policy

February 2014

TRAINING OF TRAINERS MANUAL

HEALTH SYSTEM STRENGTHENING AND EFFECTIVE MANAGEMENT FOR JHARKHAND FAMILY PLANNING

This publication was prepared by H. Chokshi, R. Mishra, H. Sethi, and A. Jorgensen of the Health Policy Project.

USAID FROM THE AMERICAN PEOPLE

NATIONAL RURAL HEALTH MISSION

HEALTH POLICY PROJECT

Suggested citation: Chokshi H., Mishra R., Sethi H., and Jorgensen. A. 2013. *Health Systems Strengthening and Effective Management.Implementing the Jharkhand Family Planning Strategy. Training of Trainers Manual* Washington, DC: Futures Group, Health Policy Project.

The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. HPP is implemented by Futures Group, in collaboration with CEDPA (part of Plan International USA), Futures Institute, Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

Training of Trainers Manual

FEBRUARY 2014

This publication was prepared by H. Chokshi, R. Mishra, H. Sethi, and A. Jorgensen of the Health Policy Project.

CONTENTS

ABBREVIATIONS

ACMO	additional chief medical officer
AHS	Annual Health Survey
ANM	auxiliary nurse midwife
ASHA	accredited social health activist
AWC	anganwadi centre
AWW	anganwadi worker
AYUSH	ayurveda, yoga, naturopathy, unani, siddha, and homeopathy
BCC	behavior-change communication
BPMU	block programme management unit
CBO	community-based organisation
CHC	community health centre
CINI	Child in Need Institute
DH	district hospital
DHAP	District Health Action Plan
DLHS	District-Level Household Survey
DoHFW	Department of Health and Family Welfare
DM	district magistrate
DQAC	district quality assurance committee
ECP	emergency contraceptive pill
FP	family planning
FRU	first referral unit
GOI	government of India
HMIS	health management information systems
HPP	Health Policy Project
ICT	information and communication technology
IEC	information, education, and communication
IMR	infant mortality rate
IPC	interpersonal communication
IPHS	Indian Public Health Standards
IFPS	Innovations in Family Planning Services
ITAP	Innovations in Family Planning Services (IFPS) Technical Assistance Project
IUCD	intrauterine contraceptive device
IUD	intrauterine device
LHV	lady health visitor
M&E	monitoring and evaluation
MCH	maternal and child health
MIS	management information systems
MMR	maternal mortality ratio
MoHFW	Ministry of Health and Family Welfare
MOIC	medical officer in-charge
NDCP	National Disease Control Programmes
NFHS	National Family Health Survey
NGO	nongovernmental organisation
NHSRC	National Health Systems Resource Centre
NRHM	National Rural Health Mission
NSV	non-scalpel vasectomy
OCP	oral contraceptive pill

PHC	public health centre
PHRN	Public Health Resource Network
PIP	Programme Implementation Plan
PPIUCD	postpartum intrauterine contraceptive device
PRI	panchayati raj institution
QA	quality assurance
QAC	quality assurance committee
RCH	reproductive and child health
RKS	rogi kalyan samiti
SC	sub-centre
SN	staff nurse
SRH	sexual and reproductive health
SRS	sample registration system
STI	sexually transmitted infection
TFR	total fertility rate
TOT	training of trainers
VHND	village health and nutrition day
VHSC	village health and sanitation committee
WCD	Ministry of Women and Child Development
WHO	World Health Organisation

ACKNOWLEDGEMENTS

The Health Policy Project worked closely with the Government of Jharkhand's Department of Health and Family Welfare (DoHFW) to develop and implement a capacity-building and mentoring programme that will enable the Family Planning (FP) Cell and district functionaries to effectively implement the Family Planning Strategy in the state. The programme included working with state experts to (1) design a comprehensive training curriculum to strengthen functional skills, (2) train functionaries, (3) provide mentoring and supportive supervision, and (4) strengthen linkages and partnerships for greater multisectoral coordination. The programme's development was informed by significant stakeholder input, ensuring its effective implementation and subsequent scale-up by the Government of Jharkhand.

The authors would like to acknowledge the main contributors. First, sincere appreciation goes to Smt Aradhana Patnaik and Shri Siddique Aboobakar (Former Mission Director, National Rural Health Mission (NRHM), Jharkhand) for initiating the process, facilitating the discussions, and encouraging critical thinking on taking a comprehensive approach. We also thank Dr Manish Ranjan Mission Director, NRHM, for recognising the programme's value and scaling up the approach to more priority districts in Jharkhand through the programme implementation plan for 2013–2014. We appreciate the directions of the following state officials to implement the program: Dr Sumant Mishra, Director Health, Dr Praveen Chandra, Director in Chief and Dr M.N.Lal, Director FP Cell.

Further, we acknowledge the participation and guidance of FP Taskforce members on developing the FP curriculum and leadership in review and monitoring. We also acknowledge the active contributions of staff of the FP Cell and experts from civil society organisations in the trainings and mentoring.

Finally, we are grateful for the support and technical input from the United States Agency for International Development, especially Ms Sheena Chhabra, Team Leader Health Systems Division; Dr Neeta Rao, Senior Advisor Monitoring and Evaluation; and Dr Amit Shah, Senior Advisor Family Planning and Reproductive Child Health.

PREFACE

Jharkhand's 2008 Population and Reproductive and Child Health Policy describes the state's commitment to making high-quality reproductive and child health (RCH) services a priority by following a life-cycle approach to reduce maternal and child mortality and morbidity (the relative incidence of disease). The policy outlines a broad focus on gender and human rights issues and services to disadvantaged groups and to adolescents, with the aim of eliminating discrimination in the provision of reproductive and child health services at all levels and in all sectors. The state is fully committed to achieving replacement-level fertility and, thereafter, to stabilise population growth by promoting informed choice; expand access to a range of contraceptive choices; empower communities and women; involve all stakeholders from private, public, nongovernmental organisations (NGOs), and industrial sectors; and encourage use of modern contraception, particularly spacing methods.

In 2010, the state formulated the Family Planning Strategy, which includes these overall objectives:

- Reduce the total fertility rate (TFR)—that is, the average number of children a woman can expect to have in her lifetime—from the current estimated level of 3.2 to 2.1 by 2020
- Increase modern contraceptive prevalence from 31 percent to 54 percent by 2020

The strategic intervention areas are

- Focus on adolescent health
- Promote spacing methods use and other long-acting and permanent methods to limit childbearing
- Integrate family planning with mother, neonatal, and child health (MNCH)
- Encourage male engagement
- Reach out to the rural and urban poor and other disadvantaged populations
- Increase the involvement of both private and public sectors and NGOs
- Coordinate efforts with other government departments
- Develop an effective communication strategy

In 2010, the Department of Health and Family Welfare (DoHFW) set up the Family Planning (FP) Cell to operationalise the Family Planning Strategy and monitor implementation of the state FP programme. The FP Cell comprises five staff members and is headed by the director of family planning. The Health Policy Project (HPP), funded by the United States Agency for International Development, is providing technical assistance to strengthen the capacity of the FP Cell and district- and block-level functionaries to effectively implement the strategy.

From 2011–2013, HPP, in partnership with the Government of Jharkhand, developed and rolled out a health systems strengthening programme, which began with a participatory capacity needs assessment and development of a capacity-building plan. The plan focused on strengthening individual, institutional, and systemic capacities through development of a need-based curriculum, mentoring, and a supportive supervision programme. HPP designed a package for the programme, including a curriculum, *Training on Systems Strengthening and Effective Management* (2013), and job aids, such as the *Manager's Tool* to record data during mentoring and supervisory visits. This manual for master trainers and state-level managers is part of the package.

A State Resource Group (SRG) of 16 experts and professionals from government and civil society organisations were trained to be master trainers. The implementation and management skills of 65 district and sub-district functionaries were also strengthened through a formal training workshop and a mentoring and coaching programme. HPP fostered partnerships and linkages between the FP Cell and state-level academic and training institutes to improve implementation and the monitoring, reporting, and analysis of FP data. The outcomes and impact of HPP's efforts in health systems strengthening and effective management to implement the FP Strategy in Jharkhand was measured from the data collected through a *Manager's Tool*. While the period of implementation was too short to gauge any impact on FP service uptake, a trend toward increased uptake appears to be emerging; and although this capacity-building programme was developed specifically for Jharkhand, this toolkit and training manual may be useful for other states facing similar challenges.

BACKGROUND TO DEVELOPMENT OF THIS TRAINING AND FACILITATOR'S MANUAL

The Health Systems Strengthening and Effective Management training for state programme managers and public health experts from civil society and nongovernmental organisations (NGOs) focuses on leadership, team building, and programme management skills related to family planning (FP) and contraceptive technology. This Training of Trainers (TOT) manual will help build capacity in the following areas:

Experiential Training, Leadership, and Team Building

- Achieving a common vision and motivating performance
- Promoting team building and effective coordination and communication
- Taking initiative and being innovative in implementing the FP programme
- Solving problems to achieve FP goals
- Understanding the meaning and components of supportive supervision
- Using available tools for effective programming

Programme Management

Sub-areas

- Strategic planning; data use and analysis; information management; contraceptive supply management; quality assurance; human resource planning; and information, education, and communication (IEC)
- National and state policies and strategies for FP, including the rationale for a noncoercive, non-target-driven approach
- Understanding the relevance of the Jharkhand FP Strategy
- Identifying constraints and bottlenecks in service provision

FP Technical Competencies

- Fundamentals of the FP programme and its relation to overall health goals, especially for maternal and child health (MCH)
- Contraceptive technology update

Training of Trainers Workshop

This TOT is intended to train health managers and administrators at state and district levels to be more effective in planning, implementing, and monitoring the family planning programme. It is envisioned that these health professionals will become trainers, as part of a state resource group, who can train district- and subdistrict-level managers in health systems strengthening and effective management of the public FP programme.

The goal of the workshop is to build skills to become trainers of district-and block-level managers in health systems strengthening and effective management to improve FP programming.

Specific Objectives: By the end of this training, participants will

- Understand experiential training theory and methods of designing and delivering training
- Learn and practice how to train effectively using experiential methods, and how to give and receive feedback
- Become familiar with the national and state family planning policies and strategies, contraceptive methods, and reproductive rights-based approaches
- Understand the key policy processes, the World Health Organisation's (WHO) framework for effective health systems, and activities to address need gaps and bring about policy change
- Strengthen analytical skills and abilities to use existing data to understand the status of family planning programs, and use data for program decision making
- Learn and practice using mentoring and management skills
- Identify capacity-strengthening needs to improve FP programming at district and block levels

About the Manual

This manual provides guidance on training trainers to build capacity for a stronger health system to support FP programs. Each session includes

- **Title:** the main topic of the session.
- **Learning objectives:** describe the competencies participants will gain by the end of the session such as demonstrating increased knowledge, improved skills, or changed attitudes. The trainer should write the learning objectives on a flip chart prior to each session and use it to open the session.
- **Time:** indicates the planned duration of the session, assuming 12–18 participants.
- **Materials:** lists the materials required for the session.
- **Handouts:** refers to the respective Annex as a handout for the session.
- **Session Designs:** help facilitate each session. In general, the TOT is built upon the four components of David Kolb's Experiential Learning Cycle (http://academic.regis.edu/ed205/Kolb.pdf), which are important concepts for training of trainers: *experience, reflection, generalisation*, and *application*. The *experience* is an exercise or participatory presentation in which information is presented for discussion and learning. *Reflection* helps participants think about and analyse new information and develop their own ideas about a topic. *Generalisation* allows participants to draw broad conclusions and lessons

learned about the new information. *Application* enables them to visualise or practice how they may apply their new skills in the future (CEDPA, 1995).

This manual is based on the following adult learning principles (Knowles, 1996):

- Learning is self-directed.
- It fills an immediate need and is highly participatory.
- Learning is experiential (i.e., the participants and the trainer learn from one another).
- Time is allowed for reflection and corrective feedback.
- A mutually respectful environment is created between the trainer and the participants.
- A safe atmosphere and comfortable environment are provided.
- Practice what participants have learned through real-life settings.

Training Techniques

The training techniques used include

- **Icebreakers and interactive activities:** Set the climate for the next session or transition between sessions, energise participants and make them more alert, and provide a break between 'heavy' sessions.
- **Lectures:** Activities conducted by the facilitator or a resource specialist to convey information, theories, or principles.
- **Large and small group discussions:** Sharing of experiences and ideas, and joint problem solving among participants.
- **Action planning:** Creation of plans by participants to apply new knowledge and skills.
- **Mini case studies:** Use of health management information system (HMIS) data and district scenarios by the participants to suggest solutions to the health system problems.
- **Practicum:** Participants have the opportunity to practice with facilitators at the field site.
- **Peer learning, support, and feedback:** Participants provide immediate feedback to one another to strengthen skills and generate new ideas.

