risen from levels far below the national average in 2000 to among the highest per capita in the nation (*Reserve Bank of India Bulletin*, 2010) and b) partnerships with nongovernmental organizations (NGOs) and civil society to expand the reach and supply of health services to rural households. Yet successful implementation of Jharkhand's health and reproductive and child health (RCH) policies has been hampered by a lack of human resources. According to the Ministry of Health and Family Welfare (MOHFW; 2012), there is an acute shortage of specialists (including obstetricians, gynecologists, pediatricians), other medical practitioners, paramedics and other health providers. Under the National Rural Health Mission (NRHM), the state has established state, district, and block program management units, which position managers at each of these administrative levels to support the health and family welfare program through planning, implementation, and monitoring. This relatively new cadre in the workforce aims to strengthen the health system.

There is strong recognition within policy circles that institutions implementing policies and programs in the Empowered Action Group states,[1] which include Jharkhand, need to be strengthened to improve the quality and efficiency of services and access to them (*Indian Journal of Pediatrics*, 2006; World Bank, 2007). Jharkhand has identified family planning (FP) and reproductive health (RH) as its priority health service areas to achieve the United Nations Millennium Development Goals in maternal and child health. The state formulated its Population and Reproductive and Child Health Policy in 2004, with the objective of achieving a total fertility rate (TFR) of 2.1 by 2020. In the years since, it has developed strategies and operational plans for health and family welfare.

State Context

Jharkhand has a diverse geography of hills and forest reserves. According to the Census of India for 2011, the population of Jharkhand is 33 million; about 25 percent are indigenous tribes. Although the state is rich in mineral resources, 36 percent of the population lives below the poverty line (Planning Commission, 2011).

The overall TFR of Jharkhand is 2.9 (SRS, 2011) but ranges from 2.4 in urban areas to 3.3 in rural areas. Forty percent of births are higher order (triplets and above). Even though awareness of modern contraceptive methods is widespread, uptake of FP methods is low. According to the Annual Health Survey (AHS, 2011–12) (ORGI, 2012) Jharkhand's TFR is 3.1 that varies from 2.4 in urban areas to 3.3 in rural areas; 40 percent of births are of higher order (3 and above); 30 percent in urban Jharkhand and 43 percent in rural Jharkhand; 61 percent reported wanting no more children; and the median age at first live birth is 21.6 years. Modern contraceptive use is only 38 percent, 35 percent in rural areas and 47 percent in urban areas; use of modern spacing methods is low (8.3%) leading to a high unmet need for contraception stands at 31 percent, unmet need for spacing is 16.2 percent and limiting is 14.3 percent. Not just fertility indicators, Jharkhand's maternal mortality ratio (MMR) is high at 278; infant mortality rate (IMR) is 41/1000 live births; neonatal mortality rate (NMR) is 26/1000 live births; and under-five mortality rate is 59/1000 live births.

These figures point to Jharkhand's challenge to achieve the desired fertility rate of 2.1.

[1] The Empowered Action Group (EAG) was set up in 2001, to facilitate preparation of area-specific programs in eight States, namely, Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand which have lagged behind in containing population growth to manageable levels, under the MOHFW. The eight states are called the EAG States.

Evolution of Jharkhand's Family Planning Policies and Program

Jharkhand's Population and Reproductive and Child Health Policy, formulated in 2004, outlines the state's commitment to provide high-quality RCH services, following a life-cycle approach to reduce maternal and child mortality and morbidity. The policy focuses on gender and human rights issues and on services to disadvantaged groups and adolescents, with the aim of eliminating discrimination in the provision of RCH services at all levels and in all sectors. Despite policy directions and government efforts, demand for and use of RH services have not increased. The unmet need for FP (31% in AHS, 2011–12) was especially high in rural areas, owing to such factors as sociocultural beliefs and practices, the early marriage of girls, adolescents experiencing child birth, low male engagement, and weak health systems affecting service delivery.

In 2010, the state—with assistance from the Health Policy Initiative[2] of the U.S. Agency for International Development (USAID)—formulated a state Family Planning strategy to reinvigorate its FP program. The evidence-based strategy, developed with multisectoral participation, advocates two goals to be met by the year 2020:

- Reduce the TFR from the estimated level of 3.2 to 2.1
- Increase the use of modern contraceptive methods from 31 percent to 54 percent.

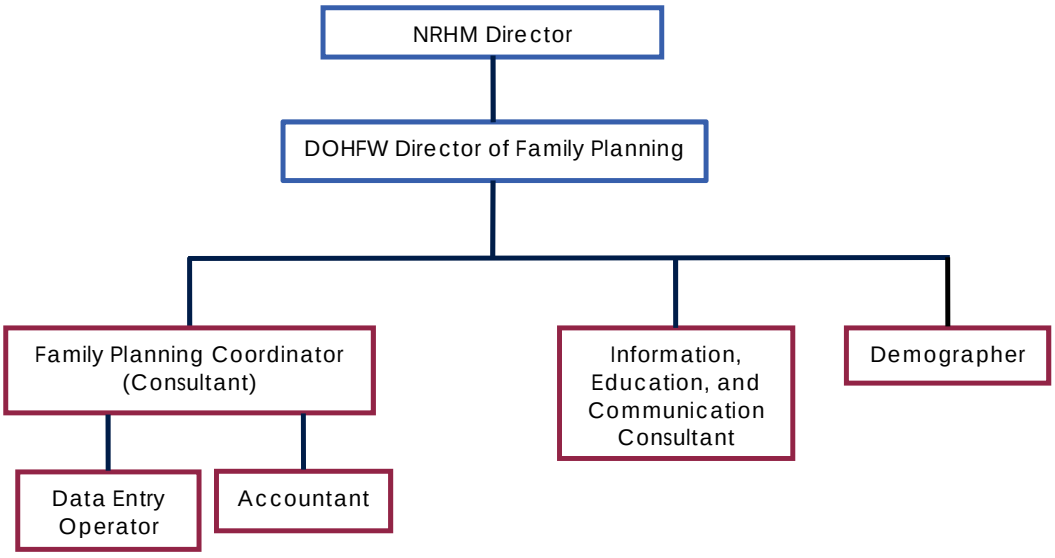
To achieve these goals, the strategy seeks to reduce the unmet need for spacing and permanent FP methods among various resource-poor groups—including urban, rural, scheduled caste, and scheduled tribe populations—to ensure universal coverage and access to FP/RH services statewide. The strategy specifies nine interventions:

- Increase the age at marriage and delay first pregnancy.
- Promote use of spacing methods.
- Promote long-acting permanent methods, to meet the demand for limiting births.
- Integrate FP and maternal, newborn, and child health (MNCH).
- Foster male engagement.
- Reach out to the rural and urban poor and marginalized populations.
- Increase involvement by the private sector, NGOs, and public sector undertakings.
- Coordinate with other departments.
- Adopt an effective communication strategy.

In 2010, the Department of Health and Family Welfare (DOHFW) created a team—the Family Planning Cell—to oversee the implementation and monitoring of the FP program in the state and in the districts. The cell is under the overall guidance of DOHFW's secretary. The organogram below explains the cell's structure.

[2] The Health Policy Initiative, Task Order 1 was funded by the U.S. Agency for International Development and implemented by Futures Group International, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), Futures Institute, and Religions for Peace.

Organogram – Family Planning Cell



The cell is responsible for

- Streamlining the program's financial and administrative processes
    - Identifying unspent money; monitoring utilization reports; reviewing and streamlining flow of funds; and developing processes to minimize delays in fund disbursement
- Conducting periodic situational reviews of impacts, indicators, and gaps
- Strengthening the monitoring and evaluation process
- Strengthening information, education, and communication (IEC)/behavior change communication (BCC) and integrating them with all FP services and activities
- Reviewing existing training material for comprehensiveness and applicability
- Documenting best practices and lessons learned
- Overseeing clinical and nonclinical quality assurance

The FP Cell's blueprint was developed with support from USAID's Innovations in Family Planning Services Technical Assistance Project.[3] In 2011, in discussion with DOHFW, the state gave the USAID-funded Health Policy Project (HPP) the task of designing and implementing a capacity-building program to improve functional and management skills of the staff responsible for the FP program. The key objective was to build the skills of the program management unit to improve last-mile service delivery.

[3] From 2005 to 2012, Futures Group India and partners provided technical assistance to the Innovations in Family Planning Services Project, a collaborative effort of the Government of India and USAID. The project's primary objectives were to create demand for RH/FP services and products, foster public/private partnerships to improve access to high-quality health services, and encourage informed decision making at all levels.

Purpose of the Report

From September 2011 to September 2013 HPP, as requested by DOHFW, conducted a needs assessment of the capacity of the FP Cell and district- and block-level staff to carry out the FP strategy and developed and implemented a plan to address gaps. The plan had four components:

- Develop a comprehensive curriculum—a training resource—especially for FP.
- Build skills and competencies through training workshops.
- Provide mentoring and supportive supervision in places of service delivery,
- Strengthen linkages and partnerships for greater multisectoral coordination.

In collaboration with DOHFW, HPP implemented the training and mentoring program in Simdega, Giridih, and Chaibasa—districts of special concern. HPP worked with two civil society partners: Child in Need Institute (CINI), a local civil society organization (CSO) with extensive experience in the public health sector, and Public Health Resource Society (PHRS), a network of public health professionals. These two partners provided assistance to HPP to roll out the stipulated activities under the capacity-building program.

This report describes how the training and mentoring program works and the directions of change that it has brought about in the three pilot districts. The report also describes the key components or steps in design and roll out of this health systems approach—a useful approach for states and civil society groups working in the areas of health and FP. As Jharkhand scales up the approach from the three pilot districts to several high-priority districts, this document will be a useful reference.

2. CAPACITY BUILDING: THE TRAINING AND MENTORING PROGRAM

Approach

The approach for Jharkhand is based on *Capacity Development Framework and Approach for Health Policy, Governance, and Social Participation*, developed by Health Policy Project.[4] The framework identifies governance and social participation as the principal elements in fostering ownership, transparency, and effectiveness, which are essential to health policy stewardship. Additionally, the framework identifies a staged process of capacity development that is not necessarily linear in its progress but anticipates a movement from dependence on support from outside agencies toward independent, effective stewardship. This framework embraces the following levels of capacity building:

Photo by Health Policy Project

- The *individual level* emphasizes competence—that is, the knowledge, skills, and attitudes that people exercise as agents of change (Baser et al., 2008). In Jharkhand, capacity building at this level focuses on state, district, and block staff and representatives of civilsociety and advocacy organizations.
- The *organizational level* deals with the institutionalization of organizational capabilities for key aspects of the policy process within different entities, such as NGOs, the units and departments of ministries, large institutions, or multisectoral bodies. In Jharkhand, capacity building at this level focuses on organizational structures of the FP Cell and the DOHFW, interaction and communication between the cell and the department and with other cells, and systems for review and monitoring.
- The *system* refers to the overall collective of people and institutions and the environment in which they interact. A number of government and academic bodies and CSOs were identified in Jharkhand, and capacity building focused on strengthening the FP Cell's collaboration with them.

[4] Jorgensen, A., K. Hardee, E. Rottach, A. Sunseri, M. Kinghorn, and A. Bhuyan. 2012. *Capacity Development Framework and Approach for Health Policy, Governance, and Social Participation*. Washington, DC: Futures Group, Health Policy Project.

Key Steps in the Design of the Capacity-Building Plan

This section lays down the steps and approaches used by HPP to design a needs-based capacity-building plan tailored to Jharkhand:

1. *Government buy-in:* The first step in developing the plan was to bring the government on board and develop a program responsive to the state's needs. HPP had several rounds of discussions with the directors of NRHM and of the FP Cell to clarify training and capacity-building needs. Strengthening the capacity of the FP Cell's staff (who were new to the FP program) and orienting them to national and state priorities and to the components of the FP program emerged as clear requirements during these discussions. The discussions highlighted that the cadre of NRHM managers at the district and block levels who are responsible for implementing of the mission's health and FP programs required support, too—both to develop their skills and to increase their understanding of the health systems. Even though the state government provides some orientation of its employees, high turnover hinders service delivery.

   It was agreed that HPP would develop an approach to strengthen the capacity of the FP program's managers at the state, district, and block levels.

2. *Capacity needs assessment:* Identifying gaps in existing capacities and understanding the participants' expectations of the program was the second crucial step. A needs assessment was designed to assess and document skills and capacities across key components of program management—leadership, management, and technical knowledge. The assessment was qualitative and comprised in-depth interviews, group discussions, observation, and review of key documents. Two discussion guides were developed for interviews with state policymakers and for interviews with program managers at the state, district, and block levels. The discussion guide for managers inquired about such organizational factors as technical capabilities, leadership, financial management, monitoring, data use, quality assurance, IEC and BCC, knowledge management, and perceived confidence to perform their tasks.

Photo by Health Policy Project

   Interviews and discussions were conducted with the state leadership and more than 60 staff members.

3. *Prioritization of needs and developing the capacity-building plan:* The findings of the capacity assessment at the individual, institutional, and health system levels were shared with the people who had been interviewed to validate the findings and set priorities. Highlights of the assessment are as follows:

    - Gaps in knowledge of the policies and guidelines governing the FP program existed among staff at the district and block levels.
    - Especially at the district and block levels, staff had limited exposure to subprocesses of the FP program: quality assurance, planning, logistics and supplies, and monitoring of FP indicators.
    - Systems for monitoring and supervision were inadequate. Even though reviews were done regularly at all levels, their rigor and intensity diminished from higher to lower staff levels, and the lower levels were where reviews were needed most.
    - Knowledge of the HMIS system was limited. Even though the FP Cell was making a major effort to support the findings of routine data collection through the health management information system and make adjustments accordingly, the cell had not participated in any HMIS trainings. At the district level, the meaning of the FP indicators was not clearly understood, which affected the quality of data collected and reported.

Box 1. Capacity-Building Areas of Focus in Jharkhand

I. Program Management

- Strategic planning using data and information
- Contraceptive supply management
- Quality assurance
- Human resource planning
- IEC
- National and state policy framework

II. Technical Competencies

- Fundamentals of the FP program
- Contraceptive technology update

III. Leadership

- Skills to achieve a common vision and motivate performance
- Team building and effective coordination and communication
- Confidence to take initiative and introduce innovations
- Problem solving to achieve FP goals (skill component)
- The meaning and components of supportive supervision
- Use of tools for effective programming (skill component)

    - Technical knowledge of contraceptive methods was limited. Service providers rated themselves as average in providing contraceptive methods. More than half of providers interviewed had not received any training on providing contraceptive services.
    - At the institutional level, a well-documented organizational structure for the FP Cell and clear understanding of roles and responsibilities existed. However, at the district level there was a lack of clarity on roles and responsibilities, especially for FP program implementation.
    - At the system level, the information management system needed strengthening, especially to improve the quality of data for FP. District and subdistrict staff were found to be at a learning stage in the analysis and use of data to design, implement, and monitor the FP program.
    - At the state level, training in team building, management, and technical areas of the program was needed.

Using the findings from the assessment, several rounds of discussions were conducted to firm up the areas requiring strengthening, and possible approaches and resources required were developed. A capacity-building plan for 2012–2013 was developed, framed by the functions of the FP Cell and the district and block management units. Box 1 summarizes the plan's areas of focus.

Components of the Capacity-Building Plan

HPP identified the following critical components of the capacity-building plan. These included reviewing existing tools, methods, and approaches and then refining them to meet the state's requirements. The plan assumed that the state leadership in Jharkhand would continue to support the mandate of the FP Cell, to make FP a high priority, and to invest in improving institutional and systems capacity after one year of HPP support. The plan attempted to minimize the risk of lack of technical support by establishing partnerships with state organizations, which can carry out individual and institutional capacity building as needed.