TRAINING OF TRAINERS AGENDA

Session	Objectives: The Participants…	Materials	Lead Trainer	Co-facilitators/ Resource Persons	Duration in Minutes
DAY 1					
Registration and completing the Pre-training Evaluation Form	Register themselves, collect the training package and complete the pre-training form and submit it	Training package Pre-training forms (refer to Annex 9)			30
Session 1: Introduction	Become familiar with each other, understand the importance of working in teams and know the workshop objectives	Sticky note pads, flip chart and markers and PowerPoint presentation #1			40
Session 2: Moving from Dependence to Independence	Explain the Staged Capacity Building Model and assess their existing health system for family planning and the stage at which it is	Large flip chart (join two) with the staged capacity building model with empty spaces and PowerPoint presentation #2			30
Session 3: Adaptive Roles in Providing Capacity Development Support	Determine the various roles they can play as capacity builders for the state and distinguish between the various roles	PowerPoint presentation #3			30
Session 4: Role of the Facilitator	Recognise skills required to be a good facilitator and identify different ways to facilitate while training district and block-level functionaries	Flip charts, PowerPoint presentation #4, video of a trainer/facilitator, checklist of verbal and nonverbal skills (Annex #4)			90
Session 5: Understanding the Policy Process	Describe the policy process, identify their responsibility to ensure that the last two stages are accomplished, and recall their roles and responsibilities for policy implementation, and monitoring and evaluation (M&E)	PowerPoint presentation #5, copies of the Jharkhand Health and Family Planning Policy and Family Planning strategy document, pre-prepared flip chart for functionaries and roles activity			60

Session	Objectives: The Participants…	Materials	Lead Trainer	Co-facilitators/ Resource Persons	Duration in Minutes
Session 6: Understanding FP Policies, Programs and Strategies	Summarise the FP Programs and strategies and the status of Family planning and other health indicators. Describe the challenges and opportunities the state has with respect to family planning.	PowerPoint presentation #6, Policy and Strategy handouts including: • NRHM Policy for FP • Jharkhand Population and RCH Policy • Jharkhand FP Strategy • FP Section of the Program Implementation Plan (PIP) 2012–13 • Flip charts, marker pens, whiteboard, LCD projector			120
Session 7: Contraceptive Update	Describe the rights of the clients and various contraceptives, their use, benefits and shortcomings	Flip charts, markers, the Contraceptive Update booklet in Hindi developed under the IFPS Technical Assistant Project and/or the *Family Planning—A Global Handbook for Providers 2011 Update,* PowerPoint presentation #7			120
DAY 2					
Session 8: Components of Health Systems	Summarise the six building blocks of health systems and describe the components of health systems within the family planning program	Flip charts, markers, whiteboard, LCD projector, State PIP, District Health Action Plans of each district (DHAPs), PowerPoint presentation #8		Multiple resource persons from the SPMU, cells and FP task force	

Session	Objectives: The Participants…	Materials	Lead Trainer	Co-facilitators/ Resource Persons	Duration in Minutes
8A. Health Service Delivery	Understand the various aspects of service delivery including: • FP Services at PHC, community health centre (CHC), DH, Fixed Day Approach, FP Camps • Quality Assurance Committee Meetings and Visits • behavior change communication (BCC/IEC activities at community Level, health facilities, community level, for improved communication and counselling and other mobile or health management information unit (ICT) technology for demand generation and behaviour change • Intersectoral Convergence and Partnerships	Flip charts, markers, whiteboard, LCD projector			120
8B. Health Workforce, Health Information System and Access to Essential Medicines	Understand the various aspects of: • Health Workforce– Technical, Managerial, Community Level Human Resources, trainings and capacity strengthening • Health Management information system • Access to Essential Medicines– logistical and Supply Chain	Flip charts, markers, whiteboard, LCD projector			120
8C. Financing for FP and Leadership and Governance	Understand the various aspects of: • Financing for FP– Fund utilisation/vs approved and Budgeting for DHAP/ State PIP • Leadership and Governance– State Level initiatives (FP cell and task force) and Community Participation (RKS, VHSC and VHC)	Flip charts, markers, whiteboard, LCD projector			60

Session	Objectives: The Participants…	Materials	Lead Trainer	Co-facilitators/ Resource Persons	Duration in Minutes
DAY 3					
Session 9: Developing the Workplan	Will be able to consolidate the key activities for health systems strengthening identified throughout the training and reconstruct the plan to include the key person responsible and a proposed timeline for the same.	Plans and templates developed by the participants in the earlier sessions, PowerPoint presentation #9			120
Session 10: Developing the Mentoring and Supportive Supervision	Develop a mentoring and supportive supervision plan for at least six months while using the Managers tool	Gantt chart for developing field plan and copy of the *Manager's Tool*, PowerPoint presentation #10			120
Session 11: Practicum–Preparing for District level trainings	Strengthen their skills in conducting the district level trainings by designing and enacting a mock training session	All and any materials used in the previous sessions			120
DAY 4					
Session 11 continues: Practicum–Preparing for District level trainings	Strengthen their skills in conducting the district level trainings by designing and enacting a mock training session	All and any materials used in the previous sessions			120
Questions and Answer session **Filling up of the Post-training Form and Feedback form**	Clarify any questions or doubts they may have, provide feedback to the training and complete the Post-training forms. Sum Up of the four-day workshop	Post-training and feedback forms			30

SESSION 1: INTRODUCTION

Learning Objectives	By the end of the session, the participants will: • Become familiar with each other • Know the workshop objectives
Materials	Sticky note pads, flip chart and markers, and PowerPoint presentation #1
Methodology	Game, presentation, discussion
Duration	40 minutes

Activity 1: Introductions and Expectations

STEP 1

Ask participants to introduce themselves.

STEP 2

Have participants share expectations:

- Provide two sticky notes to each participant and ask them to write down their expectations from the workshop in terms of strengthening their competencies. Ask the question, "When you go back, what two things would you want to be able to do in improving the health systems at your level?" Give them about five minutes to think and write.
- Invite the participants to read out their responses and stick them on a flip chart.
- Once everyone has shared their expectations, the facilitators can group and categorise the expectations and write the keyword or phrase around that set of expectations.

STEP 3

Summarise participant expectations and share workshop objectives and an overview of the agenda using the PowerPoint presentation or a flip chart.

Activity 2: Establishing Workshop Norms

STEP 1

Ask the participants to discuss norms to be followed during the workshop to make it most effective. Write these norms on a flip chart. If participants cannot think of any, offer some examples and ensure that the participants understand and agree with them.

- Listen respectfully to every participant's opinion, even if disagree.
- Feel free to voice your opinions positively.
- Be punctual.
- Give all participants an equal opportunity to contribute.

- Put mobile phones on silent mode or switch them off; take urgent calls only outside the training room.

STEP 2

- Inform the participants about the logistic arrangements during the workshop (lodging, timing, etc.).

Activity 3: Overview of Capacity-Strengthening Plan

STEP 1

Using the PPT, review the overarching plan for capacity strengthening in the state, highlighting the stakeholders, the cascading training plan, and the outputs of the TOT.

STEP 2

Ask the participants to reflect on the importance of team work as they participate in this effort. Facilitate a discussion using questions such as, “Why is teamwork so important to this undertaking?” How can you support each other as the trainings and activities roll out? How will we coordinate on lessons learned so we can make improvements as we go along?

SESSION 2: MOVING FROM DEPENDENCE TO INDEPENDENCE

Learning Objectives	By the end of the session, participants can explain the *A Staged Approach to Assess, Plan and Monitor Capacity Building* (Australian AID, 2006) and assess their existing health system for FP and the stage at which it is.
Materials	• Large flip chart (join two) with the Staged Capacity Model with empty spaces to write names of organisations doing this work or the position/level in the public health system which does that task • PowerPoint presentation #2
Methodology	Presentation, group activity, and discussion
Duration	30 minutes

Activity 1: Assess and Review Capacity Stages

STEP 1

- Share and discuss the Staged Capacity Building Model, with the help of a PowerPoint presentation.
- On the flip chart with the columns and rows of the model, ask the participants to add where they think the government is with respect to each component of programming. In places where they are not implementing it, which are the agencies or organisations that are implementing the component for the government?

	Dependent	Guided	Assisted	Independent
Type of Support	High	Medium	Low	Occasional or none
	Primary ownership of work by projects	Primary ownership of work by government		
Planning				
Doing the work				
Quality control				
Responsibility for outcomes and results				

- Ask participants to use sticky notes to write and paste ideas in each section.
- Once done, review the entire model and the participants' view of the independence of the health system to support FP programmes with respect to external donors and projects—whether it is at a good place or if there is a need for change.
- Then, use a separate coloured sticky note to indicate the desired stage at which they would want the health system to function by the end of the next financial year.
- Discuss the importance of the State Resource Group's role in helping government move toward becoming independent of external development partner support.

Refer to Annex A: Staged Capacity Building Plan Model

SESSION 3: ADAPTIVE ROLES IN PROVIDING CAPACITY DEVELOPMENT SUPPORT

Learning Objectives	By the end of the session, participants will be able to determine the various roles they can play in strengthening capacity for the state and can distinguish between these roles.
Materials	PowerPoint presentation # 3
Methodology	Presentation and discussion
Duration	30 minutes

Activity 1: Assess and Discuss

STEP 1

- On the PowerPoint presentation, share the various roles one can play to strengthen capacity.
- Lead a discussion to help the participants understand the type of and level at which most capacity strengthening is currently happening in the state. Ask what type of support is usually provided beyond trainings and workshops.
- Clarify that the State Resource Group will train and mentor district functionaries and subsequently serve as facilitators by communicating the need gaps and solutions to the district and state authorities. The district and block functionaries will in turn be trainers and mentors to the staff working at the village and sub-district levels.
- Highlight the importance of ongoing mentoring and support, as well as facilitating communications with district- and state-level officials, as important activities to supplement training and increase the effectiveness of the capacity-strengthening efforts.

Refer to Annex B: Changing Roles in Capacity

SESSION 4: ROLE OF THE FACILITATOR

Learning Objectives	By the end of the session, participants will be able to recognise - Skills required for being a good facilitator. - Different facilitation methods while training district- and block-level functionaries.
Materials	Flip charts, PowerPoint presentation #4, video of a trainer/facilitator, checklist of verbal and nonverbal skills
Methodology	Activity, discussion and presentation
Duration	90 minutes

Activity 1: Role of a Facilitator

STEP 1

- Ask participants to refer to the important verbal and nonverbal skills as a facilitator.

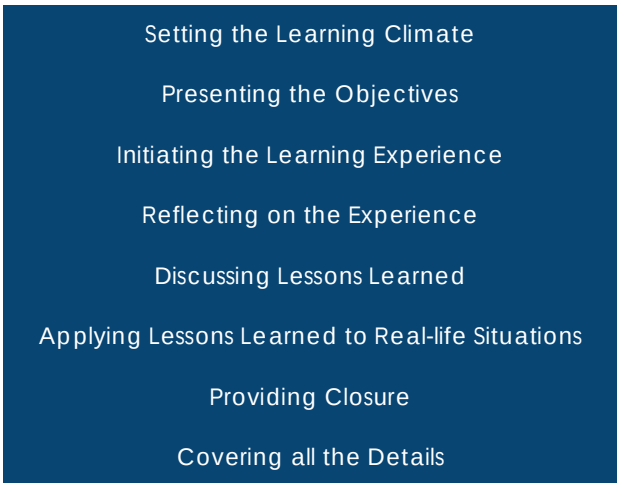
  Refer to Annex C: Role of the Facilitator

- Play the video of a trainer/facilitator and ask the participants to observe and check if the verbal and nonverbal skills were displayed.
- After everyone has noted their responses, discuss similarities and differences in observations.
- Summarise the discussion. Ensure that everyone understands the main points.

Activity 2: Effective Facilitation

STEP 1

- In the PowerPoint presentation display the "What is Effective Facilitation" slide (see figure) and ask the participants to explain how each can be achieved through certain actions.
- Summarise the discussion by reviewing the PPT slides that describe each step.



SESSION 5: UNDERSTANDING THE POLICY PROCESS

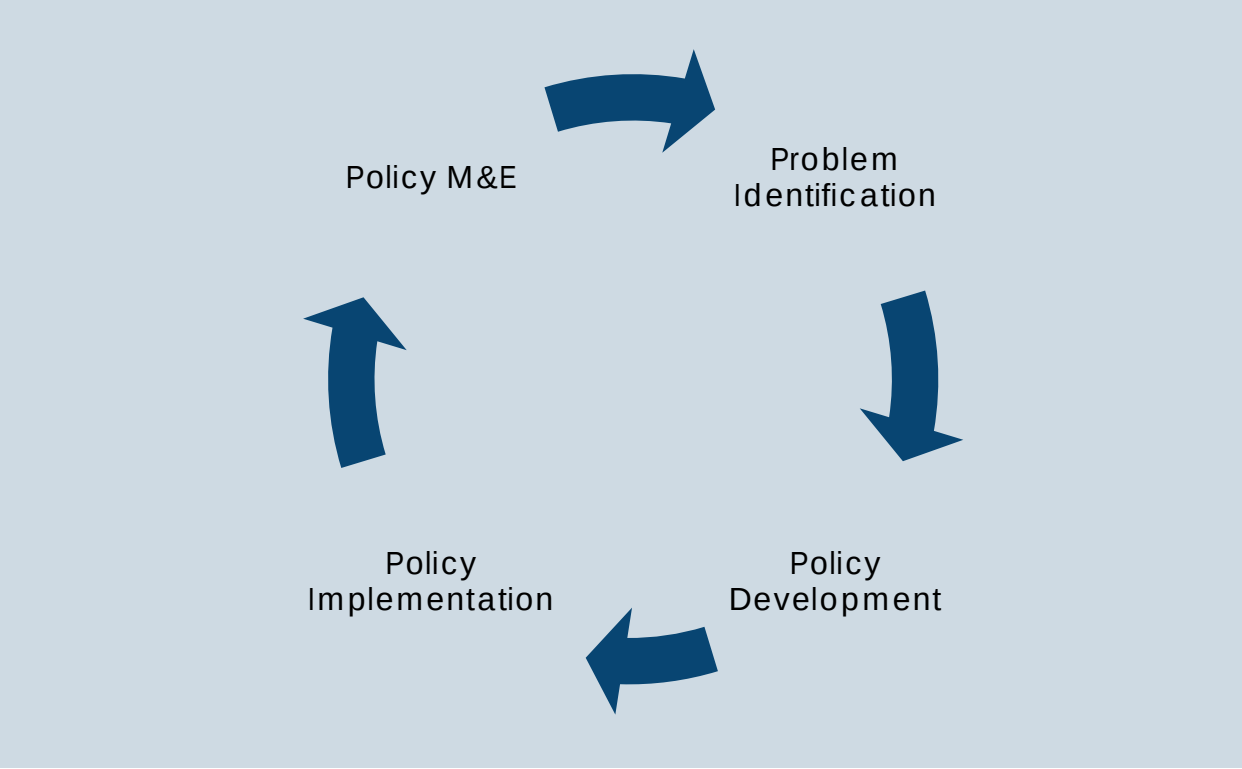
Learning Objectives	By the end of the session, participants will be able to - Describe the policy process. - Recognise their role in the last two stages (policy implementation and M&E). - Recall their roles and responsibilities for policy implementation, and M&E.
Materials	PowerPoint presentation #5, copies of the Jharkhand Health and Family Planning Policy and FP Strategy document, pre-prepared flip chart for functionaries and roles activity
Methodology	Presentation and discussion
Duration	60 minutes

Activity 1: Policy Process

STEP 1

- Ask participants what their first thought is on hearing the word "policy" and write on a VIPP card; summarise with a brief discussion of policy.
- Present the policy cycle (see figure) and ask the participants to discuss what each stage of the process means.
- Write down the key points on the flip chart. Summarise the key points in the Annex

Refer to Annex D.1: Understanding the Policy Process



Activity 2: Who Can Make It Possible?