Principles

- Build a state resource group (SRG) drawn from various levels of state government and from NGOs to scale up the trainings.
- Establish heterogeneous groups of participants for team-building at the state, district, and block levels.
- Complement formal trainings with mentoring and use of appropriate adult learning methods.
- Focus on measurable outcomes in addition to outputs.
- Maintain field support while the capacity-building plan is executed.

Developing a toolkit for health systems strengthening and effective management

A toolkit on health systems strengthening (HSS) was designed to strengthen the capacities of the master trainers and of the district and subdistrict staff working on HSS for FP. The curriculum is based on the six World Health Organization (WHO) building blocks of health systems and tailored to strengthen the implementation of FP strategy in Jharkhand (WHO, 2007). It also covers the following topics:

- Strategic planning and use of information for FP program
- Technical concepts and fundamentals of the FP program and its relation to overall health goals, especially for maternal and child health
- Contraceptive technology update
- Management and leadership
- Supportive supervision
- Achieving a common vision
- Motivating performance

A task force chaired by the Jharkhand director of NRHM and representing the FP division of the MOHFW reviewed the toolkit and its feedback was incorporated.

The table below provides a summary of the toolkit's components.

Training of Trainers Manual **Audience:** National- or state-level master trainers **Duration:** Four days **Approach:** Hands-on participation, joint planning, skill-building, and practicum **Training included:** • Technical sessions on health systems, policy and strategic framework, and contraceptive technology. • Skill enhancement sessions on capacity building, workshop facilitation, workplan development, supportive supervision, and mentoring. • Sessions to help trainers review, clarify, and bring about positive change in mentoring, supportive supervision, HSS, and contraceptive use.	**Manual to Train District and Subdistrict Managers** **Audience:** District- and subdistrict-level master trainers **Duration:** Two days **Approach:** Hands-on participation, joint planning, skill-building, and practicum **Training included:** • Technical sessions on health systems, policy and strategic framework, and contraceptive technology. • Skill enhancement sessions on workplan development, supportive supervision, and mentoring. • Sessions to help managers review, clarify, and bring about positive change in supportive supervision, HSS, and contraceptive use.
Managers' Tool The tool is in a simple Excel-based format aimed to help managers record information, make observations, identify problems, and list resolutions when they visit a facility. It uses the Indian Public Health Standards and Quality Assurance standards. The key sections covered are FP camps, quality assurance meetings, village health and nutrition days, community monitoring meetings, and accreditation of private providers. The tool provides a means for facility staff to identify strengths, weaknesses, and opportunities. It can also be used for monitoring, to inform decisionmakers about the progress being made in each block or district and issues that need addressing to strengthen the health systems for improved health service delivery. The tool also includes job aids for state managers, district- and block-level managers including civil surgeons, chief medical officers, and district RCH officers.	**PowerPoint Presentations** These presentations are dynamic and can be modified with the latest state-specific data and other information. The content of the presentations is also offered in the annexes of the manuals above to help trainers create charts and other training aids when laptops and projectors are unavailable.

Forming a state resource group

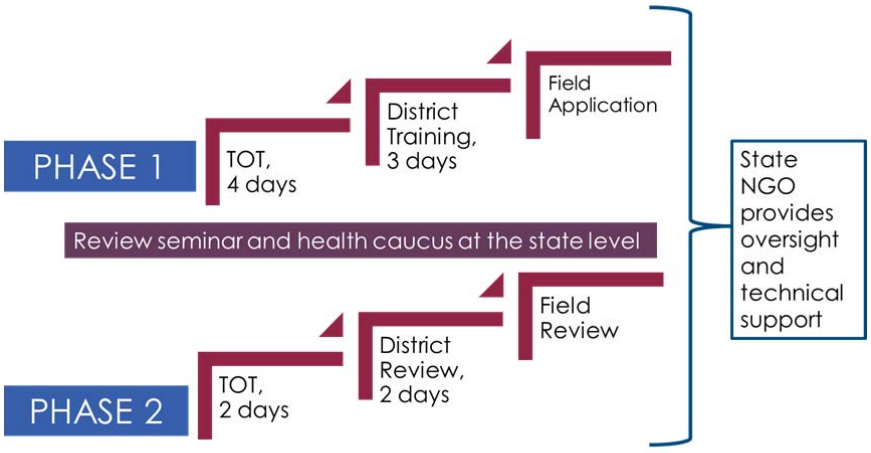
The core of HPP's program and approach was to institutionalize capacities and foster partnerships and linkages at the state and district levels to achieve sustainable improvements. HPP conducted a state assessment to identify key government offices and CSOs as potential partners to implement the program. The assessment was conducted in participation with Rajendra Institute of Medical Sciences; Health and Family Welfare Training Center, Hazaribagh; Institute of Public Health; Xavier Institute of Social Science; Nav Bharat Jagriti Kendra; Krishi Gram Vikas Kendra; Ek Jut; State Health Systems Resource Center; CINI; PHRS; and Srijan Foundation.

Institutionalizing capacities depended on selecting the right mix of experts for the SRG. The assessment documented the current responsibilities, potential role, and intention of organizations or professionals to participate in the SRG. Some of the organizations expressed interest in joining. Others could not divert faculty or staff from their current duties. Based on the results of the assessment and in discussion with the DOHFW, 16 people were identified, representing

- Staff of the FP Cell (the group primarily responsible for the implementation of the FP strategy)
- Medical officers in-charge (MOIC) from district facilities (to strengthen capacities at the district level)
- Representatives of state- and district-level CSOs (chosen for their proven track records in implementing health and family welfare programs at the community level and experience in working with the government health systems)

Offering formal cascade trainings

A cascade approach to trainings was adopted, which consisted of training the SRG members as master trainers. These master trainers then trained district and block staff.



Training of trainers (TOT) workshop: A four-day program was conducted from November 5–8, 2012, in Ranchi, facilitated by HPP along with national- and state-level experts. All 16 members of the SRG were trained as master trainers. In addition to building training skills, participants in the workshop identified areas in which the FP Cell needed to improve quickly. The key output was a measurable action plan developed by the FP Cell to improve its management of the FP program.

District training workshops: The master trainers from the SRG conducted district-level training in two phases—the first phase from November 2012 to March 2013 and the second from April to July 2013. At workshops in Simdega, West Singhbhum, and Giridih, 65 district- and block-level health

employees were trained. The trainings followed a team-building model in which the entire district team—additional chief medical officers (ACMOs), FP medical officers in-charge, and district and block program managers—participated. The training workshop was the first opportunity for all of the district managers to get together to identify FP-related issues in the districts and plan near-term actions. Through the workshops, block-level staff were able to discuss barriers with district administrators and identify ways to surmount them.

Providing mentoring and supportive supervision

The most important component of the capacity-building plan was mentoring and supportive supervision. This was instrumental in achieving a number of programmatic and facility-level changes. The mentoring visits were structured and adopted a problem resolution approach. The mentors (master trainers from the SRG) visited the districts and assisted in addressing the barriers that had been identified at the district workshops. Additionally, they used the Managers' Tool (described above) to record their observations of conditions at the facility; identify solutions to issues, in discussion with the facility's medical officer in-charge; and take action. After the visits, the master trainers proactively engaged with the district's civil surgeon, briefed him or her on the actions and solutions decided, and advocated increased administrative support.

From December 2012 to February 2013 and from May to July 2013, the master trainers along with the district program manager (DPM), the block program manager (BPM), or the MOIC made field visits to the three districts and supervised district and block managers as they implemented the actions identified at the district training workshops. In all, 71 visits were made to 33 health facilities: subcenters (SCs), primary health centers (PHCs), and community health centers (CHCs).