STEP 1

- Show the participants the tasks under policy implementation, policy monitoring, and evaluation and ask them which functions are the responsibility of the state-, district- and sub-district-level functionaries (see figure below).

- Ask participants to list on the pre-prepared table on the flip chart all the functionaries in the health system responsible for ensuring the implementation and monitoring of the FP Strategy. Start with the state level, then the district level, and finally, the sub-district level. If participants have not included some of the functionaries and stakeholders listed below, augment the list.
- After listing the functionaries on the flip charts, ask the participants to add the role of each functionary in policy implementation and policy M&E. The facilitator can consolidate the responses and summarise.

Policy Implementation

- Mobilise resources for dissemination, training, and implementation.
- Plan for health system needs, modifications, resources, and information.
- Disseminate policies and guidance, and provide training.
- Establish communication and M&E mechanisms.
- Manage and coordinate effective/efficient use of resources (human, financial, material, information) to support implementation.
- Steward private sector and NGO participation in implementation.
- Address bottlenecks in implementation and systems.

Policy Monitoring and Evaluation

- Commission periodic reviews of performance indicators.
- Support forums to include feedback.
- Conduct epidemiological analysis, coverage studies, and cost-effectiveness analysis.
- Implement M&E plans.
- Track expenditures.
- Link operations data (Management Information Systems (MIS) to decision making and policy reform.
- Establish feedback mechanisms and forums for public debate and citizen participation

Refer to Annex D.2. Roles and Responsibilities of the State-, District-, and Sub-district-level Functionaries.

Policy Functionaries and Stakeholders Flipchart

Level	Position	Policy Implementation	Policy M&E
State			
	MD NRHM		
	Director in-charge		
	FP Cell		
	QA Cell		
	IEC cell		
	Training cell		
	State statistics division		
	State FP task force		
	State Health Systems Resource Centre (SHSRC)		
	NGOs		
District/block			
	District program manager		
	District data manager		
	Block program manager		
	Medical officer in-charge		
	Block data manager		
	District program coordinator		
	RKS		
	VHSCs		
	QA Committee		

SESSION 6: UNDERSTANDING FP POLICIES, PROGRAMS AND STRATEGIES

Learning Objective	By the end of the session, participants will be able to • Summarise the FP programmes and strategies, and the status of FP and other health indicators.
Materials	PowerPoint presentation # 6, policy and strategy handouts including: • NRHM Policy for FP, special programmes and schemes • Jharkhand Population and RCH Policy • Jharkhand Family Planning Strategy • Family Planning section of the state PIP 2012–13
Methodology	Discussion, group work and presentations
Duration	120 minutes

Activity 1: Population Policies and Issues

STEP 1

- Deliver PowerPoint presentation #6, *FP Issues and Directions* (slides 1–41), and facilitate a follow-up discussion on the population of India, the state, and the associated FP issues. Highlight the following points:
    - Population of India and the state
    - Current status of fertility and mortality
    - Impact of high fertility and other health indicators on social and economic development
    - Challenges and barriers
    - Opportunities
    - Benefits of FP
- Continue with PowerPoint presentation #6 (slide 42 onwards) and facilitate a follow-up discussion on the how national and state policies are in line with one another and that specific modifications have been made to address issues in the state. Highlight the following:
    - National, state, and district policy and strategy documents that affect FP programme implementation in Jharkhand

Refer to Annex E: Family Planning: Issues and Strategic Directions

STEP 2

- Divide the participants into four groups. Give each group one of the policy and strategy documents listed above.
- Ask the groups to review the document, highlight the key points and prepare a presentation for the entire group. They can use and augment the slides shown above or use another methodology

more appropriate for the district setting. Allow 60 minutes to review the documents and prepare the presentation. Presentations should address the following:

  - When was the policy/strategy launched?
  - What are the key highlights of the policy/strategy?
  - What are the strategic directions/recommended activities to achieve the desired objectives?
  - What are the targets of achievement and when are they expected to be achieved?

- Allow each group 10 minutes to present. Ask the participants to keep it crisp, with 1–2 slides per section.
- After each group presents, ask the other groups if they have any questions or suggestions.
- Once all the groups have presented the policies and strategies, highlight any key points that the groups may not have captured, based on the summary slides in PPT presentation #6. Clarify any concerns or questions participants have about delivering this information in the districts.
- Summarise and discuss how the national and state visions compare.

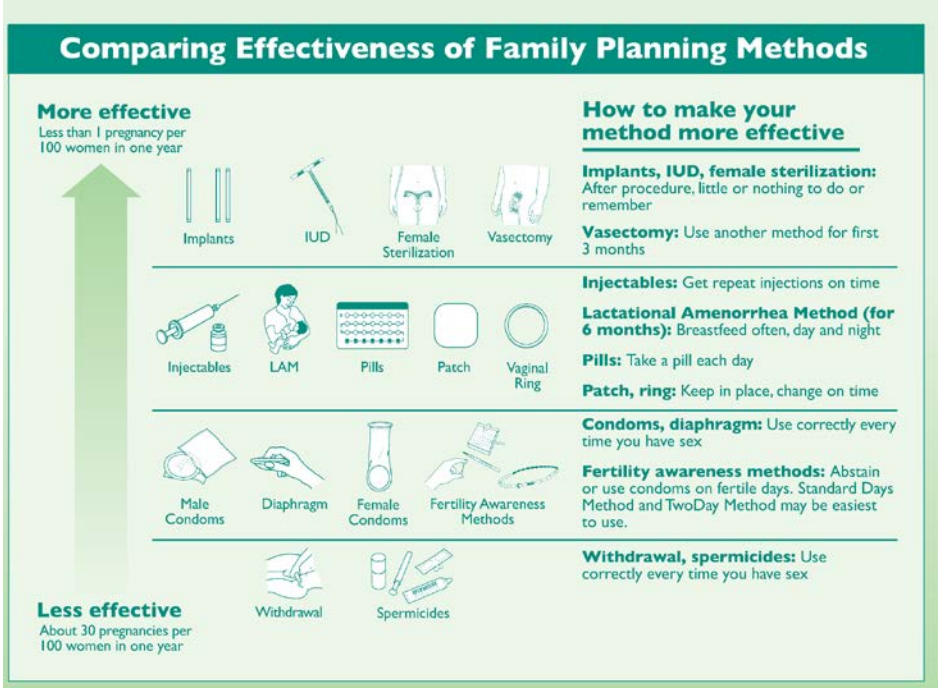
SESSION 7: CONTRACEPTIVE UPDATE

Learning Objectives	By the end of the session, participants will be able describe the rights of the clients and the use, benefits, and shortcomings of various contraceptives
Materials	• Flip charts, markers, sticky dots, and the *Family Planning—A Global Handbook for Providers 2011 Update* • PowerPoint presentation #7
Methodology	PowerPoint presentation, small group work, discussion
Duration	120 minutes

Activity 1: Basket of Contraceptives

STEP 1

- Hang charts in three corners of the training room with the following written in large fonts—Highly Effective Contraceptive Method; Moderately Effective Contraceptive Method, Less Effective Contraceptive Method.
- Ask each participant to name a contraceptive method and ask them to write it in large letters on an A4 sheet of paper.
- Ask each person to stand in one of the three corners based on whether their chosen method is a highly, moderately, or less-effective contraceptive method.
- Open the discussion to the entire group. Ask if they agree with where each method is placed, if not, where they would like to shift it, and why?
- Once the entire group has agreed with the new categorisation, ask if they see commonalities in the methods among each category.
- Open slide #11 from PowerPoint presentation #4 on Comparing Effectiveness of FP Methods and share more details from the *Family Planning Handbook for Health Providers, 2011 Update*.



Source: WHO, 2011.

STEP 2

- Give a copy of the *Family Planning—A Global Handbook for Providers 2011 Update* to all the participants.
- Ask them to prepare, individually or in groups of two or three, a one-hour update session on any one method for auxiliary nurse midwives (ANMs) or accredited social health activists (ASHAs).
- Ask each participant to give a presentation on how they would do the session. Give them 20 minutes to prepare and 10 minutes to present.

Activity 2: Rights and Family Planning

STEP 1

- Ask the participants to share their thoughts or define 'Voluntary Decision Making' with respect to contraceptive choices.
- List their responses on a flip chart and let them discuss whether they agree or disagree with the responses.
- Explain that the term "informed and voluntary decision making" (EngenderHealth, 2008) is used to underscore the importance of the decisions that individuals make in every area of sexual and reproductive health (SRH), even when options are limited and their need is urgent. "Examples of decisions that people make concerning their SRH include the following:
    - **For FP:** whether to use contraception to delay, space, or end childbearing; which method to use; whether to continue using contraception when side effects occur; whether to switch methods when the current method is unsatisfactory; and whether to involve one's partner(s) in decision making about FP.

- **For HIV and other sexually transmitted infections (STIs):** whether to use a condom with every act of sexual intercourse; whether to use a dual-protection strategy (to prevent both unintended pregnancy and STIs); whether to limit the number of sexual partners; whether to seek treatment for apparent infection; whether to inform partner(s) if an infection is diagnosed; whether to delay sexual intercourse until the infection is completely treated, and whether to be tested for HIV.
- **For maternal healthcare:** whether to seek antenatal care during pregnancy, whether to improve one's nutrition during pregnancy; whether and when to have sex during pregnancy; whether and when to go to a healthcare setting for assistance with delivery; whether to breastfeed exclusively and for how long; and whether and when to use contraception after delivery.
- **For post-abortion care:** when to seek care following signs of spontaneous abortion; whether and when to seek care for complications of abortion; and whether to use contraception to prevent or delay future pregnancies."

STEP 2

- Give each participant 20 green sticky dots and 20 red sticky dots (or use red and green markers).
- Post the list of 19 statements.
- Ask the group to put a red dot on statements they disagree with and a green sticky dot on statements with which they agree.
- When complete, ask the group for observations, and for those statements where there is a mix of responses, ask for volunteers to explain their answers.
- Discuss which are statements of values and which are factually incorrect (i.e., 9, 10, 19)
- Use the following Survey of Sexual Attitudes (Solter, 1998). Mention the source of the survey clearly.

Survey of Sexual Attitudes (Solter, 1998)	
1. Women should be virgins when they marry. 2. FP should be available for married people only. 3. The average woman wants sex less often than the average man. 4. FP goes against this country's tradition. 5. Vasectomy should not be considered by a man who has only one or two children, or who is under the age of 35. 6. Most people who contract sexually transmitted diseases (STDs) have had many sexual partners. 7. The choice of sterilisation should always be voluntary. 8. Men enjoy sex without love more than women do. 9. Easy availability of FP encourages sexual activity, especially among young people.	10. Using FP methods is not a good idea before the wife has had her first child. 11. It is not unusual for people to be in love with more than one person at a time. 12. Couple should not marry until they have had sexual intercourse. 13. Parents should not allow their daughters as much sexual freedom as they allow their sons. 14. Marital infidelity is equally acceptable or unacceptable for both sexes. 15. A child should be given sex education at school. 16. Abortion is an acceptable form of FP. 17. Couples should only be allowed two children. 18. Prostitutes provide a useful social service. 19. STDs are more common among poor, illiterate people.

- Ask each participant one by one to explain why s/he agrees or disagrees with the statement.
- Summarise the exercise by stating that people's experiences often lead them to different conclusions. We must first of all be aware of our own value systems and respect others' values and beliefs. However, we also need to emphasise rights and correct misinformation.
- Highlight that the rights-based approach to FP and SRH assumes that health and rights are inseparable and that individuals have the right and the capacity to make decisions about their lives. Basic elements of this approach include: gender equity and equality, rights to SRH, and client-centred SRH care. The rights-based approach was adopted at the 1994 United Nations International Conference on Population and Development (ICPD). Share the seven Clients' Rights with the participants.

Clients' Rights (Engender Health, 2008)	
The Rights of Clients Information: Clients have a right to accurate, appropriate, understandable, and unambiguous information related to reproductive health and sexuality, and to overall health. Educational materials for clients should be made available in all parts of the healthcare facility.	**Safety of services:** Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to the proper use of service-delivery guidelines, the existence of QA mechanisms within the facility, counselling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.
Access to services: Services must be affordable and available at times and places that are convenient to clients, without: physical barriers to the healthcare facility; inappropriate eligibility requirements for services; and without social barriers such as discrimination based on gender, age, marital status, fertility, nationality or ethnicity, belief, social class, caste, or sexual orientation.	**Privacy and confidentiality:** Clients have a right to privacy and confidentiality during delivery of services—for example, during counseling and physical examinations and in the way staff handle clients' medical records and other personal information.
Informed choice: A voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding represents his or her informed choice. The decision making process begins in the community, where people get information even before coming to a facility for services. It is the provider's responsibility either to confirm a client's informed choice or to help him or her reach one.	**Dignity, comfort, and expression of opinion:** All clients have the right to be treated with respect and consideration. Providers must ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, especially when their views differ from those of service providers.
	Continuity of care: All clients have a right to continuity of services and supplies, follow up, and referral.

- Close the day with a recap of the day's activities. Ask participants to share their thoughts on the most important aspects of the day, what they will take away from the sessions, and any suggestions for improvement.

SESSION 8: COMPONENTS OF HEALTH SYSTEMS

Learning Objective	By the end of the session, the participant will be able to summarise the six building blocks of health systems and describe the components of health systems within the FP programme
Materials	Flip charts, markers, whiteboard, LCD projector, State PIP, District Health Action Plans (DHAPs) of each district represented in the TOT PowerPoint presentation # 8
Methodology	Presentation, small group work, discussion
Duration	300 minutes

Preparation: At least two or three weeks before the training, invite relevant state or district experts from the state departments, other cells, or the FP task force to prepare to facilitate a session on one or more of the six components of the health systems within the FP context at state and district levels. Provide background information on the training program and the overview presentation (#8) that will precede their sessions. Provide guest presenters with Annex H, so they are familiar with the summary information that will be provided to the participants. Be sure each presenter knows the amount of the time allotted for his/her presentation and for questions and answers.