Salient Features of Supportive Supervision

- Seek to resolve problems rather than find fault.
- Plan realistic, time-bound actions and followup.
- Use the opportunity to praise staff and express appreciation of the challenges they face. Engage the district administration to create an enabling environment.
- Share positive stories from the subdistrict and district with the state.

The Managers' Tool and the approach of supportive supervision are being used by the DOHFW during the state review missions.

Focus of mentoring: The objective was to help the district team to carry out the action plans developed at the district workshops. During the mentoring phase, the district program management unit (DPMU) and the FP Cell worked on the following health system needs:

- *Improving the quality of FP services*, by ensuring the availability of FP stocks for spacing methods at all delivery points; ensuring the availability of fixed-day services for long-acting and limiting methods; and improving the functioning of quality assurance committees or cells (QACs).
- *Improving data quality of the HMIS* through orientations and monitoring of data.
- *Improving community monitoring mechanisms*, by regularizing *rogi kalyan samities* (RKS), hospital management committees, and village health and sanitation committees.
- *Increasing demand-generation efforts* for FP by ensuring that IEC/BCC budgets are used for FP and that IEC materials provided by the states to DPMUs are disseminated.
- *Managing human resources effectively to improve service delivery.*
- *Fostering intersectoral convergence with other departments* through increased coordination and co-working.

Highlights of mentoring: With mentoring support from HPP and the SRG, the FP Cell was able to achieve the following:

- FP counselors were appointed to the reproductive, maternal, neonatal and child health (RMNCH) services in high-caseload facilities in FY 2013–2014.
- The state program management unit (SPMU) was trained and sensitized on the need for quality assurance and for facilitating the use of protocols and checklists at the districts, in partnership with the QAC.
- A process was initiated for establishing a grievance redress system to obtain feedback from clients on the quality of services.
- Coordination was forged with the state IEC/BCC cell to make FP information and material available to districts and to plan together for future.
- Key directives from the state leadership were facilitated, to reinforce the need for the districts to improve FP implementation and monitoring.

Section 3 of this report analyzes the information generated by the Managers' Tool, but highlights of quick wins are shown in the tables below.

Table 1: Actions Achieved through Mentoring

Component	Indicators	Status from May–June 2013		
		Simdega	Giridih	W. Singhbhum
Quality of services	FP stock lists updated monthly	Stock lists are updated; three-month supply of spacing methods (condoms and OCPs) is in stock.		Stock lists are updated, but in January and February a stockout of OCPs and condoms at the district level occurred for a few months.
	Monthly ordering of FP products and equipment	Products and equipment are ordered regularly by all facilities; at least a three-month supply of contraceptives is in stock.		
	Quarterly meetings of district QAC	Quarterly meetings are reported and the minutes sent regularly to the state QA cell.		Regular meetings are conducted, but submission of the minutes is irregular.
	Monitoring and supportive supervision	A district team is constituted and conducts regular supportive monitoring and supervisory visits.		
HMIS data quality	Monthly reports from districts to state	Submission of reports is timely.		
Demand generation	IEC/BCC budget for FP utilized	All districts used unspent money for demand generation, printing and disseminating approved designs from the state IEC cell, in accordance with district requirements.		
	Campaigns for spacing methods increase	MOICs of the CHCs reported that door-to-door delivery of contraceptives by *sahiyas* (community health workers) has improved and postpartum intrauterine contraceptive device (IUCD) service uptake has also risen.		

Component	Indicators	Status from May–June 2013		
		Simdega	Giridih	W. Singhbhum
Human resource management	Service providers available for fixed-day services and camps	Monthly roster of available trained service providers with details on camps/facilities to be covered is maintained and followed.		Roster of service providers has been developed, but unable to ensure distribution of doctors and surgeons

Building an enabling environment for policy action

Just as mentoring and supportive supervision were necessary measures to bring about positive systemic changes, dialogue and advocacy with the state and district leadership were necessary to create an enabling environment for policy implementation. Some key methods were regular updates by the FP Cell to the NRHM director and program leaders and administrative support to help the districts strengthen implementation. During the implementation phase, several government orders were issued to districts to improve HMIS data quality, improve FP monitoring in the districts, and engage civil society.

Photo by Health Policy Project

Similarly, at the district level DPMs and BPMs gave regular updates to the civil surgeons and chief medical officers on progress towards resolving issues.

At the state level, HPP, in partnership with the FP Cell, facilitated a "Caucus on Health Systems Strengthening and Effective Management" to facilitate dialogue between state-level decisionmakers and state- and district-level implementers. The caucus's purpose was to appraise health systems strengthening efforts to date at the state and district levels; share experiences; report improvements and operational barriers; and advocate policy revisions. Thirty representatives of the state health directorate, the FP task force, USAID, MOHFW, and CSOs participated. The districts presented the changes and improvements in service delivery that had come about as a result of the mentoring and supportive supervision provided by HPP and the challenges they continued to face. At the caucus, the decision was made to scale up the training and mentoring program to other high-priority districts.

3. RESULTS OF THE PROGRAM

This section captures the findings and observations that participants in the HPP capacity-strengthening program reported during and at the end of the mentoring program. Although the implementation period was short, several changes were perceived. These include a significant positive impact on the uptake of FP service in the districts; improvements in the health facilities; improvements in management, evidenced (for example) by increased financial resources devoted to monitoring; and increased government ownership. Although these results cannot be attributed to HPP activities alone, the recipients' feedback on the training and mentoring program affirms the usefulness of the approach.

Photo by Health Policy Project

Improved Health Systems for the Implementation of Family Planning Strategy

As part of their mentoring and supervisory visits to health facilities, the master trainers reported the gaps and barriers that were identified, the solutions that were decided, and the actions that were taken. In all, the trainers made 71 visits to the 33 facilities; each facility received at least one visit and some received four. For the purpose of analysis, the first visit to the facility was considered the pre-intervention phase and the final visit as post-intervention, to record progress, changes, and challenges.

Table 2: Number of Facilities Visited

District	Community health centers	Primary health centers	Health subcenters	Total facilities
Giridih	4	-	8	12
Simdega	4	-	8	12
West Singhbhum	3	2	4	9
Total	11	2	20	33

The data analyzed from reports using the Managers' Tool showed improvements in the quality of services at each facility with respect to improved supplies of FP products; human resources and training; fund utilization; community participation; demand generation and BCC; and overall management. The biggest impacts of the mentoring and supportive supervision program were improved conditions and functioning of health facilities, better quality of service delivery and staff behavior, and a more open and enabling environment for collective problem solving by facility staff.

Improvements in the health management information system

A block's HMIS data are entered and uploaded at the CHC. Eighty-two percent of the CHCs visited had the software installed and reported uploading the data on time with required signatures by MOICs or medical officers. However, the quality of data (completeness and correctness) was a challenge. Actions during the mentoring phase to improve data quality included organizing training of district and block managers for data interpretation; orienting auxiliary nurse midwives (ANMs) in Giridih district; and on- site support to managers and medical officers. Key improvements were seen in the following areas:

Photo by Health Policy Project

Training ANMs on data use and quality.

- Increase in timely reporting from 27 percent to 91 percent at the CHC level and from 20 percent to 93 percent at the SC level.
- Improved monitoring of data for quality and accuracy by BPMs, increasing from 27 percent to 91 percent at the CHC level and from 7 percent to 93 percent at the SC level.
- Improved understanding of HMIS indicators among MOICs and medical officers, which resulted in better monitoring of data by medical officers before they signed the reports. HMIS data completion on due date improved from 27 percent to 82 percent at the CHCs and from zero to 93 percent at the SCs.

DPM and BPM have started to look at data carefully, check for discrepancies, double- check numbers with ANMs, and discuss at district level to see trends and make relevant changes.

—SRG member, Ranchi; August 2013

Khunti block of West Singbhum is unable to update its HMIS on time due to absence of a trained data manager, rest are doing fine. This was discussed during the health caucus at Ranchi.

—MOIC, West Singbhum; August 2013

Our Mother and Child Tracking System is updated 100 percent and has no backlog. We contract data entry operators from the flexible funds to get this done, since we don't have a data manager.

—MOIC, Simdega; August 2013

Improvements in family planning supply management

At the CHCs and SCs, condoms and OCPs were mostly in stock and were distributed by the *sahiyya* as part of the door-to-door social marketing of contraceptives. However, stocks of emergency contraceptives (ECPs), IUCDs, and nonscalpel vasectomy kits were erratic. Other issues reported were irregular maintenance of stock registers and ordering procedures. Through the mentoring visits, the storekeeper, ANM, BPM, and the staff responsible for maintaining the stock and supplies were oriented and encouraged to regularly update and order to ensure no stockouts. The master trainers also made sure that the state sent stocks to districts until the system was regularized. Some of the notable changes reported are as follows:

- Availability of ECP stocks at the CHCs improved from 18 percent to 55 percent. The availability of IUCDs rose from 82 percent to 100 percent and for nonsurgical vasectomy kits from 73 percent to 82 percent.
- Regular update of stocks and equipment register improved from 27 percent to 91 percent at CHCs and from 20 percent to 73 percent at the SCs.

Photo by Health Policy Project

Indenting for stocks is regularized.

—BPM, Simdega, August 2013

We have started updating our stock registers after mentors showed how to ensure contraceptives are available and how and when to request for more. Now, I have also started keeping track of stocks.

—Medical Officer in Charge who was visited thrice, August 2013

… the problem is contraceptive supplies are not sent from the center to state. We had almost three-month stockouts for ECPs; [postpartum] *IUCD forceps are still not being given to all facilities.*

All district and block program managers mentioned this during the HSS trainings in December 2012

Stock registers are updated regularly now. On my last visit to CHCs they were updated and signed. MOICs are signing off and they are holding at least 3 months stock and placing orders when this depletes.

—DPM, Simdega, August 2013

ANMs are maintaining stock registers after we had a half-day orientation.

—BPM. Giridih, August 2013

Improvements in human resources and training

> *Health workforce includes a host of human capital at the state, district, sub-district and community level. Some of these are health promoters, some technical experts and some managers. It is the responsibility of the state and districts to have all the designated staff in place and ensure that they are: skilled to do their jobs well; provided regular trainings and mentoring to upgrade their skills and knowledge for them to perform to their fullest; provided a conducive work environment; and their financial needs and compensation are taken care of.*
>
> —WHO, 2007

During the mentoring visits the master trainers encouraged the DPMs and BPMs to focus on resolving the human resource challenges when they undertook monitoring in the field. Some of these issues were

- Ensuring that *sahiyyas* counsel, provide condoms and OCPs, and refer clients for clinical services as part of the door-to-door social marketing of contraceptives.
- Ensuring that ANMs and lady health workers counseled, provided IUCD services, and placed orders regularly to prevent stockouts.
- Mapping of providers to determine the availability of nurses and trained doctors for clinical services, reporting gaps in availability to the district head, and identifying ways to ensure that surgeons and other doctors are available at fixed-day services.
- Recruiting FP counselors for selected facilities.

Photo by Health Policy Project

After training in PPIUCD [postpartum intrauterine contraceptive device], *we are topping in the number of PPIUCD cases in Simdega, and our ANMs and nurses are providing counseling to women who come for JSY* [a safe motherhood program].

—MOIC, Simdega, August 2013

ANMs that hadn't received training in IUCD recently were sent to be trained and are now providing IUCD at the subcenters. In four blocks, we don't have enough doctors trained in providing tubectomy, so every Thursday a doctor from the nearby district comes to camps organized in our block.

—MOIC, Giridih, August 2013

Rational distribution of surgeons is in place. Those that need training, their names were sent to district officials. While it is a state policy, state level needs to ensure this is happening in all.

—FP task force member, August 2013

Improvements in demand generation and behavior change communication

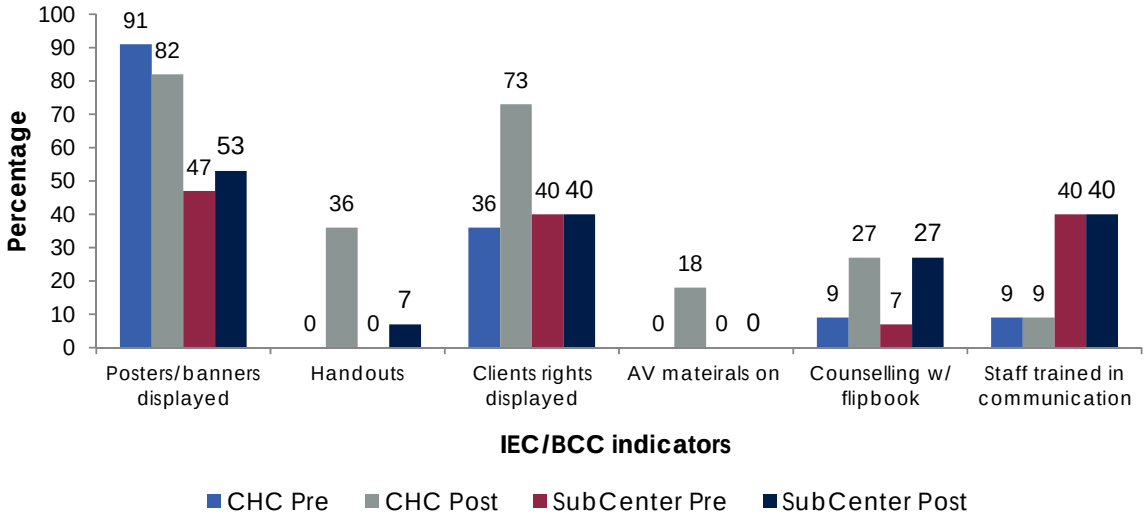
Demand generation is crucial for the use of FP services to increase. It encompasses providing information on the range of FP methods available and maintaining facilities that provide FP services and help clients make an informed choice of an FP method.

The master trainers, during the mentoring visits, looked to see if demand generation material such as posters, banners, and handouts was available, on display, and provided to the clients. They also noted whether audiovisual material was available and if the staff had been trained to use the material to counsel the clients. Key issues the trainers identified were lack of availability of IEC material at CHCs and SCs; inadequate skills of ANMs to counsel clients using facilitation tools; and lack of training of doctors and nurses at CHCs.

Through the mentoring visits, the DPMs streamlined the following aspects of demand generation:

- Artwork of the IEC material developed by the state was provided to the districts and IEC material was printed in the districts.
- All SCs had displayed clients' rights.
- Facilitation and IEC material was made available to ANMs in the community through NGOs and community-based organizations.
- The state decided to train doctors and nurses at CHCs on FP counseling as part of their training on the PPIUCD.

Figure 4: Changes in IEC/BCC Indicators at the Community Health Centers and Subcenters in Response to Mentoring



In West Singhbhum, materials were dumped at the district headquarters. Through mentoring, the ACMO recognized this barrier and rolled it out.

—SRG member,
August 2013

In our monthly review meetings we are emphasizing that all BCC/ICE materials and plans are implemented as per the guidelines, to improve FP uptake in the blocks.

—DPM, Simdega,
August 2013

FP task force at state level made multiple requests for the speedy recruitment of the FP counselors at high-caseload facilities, given that the budgets for them were approved. Now most have been recruited.

—FP task force member,
August 2013

Photo by Jignesh Patel under ITAP, Futures Group

Increased Resource Allocation for Managing and Monitoring the Family Planning Program

With a multipronged approach of training, mentoring, problem resolution, and constant dialogue with decisionmakers at the district and state levels, the efforts resulted in a greater focus on FP. When the strategic action plan for the year 2013–2014 was developed, the HPP training and mentoring program was scaled up to eight more high-priority districts.[5] Furthermore, the current plan increases allocations for quality assurance and monitoring of services. The section below summarizes these improvements.