Activity 1: Components of Health Systems

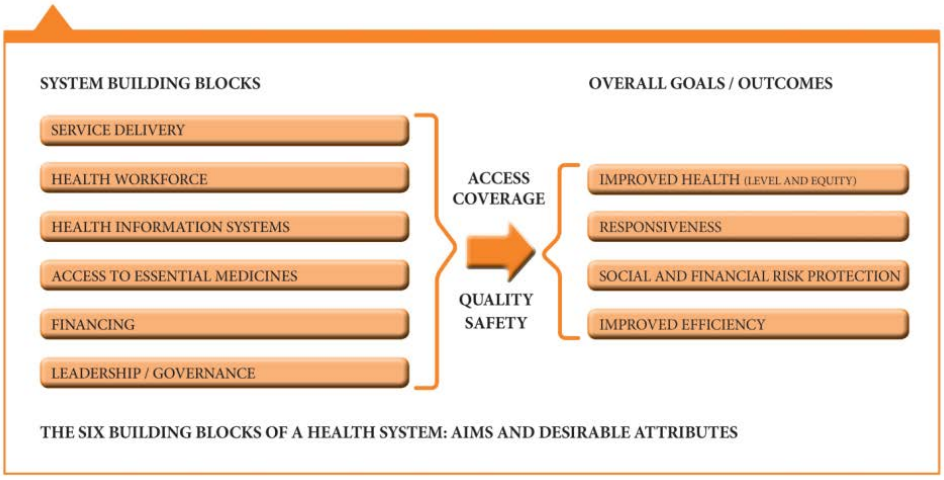
STEP 1

- Welcome participants back to the workshop. Explain the plan for the day; with the assistance of resource persons invited to the workshop, the participants will get an overview of each building block and have the opportunity to ask questions. Then, through small group work, the participants will review the building blocks within the context of the state and district plans for FP, and identify gaps and opportunities to strengthen the systems.

STEP 2

- Give the overview presentation (#8) on the World Health Organisation (WHO) building blocks of health systems.
- Ask if there are any general questions prior to moving into more detailed discussions of each building block throughout the day.

Annex F: Components of Health Systems



Source: (WHO, 2007)

- Facilitate the guest presenters and question and answer sessions for each building block, keeping track of the time to ensure enough time for group work at the end of the day. State or district experts, resource persons from the state departments, cells, or task force should undertake separate sessions on each of the six components of the health systems as outlined below:

1. Health Service Delivery
    a) FP services at public health centres (PHCs), community health centres (CHCs), and district hospitals (DHs)
    b) Fixed-day approach
    c) FP camps
    d) Quality Assurance Committee (QAC) Meetings
    e) QA visits
    f) Behaviour change communication (BCC)/IEC activities at the community level
    g) BCC/IEC display at health facilities
    h) BCC/IEC display at the community level
    i) BCC/IEC tools for improved communication and counselling
    j) Helpline and other mobile technology or information and communication technology (ICT) for demand generation and behaviour change
    k) Intersectoral convergence and partnerships
2. Health Workforce
    a) Technical human resources
    b) Managerial human resources
    c) Community-level human resources
    d) Trainings and capacity strengthening
3. Health Information System
    a) HMIS

4. Access to Essential Medicines
    a) Logistics and supply chain
5. Financing for FP
    a) Fund utilisation vs. approved funds
    b) Budgeting for DHAP/state PIP
6. Leadership and Governance
    a) State-level initiatives (FP cell and task force)
    b) Community participation (Rogi Kalyan Samiti–RKS, Village Health and Sanitation Committee–VHSC, and Village Health Committee–VHC)

STEP 3

- Divide the participants into three groups and ask them to identify the various components/activities of the FP programme recommended by the state FP strategy, the respective DHAPs, and the national priority for the year as mentioned in the National PIP guidelines, which will fall under each building block. Identify and write down the current status and need gap, and activities to address this gap.
- Allow 30 minutes for the small group exercise and clarify that each group will have 10 minutes to present its findings.
- The three groups will work on
    1. Health Service Delivery
    2. Health Workforce, Health Information System, and Access to Essential Medicines
    3. Financing for FP and Leadership and Governance
- Ask the teams to present what they discussed on chart papers, following the format in the table below.
- After each presentation, allow time for brief discussion and feedback from other groups.

#	Health Systems	Recommended/ planned in the state/district plans	Current status and need gaps	Key activities/ tasks required
1.	**Health Service Delivery**			
a)	FP services at PHC, CHC, DH			
b)	Fixed-day approach			
c)	FP camps			
d)	Quality Assurance Committee Meetings			

#	Health Systems	Recommended/ planned in the state/district plans	Current status and need gaps	Key activities/ tasks required
e)	Quality Assurance Visits			
f)	BCC/IEC activities at the community level			
g)	BCC/IEC display at health facilities			
h)	BCC/IEC display at the community level			
i)	BCC/IEC tools for improved communication and counselling			
j)	Helpline and other mobile technology or ICT for demand generation and behaviour change			
2.	**Health workforce**			
a)	Technical human resources			
b)	Managerial human resources			
c)	Community-level human resources			
d)	Trainings and capacity strengthening			
3.	**Health Information System**			
a)	HMIS			
4.	**Access to essential medicines**			
a)	Logistics and supply chain			
5.	**Financing for FP**			
a)	Fund use vs. approved funds			
b)	Budgeting for DHAP/State PIP			
6.	**Leadership and Governance**			
a)	State-level initiatives (FP cell and task force)			
b)	Community participation (RKS, VHSC, and VHC)			

SESSION 9: DEVELOPING THE WORKPLAN

Learning Objective	By the end of the session, the participants will be able to consolidate the key activities for health systems strengthening identified throughout the training, and construct a plan to include the key person responsible, and a proposed timeline for the same.
Materials	Plans and templates developed by the participants in the earlier sessions PowerPoint presentation # 9
Methodology	Small group work and PowerPoint presentation
Duration	120 minutes

Activity 1: Developing the Workplan

STEP 1

- Divide the participants based on the level where they work (district/state).
- Hand over the District Action Plans to the district team(s) and the State PIP to the state team/FP cell members.
- Ask the teams to compile their findings and proposed strategies for improving FP programming (systems strengthening, reporting, and monitoring) into one consolidated plan in the following template. Ask them to develop a yearly plan and arrive at key activities/tasks that need to be completed to strengthen the FP programme, the person responsible for completion of the task, and the timeline for completion.
- Ask the teams to present the plans for the state, district, and block levels.

#	Health Systems	Current	Recommended/ planned in the state/ district plans	Key activities/ tasks	Responsible	Timeline
1.	**Health Service Delivery**					
a)	FP Services at PHC, CHC, DH					
b)	Fixed-day Approach					
c)	FP Camps					
d)	Quality Assurance Committee Meetings					
e)	Quality Assurance Visits					
f)	BCC/IEC activities at the community level					
g)	BCC/IEC display at health facilities					

#	Health Systems	Current	Recommended/ planned in the state/ district plans	Key activities/ tasks	Responsible	Timeline
h)	BCC/IEC display at the community level					
i)	BCC/IEC tools for improved communication and counselling					
j)	Helpline and other mobile technology or ICT for demand generation and behaviour change					
2.	**Health Workforce**					
a)	Technical human resources					
b)	Managerial human resources					
c)	Community-level human resources					
d)	Trainings and capacity strengthening					
3.	**Health Information System**					
a)	HMIS					
4.	**Access to Essential Medicines**					
a)	Logistical and supply chain					
5.	**Financing for FP**					
a)	Fund use vs. approved funds					
b)	Budgeting for DHAP/State PIP					
6.	**Leadership and Governance**					
a)	State-level initiatives (FP cell and FP task force)					
b)	Community participation (RKS, VHSC, and VHC)					

SESSION 10: DEVELOPING THE MENTORING AND SUPPORTIVE SUPERVISION PLAN

Learning Objective	The participants recognise the skills and approach involved in mentoring and supportive supervision, and develops a mentoring and supportive supervision plan for at least six months, which includes the use of the mentoring plan.
Materials	Gantt chart to develop the field plan and a copy of the *Manager's Tool* PowerPoint presentation #10
Methodology	Small group work
Duration	120 minutes

Activity 1: Monitoring and Supportive Supervision

- Ask the participants to share their views on the following
    - Definition of supervision and important points to remember
    - What a good supervisor should know, do, and not do
    - Supervisor's roles and responsibilities
    - Qualities and attributes of a good supervisor
- Write their responses on large flip charts and discuss the key points on supportive supervision with PowerPoint presentation #10.

Refer to Annex G: Supportive Supervision

Activity 2: Using the *Manager's Tool*

STEP 1

- Introduce the *Manager's Tool* to the participants in this session, take them through each aspect of it, and explain the correct way to fill it out.

Refer to Annex H: Manager's Tool

STEP 2

- If possible, plan a half-day field visit to a CHC, FP camp, or Village Health and Nutrition Day (VHND) and ask the managers to use the tool and provide supportive supervision and mentoring support.
- In the field, if the managers are stuck or unable to conduct the visit and play the role of a good supervisor or mentor, gently step in and offer a positive model.
- After returning from the field, discuss the experiences with the participants, and ask for their feedback on the following:
    - Aspects of the visit that went well, and the ways in which the *Manager's Tool* was useful.
    - Difficult aspects of the visit.

- Aspects of the *Manager's Tool* or supportive supervision where the participants might have questions and would want to know more.
- Revisit the *Manager's Tool* and the supportive supervision sessions to clarify any doubts.

Activity 3: Developing a field visit plan for mentoring

- Ask the participants (as state- and district-level teams) to list the number of facilities they plan to visit each month, monitor, and supervise. Ask them to list the number of meetings or trainings they would attend and the opportunities for providing mentoring support. Separate plans can be made for each district.
- Ask the managers to use the *Manager's Tool* to record their observations, provide feedback, and take required action for each of the tasks in their plan.

Ask them to list the number of planned visits to the specific blocks. The plan below means that Mr X, District Programme Manager, will make two PHC visits in Kolibara block of Simdega district in Jharkhand. He will also visit these two PHCs in the first week of the next month as a follow up.

Ask the participants to make a realistic plan for three months, including as much detail as they can think of and plans for public holidays, mandated monthly meetings, festivals, and seasonal phenomenon where working may be difficult. Tell the participants that the focus of the meetings and visits should be to improve the FP programme and to identify issues to address in the blocks and best practices in one block for use in a similar situation.

Name: _____

Designation: _____

Location: _____

TASK	Month 1				Month 2			
	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
Sub-centre visits								
CHC visits								
PHC visits	Two at Kolibara, Simdega				Two at Kolibara, Simdega			
District Hospital (DH) visits								
RKS meetings								
QA meetings								
VHSC meetings								

VHND with FP services								
District Head Quarters								
HMIS data quality at District Head Quarters								
ARSH Clinics providing counselling on delaying								
Inclusion of FP agenda in the VHSC meetings								
FP camps and fixed-day services								
Trainings related to FP								
Others								

SESSION 11: PRACTICUM—PREPARING FOR DISTRICT-LEVEL TRAININGS

Learning Objective	Participants strengthen their skills in conducting district-level trainings by designing and enacting a mock training session.
Materials	Materials used in the previous sessions
Methodology	Small group work and presentation
Duration	120 minutes of preparation and 120 minutes of presentation

Activity 1: Preparing session plans

STEP 1

- Form groups of trainers who will conduct the district-level trainings. Ensure that there are at least three trainers per group.
- Assign one session to each group to plan, develop and gather materials, and conduct a mock session. The topics are:

  Group 1: Contraceptive Update

  Group 2: Components of Health Systems (overall) and QA

  Group 3: HMIS data quality and use
- Provide all the relevant materials and presentations to each group and give them two hours to prepare the mock sessions.
- Inform them that they can use the methodologies in the TOT manual to conduct the district-level training or modify it, if necessary.
- Give each group 30–40 minutes to present the mock session, while the other participants assume the role of district- and block-level managers.
- Ask the other group members to provide feedback and suggestions. Then, as TOT facilitators, provide any additional feedback relating to the presenters' facilitation and training skills, technical information, and methodology.

REFERENCES

AusAID. 2006. *A Staged Approach to Assess, Plan and Monitor Capacity Building*. Canberra: AusAID.

Bridgman, P., and G. Davis. 2003. "What Use is a Policy Cycle? Plenty, If the Aim Is Clear." *The Australian Journal of Public Administration.* 62(3): 98–102.

Centre for Development and Population Activities. 1995. The CEDPA Training Manual Series. Volume 1, *Conducting a Workshop in Participatory Training Techniques.* Washington DC: CEDPA.

Children's Vaccine Program at PATH. 2003. *Guidelines for Implementing Supportive Supervision*. Seattle: PATH.

Cross, Harry, Norine Jewell, and Karen Hardee. 2001. Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs. *POLICY Occasional Paper* No. 7. Washington DC: The Futures Group International, POLICY Project.

EngenderHealth/The ACQUIRE Project. 2008. *Counseling for Effective Use of Family Planning: Participant Handbook.* NewYork: EngenderHealth/The ACQUIRE Project.

Hardee, K., I. Feranil, J. Boezwinkle, and B. Clark. 2004. The Policy Circle. *POLICY Working Paper* No. 11. Washington, DC: The Futures Group, POLICY Project.

Hardee, Karen, Lori Ashford, Elisabeth Rottach, Rachel Kiesel, and Rima Jolivet. 2012. *The Policy Dimensions of Scaling Up Health Initiatives.* Washington, DC: Futures Group, Health Policy Project.

Howard, C. 2005. "The Policy Cycle: A Model for Post-Machiavellian Policy Making?" *The Australian Journal of Public Administration.* 64(3): 3–13.

International Institute for Population Sciences (IIPS) and Macro International. 2009. *District Level Household and Facility Survey (DLHS-3), 2007-09*: *Fact Sheet.* India Mumbai: IIPS.

IIPS and Macro International. 2007. *National Family Health Survey (NFHS-3), 2005-6: India: Volume I.* Mumbai: IIPS.

International Planned Parenthood Federation (IPPF). June 2006. *Supportive Supervision for Quality Improvement. Training of Trainers Guide for Health Professionals.* London: IPPF.

Knowles, M. 1996. Adult Learning. In Robert L. Craig (Ed.), *The ASTD Training and Development Handbook* (pp. 253–264). New York City: McGraw-Hill Companies, Inc.

Lasswell, Harold D. 1951. "The Policy Orientation." *In The Policy Sciences: Recent Developments in Scope and Method,* eds. Daniel Lerner and Harold D. Lasswell. Stanford: Stanford University Press.

McMahon, R. et al. 1992. *On Being in Charge: A Guide to Management in Primary Health Care.* Geneva: World Health Organisation.

Ministry of Health and Family Welfare (MoHFW). 2006. *Quality Assurance Manual for Sterilization Services*. New Delhi: MoHFW, GOI.

NRHM. 2008. Community Participation for Jharkhand State.

Office of the Registrar General and Census Commissioner (ORGI), India. 2012. *Annual Health Survey 2011–12: Fact Sheet.* New Delhi: Vital Statistics Division, Office of the Registrar General & Census Commissioner, India.

Office of the Registrar General and Census Commissioner (ORGI), India. 2011. *Provisional Population Totals: Paper 1 of 2011, Series 1.* New Delhi: Office of the Registrar General & Census Commissioner, India.

O'Sullivan, G.A., J.A. Yonkler, W. Morgan, and A.P. Merritt. 2003. *A Field Guide to Designing a Health Communication Strategy.* Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.

Planning Commission, GOI. May 2011. *Report of the Working Group on National Rural Health Mission (NRHM) for the Twelfth Five Year Plan (2012-2017).* New Delhi: GOI.

POLICY Project. 1999. *Networking for Policy Change: An Advocacy Training Manual*. Washington, D.C.: Futures Group International.

Population Council. 2010. *Facilitating Provision of Client Centered Family Planning Services through Supportive Supervision. A Guide for Human Resource Management.* Islamabad: Population Council.

Ross, John, and Ellen Smith. 2010. *The Family Planning Effort Index: 1999, 2004, and 2009.* Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1.

Sabatier, Paul. 2007. *Theories of the Policy Process*. Boulder: Westview Press.

Solter, C. 1998. "Survey of Sexual Attitudes" in *Comprehensive Reproductive Health and Family Planning Training Curriculum*. Watertown, MA: Pathfinder International.

Sundararaman, T. 2011. *HMIS Manager's Manual—User Manual for DHIS 2. VOLUME III.* New Delhi: National Health Systems Resource Centre.

United Nations Population Fund (UNFPA). 1999. Technical Report: Planning Population Development Projects with Focus on Decentralization and Quality of Care.

United States Agency for International Development (USAID). 2000. "Policy Implementation: What USAID Has Learned." Center for Democracy and Governance. Washington, DC: USAID.

USAID-supported IFPS Technical Assistance Project. 2010. *"Soch Se Amal Tak-State Level Behaviour Change Communication (BCC) Planning Workshop."* IFPS Technical Assistance Project. India.

Voorhees, R. 2001. "Competency-Based Learning Models: A Necessary Future." *New Directions for Institutional Research.* 2001(110): 5–13.

Walt, G., and L. Gilson. 1994. "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis." *Health Policy and Planning* 9(4): 353–370.

World Health Organisation (WHO). 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* Geneva: WHO.

WHO. 2008. *Training for Mid-level Managers (MLM): Module 4: Supportive Supervision.* Geneva: WHO.

WHO. 2010. *Key components of a Well-functioning Health System.* Geneva: WHO.

WHO Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. 2011. *Family Planning: A Global Handbook for Providers 2011 Update*. Baltimore and Geneva: CCP and WHO.

ANNEX A. STAGED CAPACITY BUILDING PLAN MODEL

Source: AusAID. 2006. *A Staged Approach to Assess, Plan and Monitor Capacity Building* (p. 10). Canberra: AusAID.

	Dependent	Guided	Assisted	Independent
Level of project support	High	Medium	Low	Occasional or none
	Primary ownership of work by project	Primary ownership of work by government counterparts		
Planning	Planning for capacity building is done by the project, often within the context of a wider strategic plan.	Planning is done by project and capacity building partners, in consultation with government counterparts.	Project and partners assist government counterparts to plan their work.	Planning for day-to-day work is done by government counterparts, within the context of a wider strategic plan.
Doing the work	Project does all the complex tasks. Government counterparts carry out straightforward tasks, usually under close supervision.	Government counterparts carry out straightforward tasks with limited guidance. Complex tasks require direction from the project. Government counterparts are not always aware of the scope of a task and may not realise when they need to ask for help.	Government counterparts can do most of the tasks without assistance. Government counterparts know when to ask for help, but only need to do so occasionally.	All tasks are done by the government counterparts. No input is requested from the project.
Quality control	The project controls the quality of work by checking all outputs.	The project checks most work to ensure quality.	Government counterparts take responsibility for work quality with sample checking by the project.	Government counterparts take full responsibility for work quality. No checking is done by the project.
Responsibility for outcomes and results	The project is responsible for achieving the outcomes, and will do whatever is necessary to achieve them.	The project works with government counterparts to help them understand their responsibility for achieving the outcomes.	Government counterparts understand that they are responsible for achieving outcomes but may sometimes need to be prompted.	Government counterparts are responsible for achieving the outcomes, and will do whatever is necessary to achieve them.

In summary	The project makes things happen.	The project works with government counterparts to make things happen.	Government counterparts make things happen with the occasional prompt from the project.	Government counterparts make things happen.

ANNEX B. CHANGING ROLES IN CAPACITY DEVELOPMENT SUPPORT

Source: Adapted from Jorgensen, A., K. Hardee, E. Rottach, A. Sunseri, M. Kinghorn, A. Bhuyan, and M. Hijazi. Unpublished. *Capacity Development Framework and Approach for Health Policy, Governance, and Social Participation* (pp. 31–32). Washington, DC: Futures Group, Health Policy Project.

The role of capacity strengthening and the modality through which the support is provided may be fluid in any given context, especially in situations of long-term engagement. Specifically, members of the State Resource Group will likely need to assume a variety of roles to support capacity development among its partners, ranging from more directive to more facilitative roles, as capacity improves and the needs change (see Figure 1).

Figure 1. External Assistance Role vis-à-vis Capacity Development Entry Points

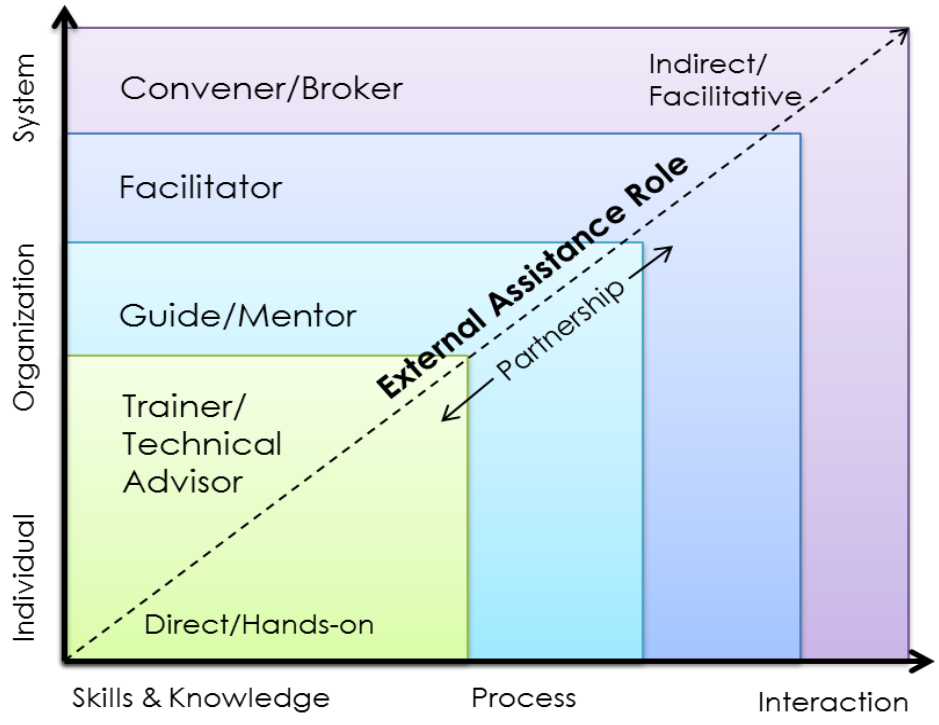


Figure 2: Role vis-a-vis Capacity Development Entry Points

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

Typical roles include the following:

Technical advisor: The State Resource Group member applies his/her technical knowledge and expertise to assist a partner in addressing a specific challenge or goal. Technical leadership comes from the advisor. Subsequent support is ongoing in the form of mentoring and joint learning.

Trainer: The training approach reinforces experiential learning aimed at supporting the recipient to apply newly acquired skills and knowledge through practical application. Similar to the technical assistance role, technical leadership still largely comes from the trainer, but horizontal (peer) learning also features prominently.

Guide/mentor: This includes offering systematic guidance to a learner or organisation as it integrates and applies new skills and capabilities, allowing the learner to pose questions, request assistance to address challenges, and engage in collegial interaction. The partner leads the activity or task, while the resource person provides feedback, advice, and occasional hands-on support. Guides and mentors must strive to demonstrate high technical standards and to embody positive relational skills.

Facilitator: This is a process-oriented role in which support is provided for planning, and strategy development.

Convener/broker: Similar to the facilitator role, this means connecting stakeholders to identify and achieve shared goals and creates new opportunities for collaboration.

Partnership cuts across all of the above. Groups or individuals offering assistance learn as much from their partners and the group interaction as they offer through providing assistance. Thus, mechanisms and opportunities for bidirectional learning should feature in every step of the capacity strengthening process.

ANNEX C. ROLE OF THE FACILITATOR

Source: POLICY Project. 1999. *Networking for Policy Change: An Advocacy Training Manual* (pp. iii–v). Washington, DC: Futures Group

Role of the Facilitator	Check if you noticed this
Nonverbal Communication	
1. Maintain eye contact with everyone in the group when speaking. Try not to favour certain participants.	
2. Move around the room without distracting the group. Avoid pacing or addressing the group from a place where you cannot be easily seen.	
3. React to what people say by nodding, smiling, or engaging in other actions that show that you are listening.	
4. Stand in front of the group, particularly at the beginning of the session. It is important to appear relaxed and at the same time be direct and confident.	
Verbal Communication	
1. Ask open-ended questions that encourage responses. If a participant responds with a simple 'yes' or 'no', ask "why?".	
2. Ask other participants if they agree with a statement someone has made.	
3. Be conscious of your tone of voice. Speak slowly and clearly.	
4. Avoid using slang or other "special" language.	
5. Make sure that participants talk more than you do.	
6. Let participants answer each other's questions. Ask "Does anyone have an answer to that question?"	
7. Encourage participants to speak and provide them with positive reinforcement.	
8. Paraphrase statements in your own words. You can check your understanding of what participants are saying and reinforce statements.	
9. Keep the discussions moving forward and in the direction you want. Watch for disagreements and draw conclusions.	
10. Reinforce statements by sharing a relevant personal experience. You might say "That reminds me of something that happened last year..."	
11. Summarise the discussion. Make sure that everyone understands the main points.	

Effective facilitation includes the following:

Setting the Learning Climate:

- Read each section and review all materials and activities before each training session so that you are fully comfortable with the content and process.
- Start on time and clearly establish yourself as the facilitator by calling the group together.
- Organise all the materials you need for the session and place them close at hand, stay within the suggested time frames.
- Gain participants' attention and interest by developing comfort between yourself and them.
- Anticipate questions.
- Prepare responses and examples to help move the discussion forward.

Presenting the Objectives:

- Provide a link between previous units and the current one.
- Use the background notes that begin each unit to introduce the topic under consideration.
- Inform participants of what they will do during the session to achieve the unit's objectives.

Initiating the Learning Experience:

- Introduce, as appropriate, an activity in which participants experience a situation relevant to the objectives of the unit.
- Let participants use the experience as a basis for discussion during the next step.
- If you begin a unit with a presentation, follow it with a more participatory activity.

Reflecting on the Experience:

- Guide discussion of the experience.
- Encourage participants to share their reactions to the experience.
- Engage participants in problem-solving discussions.
- See that participants receive feedback on their work from each other and from you.

Discussing Lessons Learned:

- Ask participants to identify key points that emerged from the experience and the discussion.
- Help participants draw general conclusions from the experience. Allow time for reflection.

Applying Lessons Learned to Real-life Situations:

- Encourage participants to discuss how the information learned in the activity will be helpful in their own work.
- Discuss problems participants might experience in applying or adapting what they have learned to their own or different situations.
- Discuss what participants might do to help overcome difficulties they encounter when applying their new learning.

Providing Closure:

- Briefly summarise the activities at the end of each unit.
- Refer to the objective(s) and discuss whether and how they were achieved.
- Discuss what else is needed for better retention or further learning in the subject area.
- Provide linkages between the unit and the rest of the workshop.
- Help participants leave with positive feelings about what they have learned.

Covering All the Details:

- Prepare all training materials (resources for research, reference materials, handouts, visual aids, and supplies) and deal with logistics (venue, tea breaks, and audio-visual equipment) in advance.
- Clarify everyone's roles and areas of responsibility if other facilitators are helping to conduct the training. Meet with the co-facilitators daily to monitor the progress of the workshop and to provide each other with feedback.
- Ask participants to evaluate the training both daily and at the end of the workshop.
- Plan follow up activities and determine additional training needs.