Photo by Health Policy Project

Improvements in family planning services

The government increased its focus on spacing methods within the overall FP program. The allocation for spacing accounted for 13.65 percent of the FP budget in 2012–2013; it increased to 20 percent in 2013–2014. Programmatically, there is a greater focus on recruiting FP counselors and on increasing the provider base by training providers of the IUCD and PPIUCD, stepping up demand generation, and encouraging and recognizing good performers. Another key focus is quality of services, with the objective of reducing failure of FP methods; hence the budget for compensation when sterilization fails was reduced by 10 percent. Also supporting this objective is increased investment in enhancing the skills of service providers through refresher trainings and quality assurance.

Improvements in program management

Through the Program Implementation Plan (PIP), the state invests to strengthen the components of program management. In an earlier version of the plan, lump sums were allocated to the state, districts, and blocks for management activities. Guidelines on where the resources could be used and monitoring of expenditures were inadequate. In 2013–2014, with technical inputs from HPP, the state allocated the overall fund for management with explicit line items for such expenditures as stationery, communication materials, monthly review meetings, workshops, conferences, and state review missions. These line items made allowable uses of the funds clear. Funds for monitoring and supportive supervision increased to support the creation of new regional coordinator positions, the cost of travel for visits to support districts and blocks, exposure visits for SPMU and DPMU staff, and common review mission.

[5] These are Latehar, Palamu, Garhwa, Ranchi, Sahebganj, Dumka, and Ramgarh. The budget for the training is provided by the state.

Improvements in monitoring and evaluation

The state made critical commitments to improve the data reported through HMIS. This has been advocated jointly by HPP, the FP Cell, and the FP task force to the state at task force meetings, review missions, and PIP planning meetings. These commitments are as follows:

- All facilities will ensure that their data are uploaded and validated.
- The NRHM director and program managers at all levels will use HMIS data for monthly reviews.
- Facilities will receive regular visits for troubleshooting and data quality checks.

Community Monitoring	ROP 2012–2013 (in rupees)	ROP 2013–2014 (in rupees)
State	1,50,000	1,50,000
District	6,00,000	7,20,000
Block	14,40,000	24,00,000

- Regular statistical officials along with contractual staff will perform monitoring and data quality checks.
- The districts, blocks, and facilities will receive timely and regular feedback on the HMIS and the Mother and Child Tracking System.
- The budget for community monitoring will increase, especially at the district level (up 20 percent) and the block level (up 66.6 percent).

Toward Implementation of the Family Planning Program

HPP conducted a rapid feedback assessment to discover how participants in the training and mentoring program were using what they learned. The master trainers reported that inputs of the HPP program had increased their ability to organize trainings and conduct review and supervisory meetings. They said their communication with the district leadership had improved considerably.

For the district managers, the biggest change reported was that their communication skills to interact with the government and nongovernmental stakeholders had improved considerably. For example, the managers structured their supervisory visits and used tools that helped them to gather information, identify barriers, and solve problems in a participatory way.

The managers in the FP Cell reported building skills to coordinate with other cells in the directorate to synergize efforts. For example, the FP Cell stepped up communication and coordination with the IEC Cell to increase demand generation activities for FP. A highlight was jointly undertaking activities using unspent budgets from previous years.

At the service delivery level, all respondents reported that during the pilot phase the quality of services, identification of eligible couples, and provision of contraceptive counseling and services had improved. The areas which still require sustained efforts are improving BCC, quality assurance, counseling for PPIUCD, and community participation.

HPP provided various capacity-building approaches including TOT workshops, district trainings, supervisory visits, mentoring, and dialogue. The recipients clearly flagged supportive supervision, mentoring, and dialogue as the most useful, and praised the program's unusual comprehensiveness in these areas.

Photo by Jignesh Patel under ITAP, Futures Group

4. LESSONS LEARNED AND CONSIDERATIONS FOR SCALABILITY

Given the program's accomplishments, the government of Jharkhand has scaled it up to eight other high- priority districts. The uniqueness of the program's approach is its focus on providing mentoring and supportive supervision. This not only provides an opportunity to monitor the program but also a way to overcome local barriers and challenges. This section outlines some considerations that are key to taking this approach to scale.

- *Seek ownership at the highest level:* Because the approach is to build capacities within a health system, it requires endorsement and ownership by state-level leadership. For staff to make a commitment to such an initiative, it must be relevant to their concerns. In Jharkhand, ownership of the program by the FP Cell was very important, because this group played a critical role in identifying gaps in capacity, approaches for skill building, and action that could be taken at the district and state levels.
- *Identify what needs to be achieved early in the project, in participation with the recipients:* This makes it possible to set realistic goals and expectations. The Jharkhand initiative's focus was to enable the FP Cell and managers at various level to review FP programs strategically; provide resolutions to the challenges faced by district colleagues; create a conduit between field issues and state leadership; facilitate and streamline subsystems within the FP Cell; build a network of resources available whenever needed; and provide not only monitoring but also supportive supervision. At the program level, the group acted to improve data quality and timeliness, increase the frequency of district QAC meetings, ensure the availability of contraceptive supplies; and build community engagement.

- *Use existing mechanisms to review progress:* In Jharkhand, the FP task force, which is chaired by the NRHM director and brings together civil society and government partners, was nominated to provide feedback on various components of the program. The task force participated in finalizing the training curriculum, offered technical support to the FP Cell and DPMUs, and held quarterly meetings to review progress.
- *Build partnerships and linkages to institutionalize capacities:* Partnerships are crucial to sustainability, by leveraging the collective strengths and reach of the public and private sectors. In Jharkhand, the state nominated experts and professionals to be part of the SRG and to be trained as master trainers. It was this group's responsibility to conduct trainings and the mentoring program. The master trainers are helping the state scale up the trainings from three districts to eight in 2013–2014. Thus, establishing formal and informal networks and linking them up with the FP Cell was a successful strategy.
- *Use dialogue to keep the program's momentum going and the participants engaged and informed:* The program organized state- and district-level seminars for participants to talk about the progress of the work and persistent challenges.

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ANNEX 1. CASE STUDY: EACH OF US CAN MAKE A DIFFERENCE

Photo by Health Policy Project

Roshan in his office.

Block: Kolibera

District: Simdega

State: Jharkhand

Type of health facility: Community health center

Designation: Medical Officer In-charge, responsible for the overall functioning of the center

Name: J. L. Roshan, M.D.

Business was usual in the little block of Kolibera, in the Simdega district of Jharkhand. As the medical officer in charge (MOIC), I run this community health center (CHC). It has a theater for basic surgeries, an outpatient department, a maternity home with four beds, a pharmacy-cum-stock maintenance department, an adolescent reproductive and sexual health clinic, a counseling center, and a malnutrition treatment center. We are in the process of building a new wing to increase the number of beds for postdelivery services.

I live on the CHC's premises and so do the ANM and the nurses who work here. This way we are readily available to attend to patients at any time of the day and do not have to worry about travelling to and from work every day. I have always preferred to live here and I encourage the ANMs to do so.

A few years ago we were an average performing facility. Few women came for deliveries; FP services were not a priority; there was little demand for spacing methods such as the intrauterine contraceptive device (IUCD); and we faced stockouts for oral contraceptive pills (OCPs), condoms, and emergency contraceptives (ECs) on many occasions. However, we were doing well on immunization.

Photo by Health Policy Project

Messages on FP on the outer wall of the CHC, freshly painted

After 2012, all this changed for the better: many things happened. First, the Ministry of Health and Family Welfare (MOHFW) scaled up its door-to-door delivery of contraceptives through the community health workers, or ASHAs (Accredited Social Health Activist), in a social marketing mode. Second, with the increase in institutional deliveries under the conditional cash transfer scheme JSY (*Janani Suraksha Yojana*) the focus on the postpartum IUCD increased. Third, there was an increased focus on better reporting under the health monitoring information system (HMIS) for improved data quality and use. While all this was happening, we did not have enough guidance from the state on how to operationalize the strategies

and expand access to FP services.