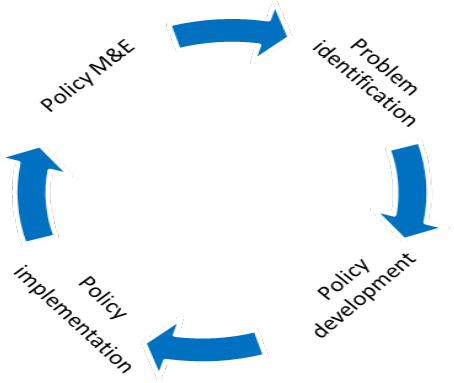
ANNEX D.1. UNDERSTANDING THE POLICY PROCESS

Source: Jorgensen, A., K. Hardee, E. Rottach, A. Sunseri, M. Kinghorn, A. Bhuyan, and M. Hijazi. 2012. *Capacity Development Framework and Approach for Health Policy, Governance, and Social Participation* (pp. 20–21). Washington, DC: Futures Group, Health Policy Project

Strengthening the capacities of multiple stakeholders to navigate the complex dynamics of developing and implementing policies requires a substantive understanding of the policy process. A number of theories and frameworks of policy have been developed over the years to describe the process (Sabatier, 2007). The policy process is clearly complex and context-dependent, and includes many feedback loops (Howard, 2005; Hardee et al., 2004). However, this framework makes use of a stages approach first articulated in the 1950s (Laswell, 1951) and still used today to facilitate identifying and defining competencies needed to engage in health policy (Bridgman and Davis, 2003). The four stages of the process are:

Problem identification. The initial step is identifying the problem requiring a policy response to be placed on the policy agenda. The problem may require developing a new policy or changing an existing one (or set). Problems can be identified through various means, e.g. studies, assessments, gender analyses, or health surveys, and by a number of stakeholders. Advocacy by civil society, women's groups, media, healthcare providers, or policymakers, is a common approach for raising issues. Problem identification is most effectively based on evidence to determine the extent of the problem and to suggest feasible and cost-effective policy responses.

Figure 4. Policy Process



Policy development. Once the problem has been established, it is framed by the diversity of stakeholders to determine if it will make it onto the policymaking agenda, and how the policy response will be formulated. Policy development requires attention to policy content (e.g. clear goals, strategic directions, institutional arrangements, resource needs, indicators of success), as well as policy processes (e.g. evidence-based, participatory processes). Different stakeholders play different roles in policy development. Policymakers determine what officially gets on the policy agenda and have official roles in voting for policies. Other stakeholders can and should influence this process by advocating for issues to be placed on the policy agenda and participating in dialogue to determine the content of the proposed policies.

Policy implementation. Implementation of policies is the actual "doing" of the actions outlined. Since policies are often broad statements of intention, they require supplemental documents in the form of strategic plans, implementation plans, and operational policies to ensure that they are carried out (Walt and Gilson, 1994; Cross, Jewell, and Hardee, 2001; USAID, 2000). Policy implementation may involve the scale-up, testing and rolling out of new or improved services in alignment with policy goals. By establishing operational policy guidelines, reliable funding, and adherence to equity principles, effective scale-up of policies and plans helps to lay the foundation so that services are not provided in an ad hoc, arbitrary, or inconsistent manner (Hardee, Ashford, et al., 2012).

Policy implementation to put policies into practice is generally the purview of technocrats. However, it is best done as a consultative process where policymakers, the private sector, and civil society

representatives alike remain engaged in outlining what, how, who, when, and where resources and efforts are needed. Scale-up and sustainability are achieved when the goals, principles, and operational guidelines of policy directives are normalised and consistently supported as part of the everyday practice of health service planning and provision. Therefore, effective policy implementation requires an understanding of existing institutions and bureaucracies, and the actions needed to create or modify programmes, or remove barriers to implementation.

Policy monitoring and evaluation. Monitoring the implementation efficiency and impact of the new policies is important both to continually improve the policies and practices that support strong health systems, as well as ensuring accountability of government to citizens. Therefore, policy monitoring and assessment should be a concern for all stakeholders to identify gaps in implementation or potentially negative consequences of the policy that may require additional policy response. Government leaders have a key role to play in fostering accountability—by guiding policy and programme implementation, harnessing resources, and answering to their citizens for pledged commitments. Civil society must be involved in policy monitoring, by serving as a watchdog to monitor how policies are actually rolling out and affecting communities. Strong civil society networks, working through social watch activities, citizen monitoring systems and grievance resolution centres, are key to accountability.

ANNEX D.2. ROLES AND RESPONSIBILITIES OF THE STATE- AND DISTRICT-LEVEL FUNCTIONARIES

Source: Adapted from NRHM *Operational Manual for Preparation and Monitoring of RCH component II of NRHM State Programme Implementation Plans* (2007) and modified by the state department of health and family welfare.

District Level
District Programme Manager • Provide managerial inputs to the district health team including Civil Surgeon, additional chief medical officer (ACMO), District Reproductive and Child Health Officer, and District Programme Officer for district health actions plans, formulating and designing project proposals, district micro plans, monitoring plans etc., from time to time. • Plan and facilitate execution and monitoring all the health action programmes introduced in the state under NRHM, 24x7 first referral unit (FRU) & Public Health Centre operationalisation, Mukhymantri Janani Sishu Swasthya Abhiyan, Routine Immunisation (RI), RCH/FP camps etc., and any other activities as per plan. • Develop monitoring plans for all the public health centres/community Health Centres in the territory and providing feedback to Deputy Director (Health), Civil Surgeon and State Programme Manager. • Ensure uniform and timely submission of reports of all the programmes under NRHM from health sub-centres, public health centres, and community health centres in line with State Programme Management Unit. • Participate in all the monthly meetings at the district level as well as in other meetings related to NRHM. • Apprise district health team on the developments under NRHM at the district level. • Update the Chairperson and members of the District Health society on the progress in the district under NRHM. • Establish and monitor the financial procedures in the district as well as public health centres for smooth functioning of the process. • Prepare and submit monthly workplan and monthly progress report to Deputy Director (Health), surgeons and State Programme Manager. • Represent the district health team in the monthly meeting at the state Head Quarters to review the progress of NRHM in the district. • Ensure proper information flow from public health centres to district Head Quarters and vice-versa. **District IEC Officer (profile being looked after by the)** • Identify the need of BCC/IEC activities at the district level. • Monitor and supervise all BCC activities in the district. • Develop IEC materials and activities with prior permission of civil surgeons of the district. • Develop BCC/IEC implementation plan for the district. **District Data Officer** • Assist District Accounts Manager in managing the affairs of the District Health Society and documenting the decisions taken during the meetings of the district bodies of the Society.

- Prepare monthly progress reports on the implementation of various programmes in the prescribed formats and their timely submission to state Head Quarters.
- Assist the District Programme Manager in developing district workplans.
- Assist the District Programme Management Unit in strengthening the MIS at district and public health centre level.
- Provide assistance to the district and public health centres for the computer hardware and software-related issues.
- Ensure functionality of the Routine Immunisation Management System in the district and the generation of reports.
- Ensure proper coordination between public health centres and district Head Quarters for timely submission of reports.
- Ensure proper coordination between district and state Head Quarters for timely submission of reports.
- Create a data bank at district and public health centre level for easy access to any data related to programmes.
- Ensure coordination with the Civil Surgeon, District Programme Manager and the State Data Officer.

Block Level

Block Programme Manager

- Provide overall leadership to all the health programmes under NRHM, and develop action plans, monitor development and suggest mid-course corrections.
- Responsible for implementation and monitoring of all programmes under NRHM, 24x7 FRU and Public Health Centre operationalisation, Mukhyamantri Janani Shishu Swasthya Abhiyan, Routine Immunisation, RCH/FP camps etc. and/or any other activities as per plan in co-ordination with the District Programme Management Unit.
- Provide managerial inputs to the block health teams including medical officers in-charge, medical officers and other health functionaries in the development of Block Health Action Plan and ensure its timely implementation, and monitoring.
- Develop monitoring plan of all the public health centres/health sub-centres in the territory and provide feedback to respective medical officers in-charge and district programme managers.
- Ensure uniformity and timely submission of reports of all the programmes under NRHM from health sub-centres, public health centres and community health centres in line with State Programme Management Unit. Strengthen documentation of the processes at the block level.
- Participate in all the monthly meetings at the block level as well as other meetings related to NRHM. Apprising block health teams on the developments under NRHM at the block level.
- Assess the training requirements of the block health personnel for enhancing their technical as well as managerial skills, especially at the community health centre/public health centre level and develop training plans for them in collaboration with the District Programme Management Unit and State Programme Management Unit and also explore local opportunities for them.
- Establish and monitor the financial systems and procedures at the block level as well as public health centres and health sub-centres for smooth functioning of the processes.
- Prepare and submit monthly workplans and monthly progress reports to the District Programme Manager, and respective Medical Officer In-charge.
- Represent block health team in the monthly meetings at the district Head Quarters to review the

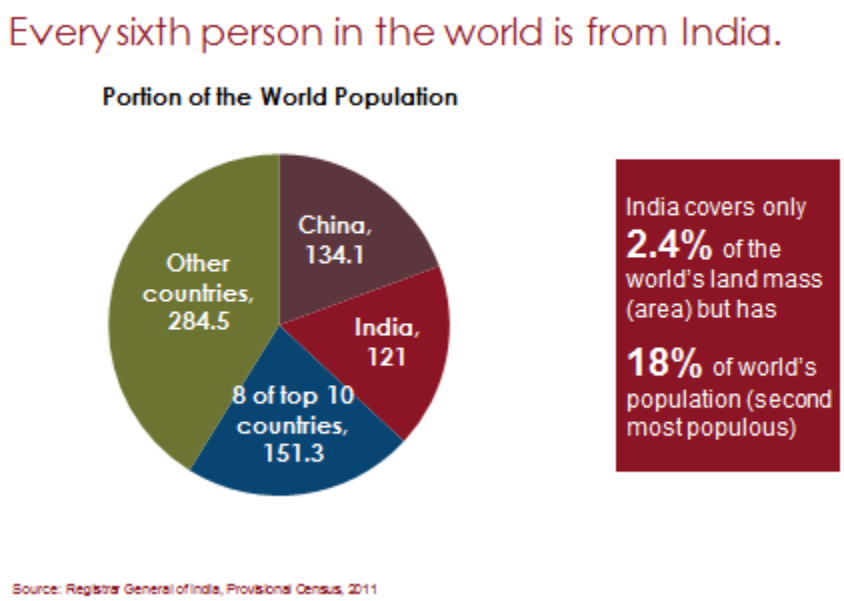
progress of NRHM at blocks.

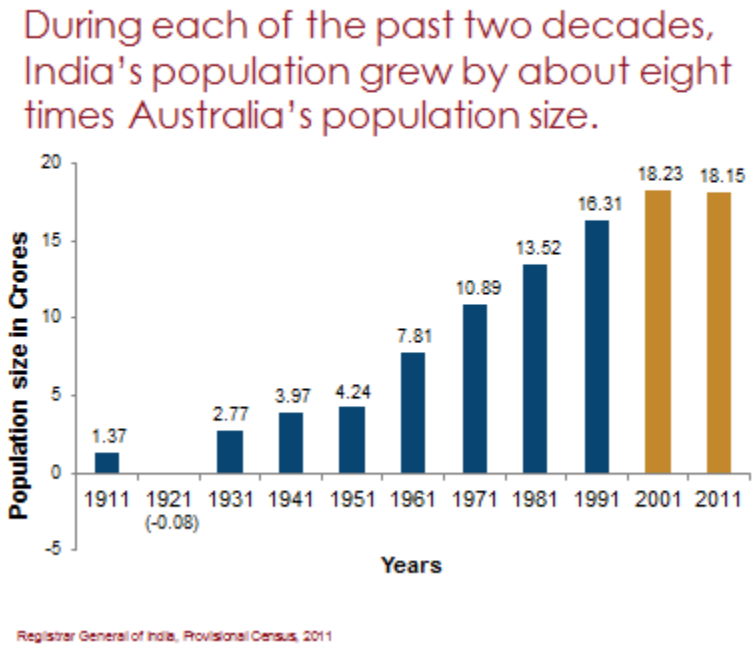
- Ensure proper information flow from health sub-centres/public health centres to block and district Head Quarters and vice-a-versa.
- Any other specific assignment as per requirement.

Block Data Manager (*No Data Manager or Data Assistant position exists in any of the districts. The Block Programme Manager or Block Accounts Manager is responsible for data compilation)*

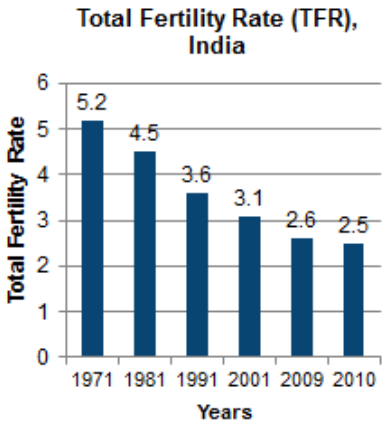
ANNEX E. FAMILY PLANNING: ISSUES AND STRATEGIC DIRECTIONS

Before looking at the effect of rapid population growth on the social and economic development in India, we present some information on historical and current population in India. India's population has almost doubled from 0.7 billion to 1.2 billion in just 30 years (from 1981 to 2011). The number of people added each decade continues to grow. Each year the population grows by the size of Australia's population (21 million).



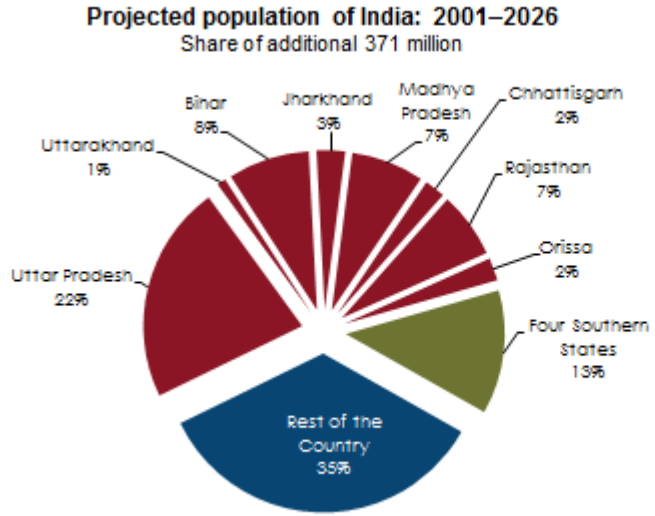


The Good News



- Declining annual population growth rate:
  - 2.16% between 1981–1991
  - 1.97% between 1991–2001
  - 1.64% between 2001–2011
- 20 states/UTs reached TFR 2.1 in 2007
- Urban TFR of 2.1 achieved in 2004

Sources: TFRs are from the Sample Registration System; Population Growth Rate is from Census of India, 2011



Half (50%) of India's population growth will be in **7 northern states.**

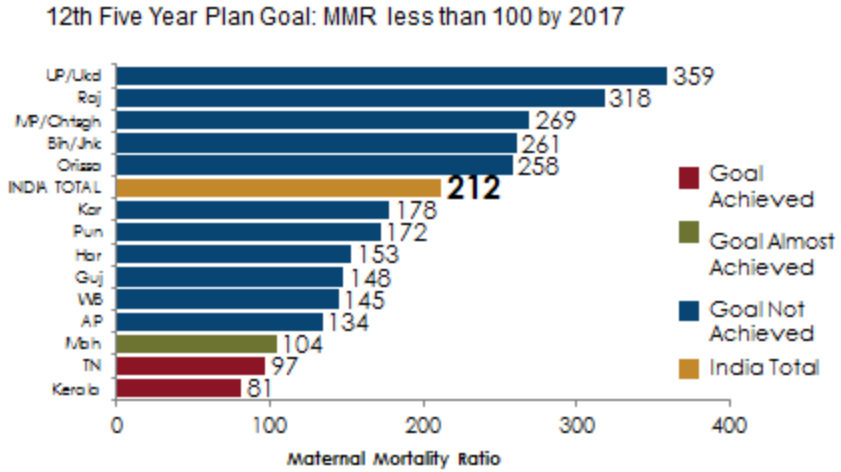
Southern states will contribute only 13% of growth.