Through the USAID-funded Health Policy Project (HPP), from November 2012 onwards, staff from our block were trained and then provided supportive supervision on how to effectively implement, manage, and monitor the FP program. During the mentoring visits to our center, they analyzed information at the facility; the availability of supplies; the cleanliness of rooms; records and registers; patient load; barriers we faced; and how we managed to overcome them. They also asked us about initiatives that we undertook on our own with the existing resources. Through the analysis and discussion, we arrived at ways in which we could improve the quality of services at the facility.

Photo by Health Policy Project

Nurses at the CHC talking about the increased uptake of the postpartum IUCD and institutional delivery and the improved hygiene of the delivery room and maternity ward in response to supportive supervision by SRG members

Additionally, we received on-the- job support to record our data correctly, to improve the timing of requests for stocks sent to the state/district headquarters, and to identify the training needs of the ANMs. We developed the plans to improve the facility jointly during these visits. To increase demand for services and the facility's visibility, we displayed a lot of communication material that had been available at the center but never used.

The supportive supervision visits were structured to help us identify gaps, and identify immediate and do-able solutions. It was also the first time we began to appreciate our skills in resource management and other assets. It was the first time that someone really listened to our problems and gave us ideas on how to improve, making us feel we were really contributing to the health of the people of our block. (Kolibera has a population of 71,368 according to the 2011 census.)

Photo by Health Policy Project

Head nurse checking on a client who recently delivered and adopted PPIUCD

The mentoring and supervisory team visited us five or six times between November 2012 and July 2013, and each time they followed up on the suggestions for improvement that they gave us. They also came through on actions and things they had promised: for example, ensuring that the ANMs here received training in postpartum IUCD insertion. They also gave us positive feedback and noted areas for strengthening. We liked to show them the improvements we made and looked forward to being appreciated and learning something new with each visit.

A little nudge towards the positive from these supportive supervisory visits by the HPP staff and members of the state resource group and the FP task force has gone a long way toward improving the overall functioning of our CHC. Today, the Kolibera CHC ranks high on the number of institutional deliveries and postpartum IUCDs provided. Though we don't have a designated counselor, our ANMs use the flipbooks we have to counsel women who come to deliver about family planning. We explain the postpartum ICUD, OCPs, and condoms. Many women opt for the IUCD once they understand its benefits and shortcomings.

Photo by Health Policy Project

Roshan making a visit to a subcenter in his block

We haven't been out of contraceptive stocks for the past few months now that we have systems in place to refresh our stocks when supplies drop to three months. I have also assigned the emergency ambulance service to transport any women who intends to deliver at our CHC. We enlarged the maternity ward to accommodate increased patient load, and improved the living quarters for our ANMs and nurses to ensure they feel comfortable living here. I have also started visiting the village-level health subcenter to check if they are functioning well, and monitor their progress. I never did this before HPP's inputs, and am more aware now of my contribution to the health system.

Photo by Health Policy Project

Roshan, medical officer in charge, Kolibera Block, District Simdega, Jharkhand

My team and I feel rejuvenated, motivated, and confident. This confidence drives me to make demands from the district commissioner (who is the custodian of most financial decisions and approvals at the block level). Now, during our monthly meetings, I push for speedy recruitment of vacant positions, continuous supplies of family planning and reproductive and child health products, the release of budgets for renovations and to maintain the center's quality, and so forth. The district recognizes my commitment and the improved quality of services our CHC is offering and provides the necessary support.

I understand today that we need to motivate more and more couples to adopt spacing and limiting contraceptive methods to ensure the health of women, reduce mortality among children and infants, and support the overall development of Simdega, and hope to keep up our good work.

ANNEX 2. COMMENTS AND OPINIONS

(Drawn from the Caucus on Health Systems Strengthening and Effective Management, in April 2013)

Photo by Health Policy Project

Dr. Sumant Mishra, current Director in Chief.

Sumant Mishra, MD, Director of Health, Jharkhand, stressed the need for effective training in data use and HMIS, supportive supervision, authentic and quality data entry, data check and feedback, and the criticality of regular quality assurance and increased coordination between cells.

Teja Ram, MD, Deputy Commissioner, MOHFW, Government of India, presented MOHFW's commitment to FP to achieve the Millennium Development Goals. He stressed that Jharkhand should focus on improving spacing, reaching the underserved populations through door-to-door delivery of contraceptives and postpartum contraception at centers with high-delivery caseloads. He added that the central governement is looking at the Jharkhand model for FP, because Jharkhand is one of few states to have an FP strategy; has constituted an FP task force; has established an FP Cell; and has taken a systems approach to improving FP programming. He recommended scaling up the efforts to other districts and also recommended replicating them in states such as Odisha or Gujarat, which have FP Cells.

Praveen Chandra, MD, Director In-charge, Health, Jharkhand, said that he had heard good reviews about the efforts being made at the district level by the master trainers, and wished that the same model of capacity strengthening and mentoring and supportive supervision could be expanded to at least three more districts. This has been budgeted in the State PIP for 2013–2014.

RK Srivastava, MD, Lead, Policy Unit, National Institute of Health and Family Welfare (NIHFW), congratulated the presenters from the districts on their efforts so far. He encouraged the MOICs to be confident and demand funds, supplies, and trainings from the state for improved FP programming. He added that at the state level there should be improved and regular review and monitoring of the FP program, and timely fund allocation and utilization to address need gaps. He said that one of the most important components of a good health system is trained and capable human resources. He suggested that Jharkhand require an institute such as the State Institute of Health and Family Welfare (SIHFW), which could be the nodal agency for all capacity strengthening in the state. He added that the Institute of Public Health (IPH) might be considered for this role, with NIHFW also playing a role.

Siddique Aboobakar, Mission Director, NRHM Jharkhand, commended the changes brought about by the mentoring and supportive supervision efforts in the three selected districts. He also commented that the systemic changes would take longer to show impact on health outcomes. While the qualitative and photo documentation did reveal a trend towards improvement, he stressed that more data was required to show the extent of the impact.

Suranjeen Prasad, MD, State Program Manager, MCHIP, and FP task force member, mentioned that under the project, even some of the small but critical concerns and issues at the facility level were

addressed. Because the intervention was short, there may not be immediate impact on FP service, but a change in the health systems is evident.

C.A. Xaxa, MD, Medical Officer, Simdega, Jharkhand, said that there are improvements in FP service delivery as well as other areas that remarkably showed improvements due to the mentoring support. The managers' tool helped identify key gaps within the facilities, pointed the way to local solutions, and prompted taking issues and requests for solutions to the higher level (district or state). While the team aimed to improve FP-related health systems, major changes have been noticed and observed beyond FP, in RMNCH services.

Suhail Anwar, MD, Medical Officer, Giridih, said that the Managers' Tool helps users to recall aspects of FP that they need to observe or check during health facility visits. The trainings in HSS are critical to kick-start doctors' managerial skills. Trainings on other managerial issues such as supplies and equipment procurement may be organized at the district level for doctors. He also said that cooperation and openness from staff members motivated an increase in supervisory visits.

B.K. Singh, MD, Medical Officer, West Singhbhum, and Poonam Mehta, MD, Medical Officer, East Singhbhum, said that mentoring visits are effective in problem solving. Their visits had brought positive changes in the mindsets of people with whom they had interacted. They cited the examples of C.B. Chaudhary, MD (MOIC- CKP), who is motivated and has changed the hospital environment. They stated that the Managers' Tool is very useful for checking if things are in place and identifying areas for further improvement. The tool also helped to improve the work relationships among facility staff.

A.K. Minj, MD, Additional Chief Medical Officer, Simdega, said that the initiative taken to strengthen systems is appreciable. BPMs and block accounts managers don't know about the importance of data and common discrepancies. This project gave them the opportunity to understand the bottlenecks in HMIS. He also emphasized that this project had helped the MOICs and program managers to understand the gaps and offered time-bound solutions to strengthen health facilities at the block level.