Maternal Mortality Ratio

- Maternal Mortality Ratio (MMR) is the number of maternal deaths per 100,000 live births
- 12th Five-Year Plan Goal: MMR less than 100 by 2017

Source: National Rural Health Mission. "Goals." http://www.nrhm.gov.in/about-nrhm/goals.html.

Maternal Mortality Ratio: 2007–2009



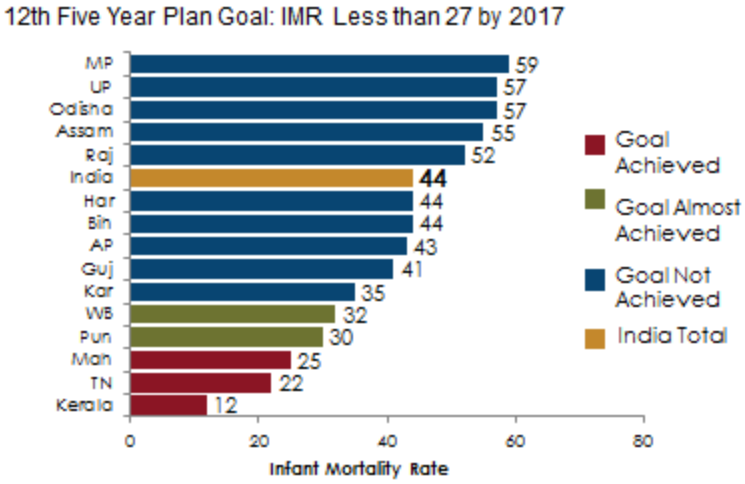
Source: SRS, 2011

Infant Mortality Rate

- **Infant Mortality Rate (IMR):** number of infant deaths per 1,000 live births
- **12th Five-Year Plan Goal:** IMR less than 27 by 2017

Source: National Rural Health Mission, "Goals," http://www.nrhm.gov.in/about-nrhm/goals.html.

Infant Mortality Rate: 2011



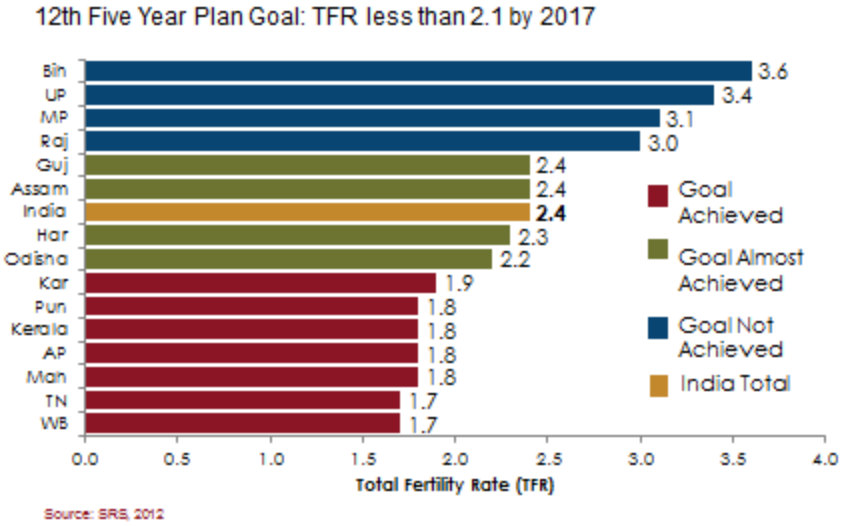
Source: SRS, 2012

Total Fertility Rate

- **Total Fertility Rate (TFR)**: number of children born per woman
- **12th Five-Year Plan Goal:** reduce TFR to 2.1 by 2017

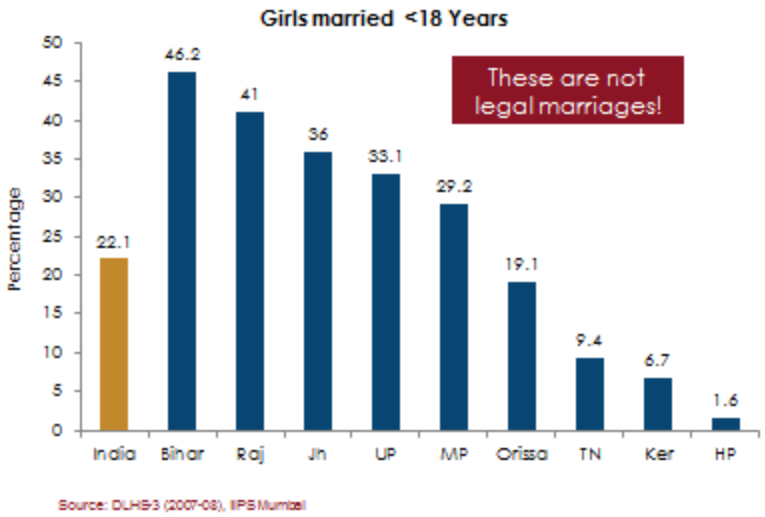
Source: National Rural Health Mission. "Goals." http://www.nrhm.gov.in/about-nrhm/goals.html

Total Fertility Rate: 2011



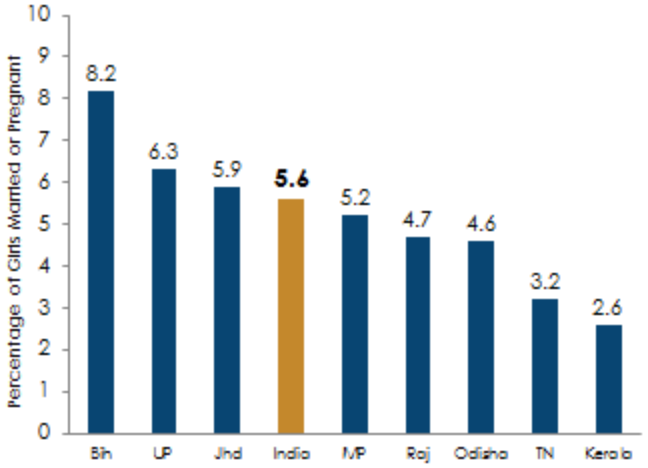
Source: SRS, 2012

Early Age at Marriage Is a Challenge in High-focus States



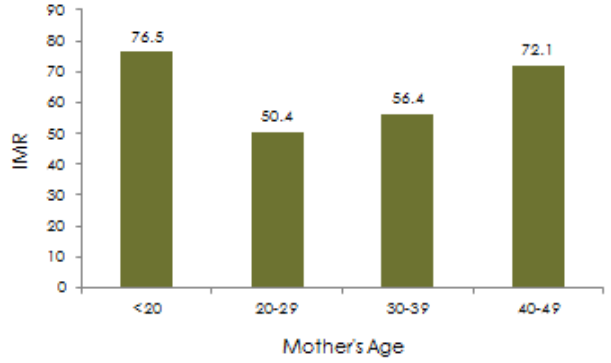
Source: DLHS-3 (2007-08), IIPS Mumbai

Percentage of Teenage Girls Who Are Pregnant or Already Mothers



Higher chance of children dying when:

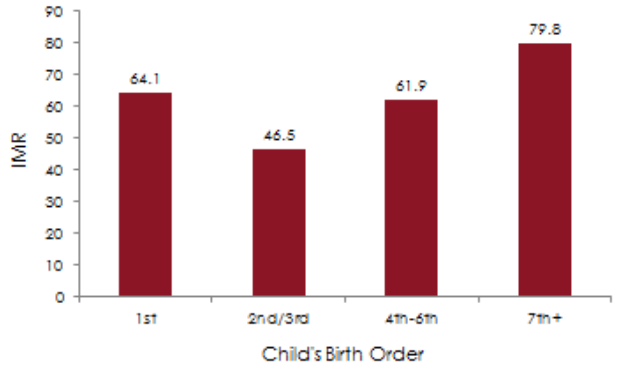
The woman is pregnant before age 20 or after age 40.



Source: DLHS-3 (2007-08), IIPS Mumbai

Higher chance of children dying when:

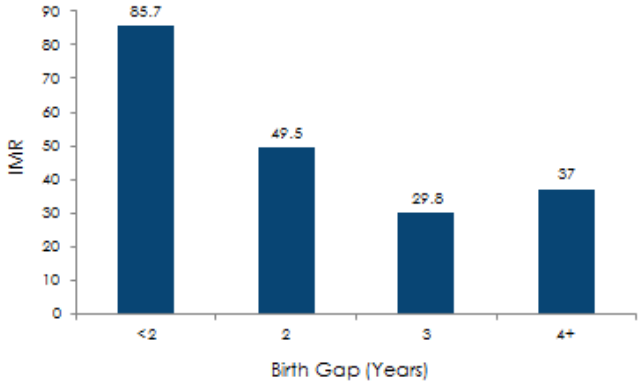
The baby is the first child or fourth and then on.



Source: DLHS-3 (2007-08), IIPS Mumbai

Higher chance of children dying when:

Gap between two births is less than 2 years.

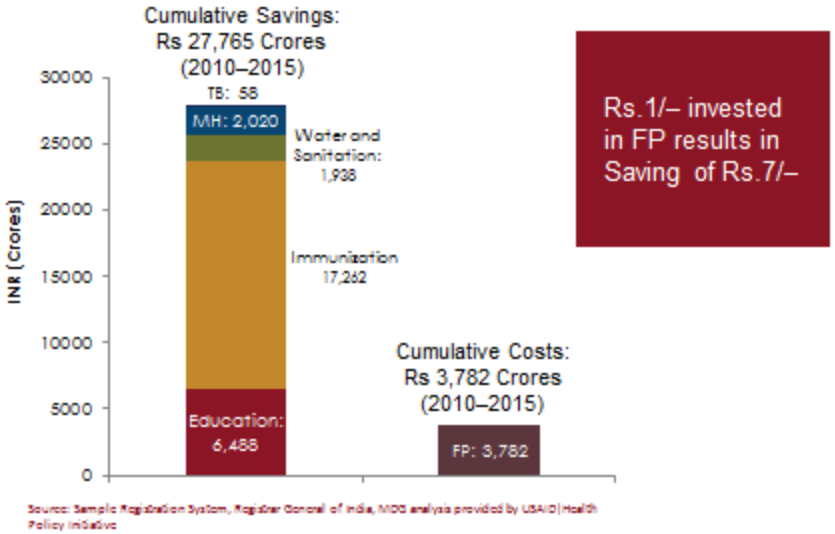


Source: DLHS-3 (2007-08), IIPS Mumbai

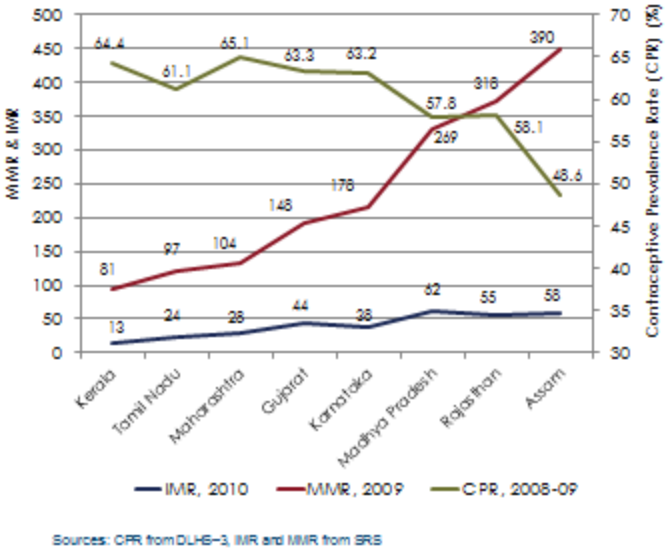
Reproductive Rights are Central to Population

- Reposition family planning
- Reduce infant and (neonatal) mortality
- Increase age at marriage and delay the first child
- Promote better spacing
- Improve access to and quality of the basket of contraceptives and reproductive health services
- End discrimination against the girl child

Social Sector Cost Savings Outweigh Family Planning Costs



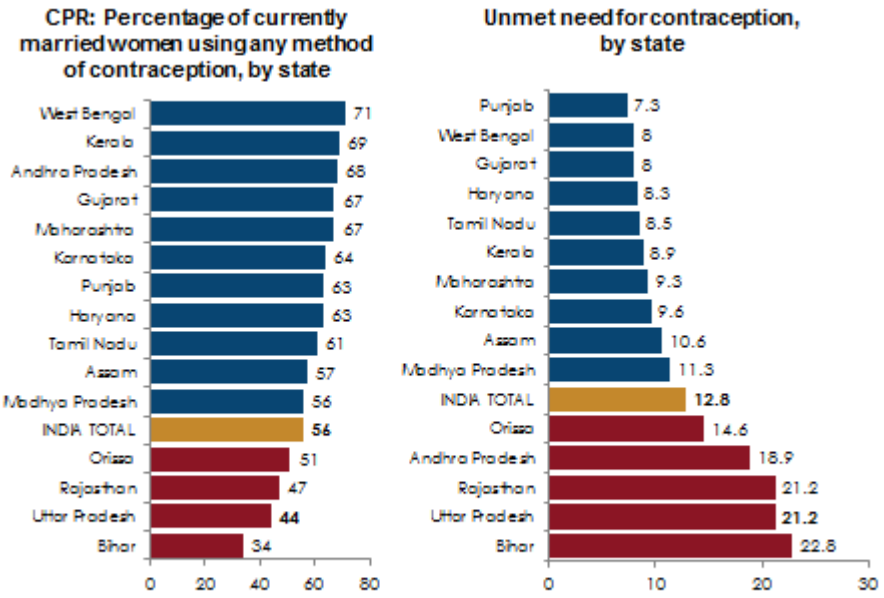
Family Planning Saves Lives



Sources: CPR from DLHS-3, IMR and MMR from SRS

As contraceptive use rises, maternal and infant deaths decline.