Anil Barla, District Program Manager, Simdega, stressed the program's importance and the need for continuity to strengthen the Community Health Center and Subcenter of Simdega districts. He said that the trainings given under the program were fruitful to the BPM and the block's MOICs, equipping them with the capacity and confidence to identify and solve minor issues on their own.

Hakim Pradhan, District Program Coordinator, Simdega, said that the training package provided an opportunity to gain knowledge and skills to identify service backlogs. This program rejuvenates the block-level and district-level health facilitators with insight into service delivery and their own performance. He also said that mentoring support helps to fill the small gaps then and there.

Rajwardhan, District Program Manager, Giridih, said that the mentoring and handholding support really helped the block and district facilitators solve their functional issues. Giridih's HMIS improved after the capacity-building and mentoring support provided by the HPP teams. The effort made by the HPP team and SRG members under the project is appreciable.

A.D.N. Prasad, MD, Civil Surgeon, West Singhbhum, said that this program provided opportunity to all MOICs and medical officers to identify gaps in services by means of the Managers' Tool.

K. Danardan, District Data Manager, West Singhbhum, shared his experience with data collection, resolution of discrepancies, common and possible errors, data linkages, and manipulated data. He said that the Managers' Tool is effective for identifying errors in the HMIS and improving data quality and use for effective decision making.

Nirmal Kumar Das, District Program Manager, West Singhbhum, said that system strengthening and effective management are very necessary in the current context and the HPP program has provided

support for that. The mentoring support really helped in identifying gaps and finding solutions through discussion. It also provided an opportunity to raise policy-level issues from blocks to districts to the state.

ANNEX 3. STATE RESOURCE GROUP MEMBERS

The following teams were constituted under the State Resource Group to provide training, mentoring, and supportive supervision to the districts.

Name of master trainer	Team/district	Organization/designation
1. Poonam Mehta, MD	West Singhbhum	MO, East Singhbhum
2. B. K. Singh, MD		MO, West Singhbhum
3. Rana Vikash		KGVK-NGO partner
4. Shantana Kumari		Demographer, state FP Cell
5. C. A. Xaxa, MD	Simdega	MO, Simdega
6. Sushma , MD Prabha Toppo		MO, Simdega
7. Subhadra Kujur		JSHRC
8. Swapan Manna		NGO partner, Srijan
9. Pooja Sinha		NGO partner, Srijan
10. Bipin Kumar, MD	Giridih	MO, Giridih
11. Suhail Anwar, MD		MO, Giridih
12. Gunjan Khalkho		Coordinator, state FP Cell
13. Swapan Manna		NGO partner, Srijan
14. Suranjeen Prasad, MD	All 3 districts (CINI)	CINI
15. Ranjan Panda	All 3 districts (CINI)	CINI
16. Prathyush SK.	All 3 districts (CINI)	CINI
17. Haldhar Mahto	All 3 districts (PHRS)	PHRS
18. Shampa Roy	All 3 districts (PHRS)	PHRS
19. Ramakant Singh	All 3 districts (PHRS)	PHRS
20. Rajesh Singh	All 3 districts (Futures Group)	Futures Group

* Note: Some of the SRG members left the group after Phase 1 and new members joined.

ANNEX 4. AREAS OF CAPACITY STRENGTHENING

To ensure effective implementation of the FP strategy at the state, district, and the facility level, the capacity of medical officers and district program managers needs to be strengthened.

At the state level, building the knowledge and skills of medical officers will allow the FP Cell or the SPMU to accomplish the following tasks:

- Facilitate the training of district- and block-level staff in health systems functions and effective management.
- Strategize and communicate with stakeholders in districts and blocks to implement the activities in the Jharkhand FP strategy.
- Conduct trainings or orientation sessions on contraceptive methods, including their use, benefits, and shortcomings and the rights of the clients.
- Help district and block managers to strategize and plan ways to strengthen service delivery, including services at PHCs, CHCs, district hospitals, fixed-day services, and FP camps.
- Help district and block managers to regularize, manage, and document QAC meetings and visits.
- Provide BCC/IEC support to develop strategic BCC plans, make existing resources available, and implement and monitor IEC/BCC fund utilization at the district level.
- Provide mentoring support to district and block managers to improve the quality of HMIS data.
- Help district and block managers to use the HMIS on a regular basis and use data generated to review FP programming at district-level review meetings, with the blocks, and with the SPMU and the FP Cell.
- Help district and block managers to plan and conduct supportive supervisory visits using the Managers' Tool.
- Help district and block managers to plan and budget for the FP program in the district health action plans (DHAPs).
- Help district and block managers to strengthen leadership and governance in FP programming—for example, regularizing district QACs and RKS meetings.
- Help district and block managers to estimate level of effort or expected levels of achievement for the provision of FP methods in order to plan DHAPs.
- Help district and block managers to strengthen the system for identifying eligible couples at the community level.
- Help district and block managers to plan and conduct FP review meetings, FP stakeholder caucuses, and so forth.
- Help district and block managers to advocate increased support for the FP program to state and district leadership.
- Help district and block managers to engage with other stakeholders such as implementing NGOs and other donor-funded projects.

If medical officers are trained to accomplish the following tasks, the FP program can be effectively implemented at the health facility level:

- Ensure that basic facilities meet Indian Public Health Association standards and follow quality assurance guidelines (for example, that the delivery room, blood bank, and maternity ward meet hygiene and sanitation and standards and that rooms have basic equipment and amenities).
- Ensure that staff (for example, obstetricians/gynecologists, general surgeons, ANMs, and support staff) are recruited and trained to provide FP services (IUCD, PPIUCD, nonsurgical vasectomy, tubectomy, and counseling).
- Ensure that contraceptive stocks and supplies are available and supply registers are updated regularly.
- Ensure the availability and use of untied funds, as required.
- Ensure that IEC/ BCC materials on FP and RH are displayed, available, and provided to the clients.
- Ensure that HMIS data quality improves, that there is consistency in reporting, and that data are used to make programmatic changes, as required.
- Ensure that transport and referral are available, as and when required.

Capacity-strengthening efforts for district-level program managers should focus on building these skills:

- Facilitate district- and block-level staff trainings in health system functioning and effective management.
- Carry out their roles and responsibilities for policy implementation and for monitoring and evaluation.
- Strategize and communicate with stakeholders in districts/blocks to implement the activities in the Jharkhand FP strategy.
- Conduct trainings or orientation sessions on contraceptive methods, including their use, benefits, and shortcomings and the rights of the clients.
- Strategize and plan ways to strengthen service delivery at PHCs, CHCs, District Hospitals, fixed-day clinics, and FP camps.
- Regularize, manage, and document QAC meetings and visits.
- Provide support for strategic BCC plans, making existing resources available and implementing and monitoring IEC/BCC fund utilization at the district level.
- Plan FP-related trainings and capacity-strengthening activities in the districts/blocks.
- Access the HMIS on a regular basis and use data generated to evaluate FP programming at the state-level review meetings, with the district/blocks, and with the FP division at the MOHFW, the district, and the state.
- Plan and conduct mentoring visits using the Managers' Tool.
- Plan and budget for the FP program in the state PIP, the district health action plans, and block health plans.
- Strengthen leadership and governance in FP programming—for example, regularizing FP task force meetings and state and district QAC meetings, and addressing problems effectively and promptly.

- Estimate the level of effort or expected levels of achievements for the provision of FP methods.
- Strengthen the system for identifying eligible couples at the community level.
- Plan and conduct monthly FP review meetings.
- Advocate increased support for the FP program to state and district leadership.
- Collaborate and engage with other stakeholders, other state cells, the FP task force, implementing NGOs, and other donor-funded projects.
- Engage with the State Health Resource Centre to strengthen FP data analysis for decision making.
- Engage the SRG, who have training and mentoring experience in HSS, in the FP program.

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