By simply supplying the unmet need for contraceptives, states can achieve replacement-level fertility.


CPR: Percentage of currently married women using any method of contraception, by state
West Bengal 71
Kerala 69
Andhra Pradesh 68
Gujarat 67
Maharashtra 67
Karnataka 64
Punjab 63
Haryana 63
Tamil Nadu 61
Assam 57
Madhya Pradesh 56
INDIA TOTAL 56
Orissa 51
Rajasthan 47
Uttar Pradesh 44
Bihar 34
0 20 40 60 80
Unmet need for contraception, by state
Punjab 7.3
West Bengal 8
Gujarat 8
Haryana 8.3
Tamil Nadu 8.5
Kerala 8.9
Maharashtra 9.3
Karnataka 9.6
Assam 10.6
Madhya Pradesh 11.3
INDIA TOTAL 12.8
Orissa 14.6
Andhra Pradesh 18.9
Rajasthan 21.2
Uttar Pradesh 21.2
Bihar 22.8
0 10 20 30
Source: NFHS, 2005-2006

National Family Planning Programme

Mission: "The mission of the National Family Planning Programme is that all women and men (in reproductive age group) in India will have knowledge of and access to comprehensive range of FP services, therefore enabling families to plan and space their children to improve the health of women and children" (National Rural Health Mission- NRHM (2005-2012) , Ministry of Health and Family Welfare, Government of India, 2005)

Guiding Principles: Target-free approach based on unmet needs for contraception; equal emphasis on spacing and limiting methods; promoting 'children by choice' in the context of reproductive health.

Strategies for States to Follow[1]:

1. Strengthening spacing methods:
    a. Increasing number of providers trained in intrauterine contraceptive device (IUCD) 380A
    b. Strengthening fixed-day IUCD services at facilities
    c. Introduction of Cu IUCD 375
    d. Delivering contraceptives at homes of beneficiaries (in pilot states/districts)
2. Emphasis on postpartum FP services:
    a. Strengthening postpartum IUCD (PPIUCD) services at least at DH level
    b. Promoting postpartum sterilisation (PPS)
    c. Establishing postpartum centres at women and child hospitals at district level
    d. Appointing counsellors at high case load facilities
3. Strengthening sterilisation service delivery
    a. Increasing pool of trained service providers (minilap, lap and non-scalpel vasectomy)
    b. Operationalising fixed-day services centres for sterilisation
    c. Holding camps to clear back log
4. Strengthening quality of service delivery:
    a. Strengthening QACs for monitoring
    b. Disseminating/ following existing protocols/guidelines/ manuals
    c. Monitoring of FP Insurance
5. Development of BCC/IEC tools highlighting benefits of FP specially on spacing methods
6. Focus on using private sector capacity for service delivery (exploring public-private partnership availability)
7. Strengthening programme management structures:
    a. Establishing new structures for monitoring and supporting the programme
    b. Strengthening programme management support to state and district levels

[1] FP Appraisal Form for State PIP 2013-14.

Recommendations in the 12th Five-Year Plan

Source: Summarised from Planning Commission, GOI. October 2011. Fast, Sustainable and More Inclusive Growth: An Approach to the Twelfth Five Year Plan (2012–2017). New Delhi: GOI.

- For addressing population stabilisation we need to take a differential approach between the seven high fertility states, including Jharkhand. Whereas in the rest, the focus is on promotion of spacing measures, without reducing the levels of achievement required for sterilisation, in the high fertility states, we need to think out of the box.
- Intensification of skill development strategy of government providers and thrust in recruiting and deploying private providers will be focused upon for both spacing and limiting methods.
- Post-partum contraception would also be promoted. In all states there would be a planned effort to promote spacing methods, especially the intrauterine device (IUD) for spacing, and better FP counselling, and focus on motivation for male sterilisations.
- Efforts will be made to introduce injectable contraceptives. Social marketing of contraceptives through ASHAs will be actively promoted and ASHAs will be paid incentives/commission for their efforts.
- Given the major load in referral medical college hospitals and large district hospitals on account of Janani Suraksha Yojana, there would be an effort to strengthen the district hospitals and increase the number of beds for providing quality antenatal, intranatal, postnatal and child care to cope with increasing case loads of pregnant women, newborns and children, and with a focus on postpartum FP services. Separate maternal and child wings may also be constructed wherever they are required to cater to the higher case load.

Population Stabilisation Goals

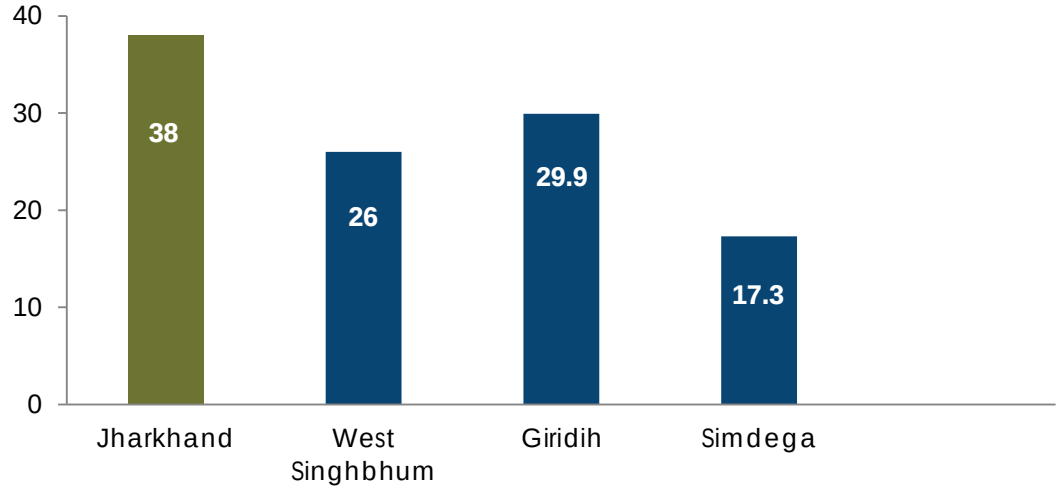
- As per the 12th Five-year Plan (2012-17) the goal is to achieve a total fertility rate (TFR) of 2.1 by 2017 nationally and state-specific targets are to be set by the states.
- The goal of Jharkhand is to achieve a TFR of 2.1 by 2020 as per the State PIPs.

The Current Status of FP in Jharkhand

- Total population of the state is about 3.3 crore (Total: 32,96,623; Males:1,69,31,688; Females: 1,60,34,550) (ORGI, 2011)
- According to the National Family Health Survey, NFHS-3, 2005-06 (IIPS and Macro International, 2007)
    - Mean age at marriage in Jharkhand is 16.3
    - Desired fertility rate in the state is 2.1
- According to the Annual Health Survey (2011-12) (ORGI, 2012)
    - Jharkhand's TFR is 3.1; 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
    - Sixty-one percent reported wanting no more children
    - 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

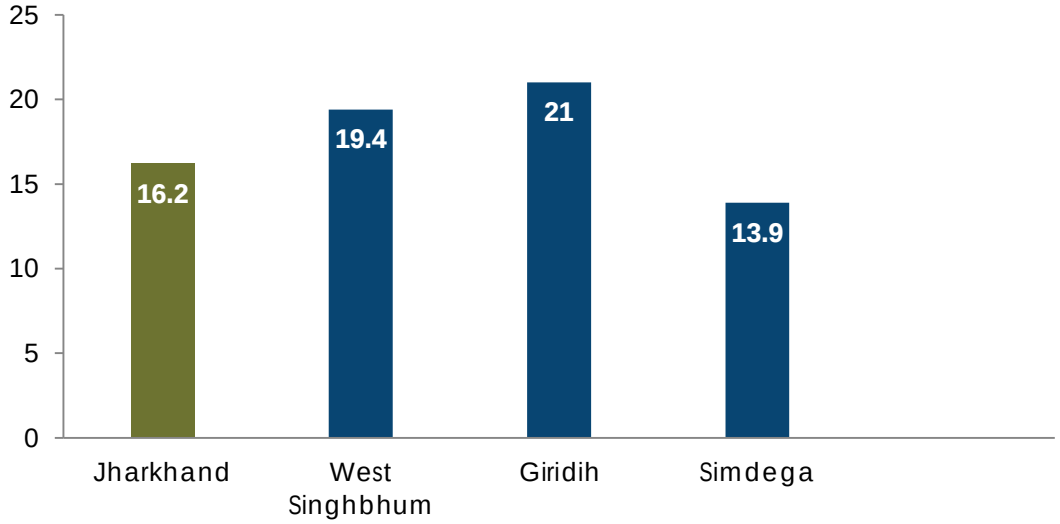
- Use of modern spacing methods is low (8.3%)
- High unmet need for contraception stands at 31 percent, unmet need for spacing is 16.2 percent and limiting is 14.3 percent
- Maternal Mortality Ratio (MMR) is high at 278
- Infant mortality rate (IMR) is 41/1000 live births; 45 rural and 26 urban
- Neonatal mortality rate (NMR) is 26/1000 live births; 29 rural and 17 urban
- Under-five mortality rate is 59/1000 live births; 66 rural and 35 urban

Figure 3: Contraceptive Prevalence Rate (Modern Method)



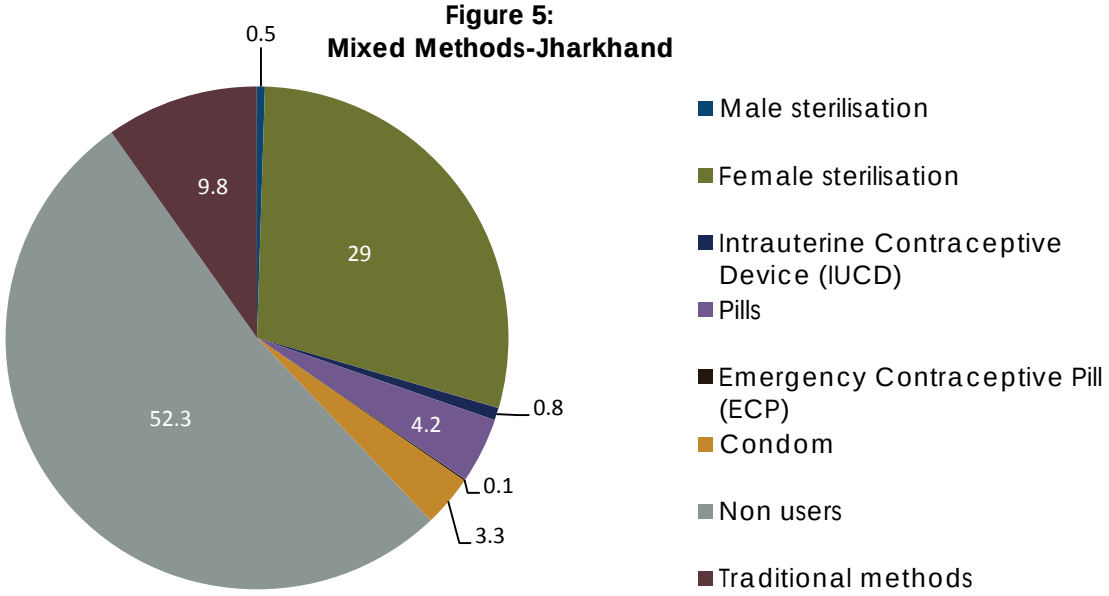
Sources: Jharkhand, W. Singbhum, and Giridih from Office of the Registrar General and Census Commissioner (ORGI), India 2012; AHS 2010–2011; Simdega from DLHS 2007–2008.

Figure 4: Unmet Need for FP: Spacing Method



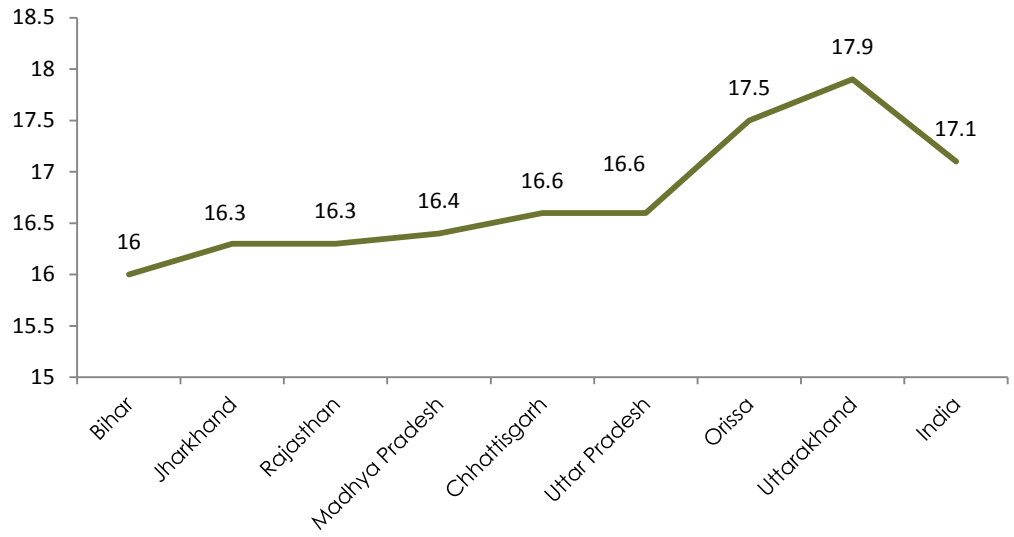
Sources: Jharkhand, W. Singbhum, and Giridih from AHS 2010–2011; Simdega from DLHS 2007–2008

Figure 5:
Mixed Methods-Jharkhand



Source: AHS 2010–2011.

Figure 6: Average Age at Marriage



Source: NFHS–3, 2005-06

Figure 7: Parents Want More Sons than Daughters

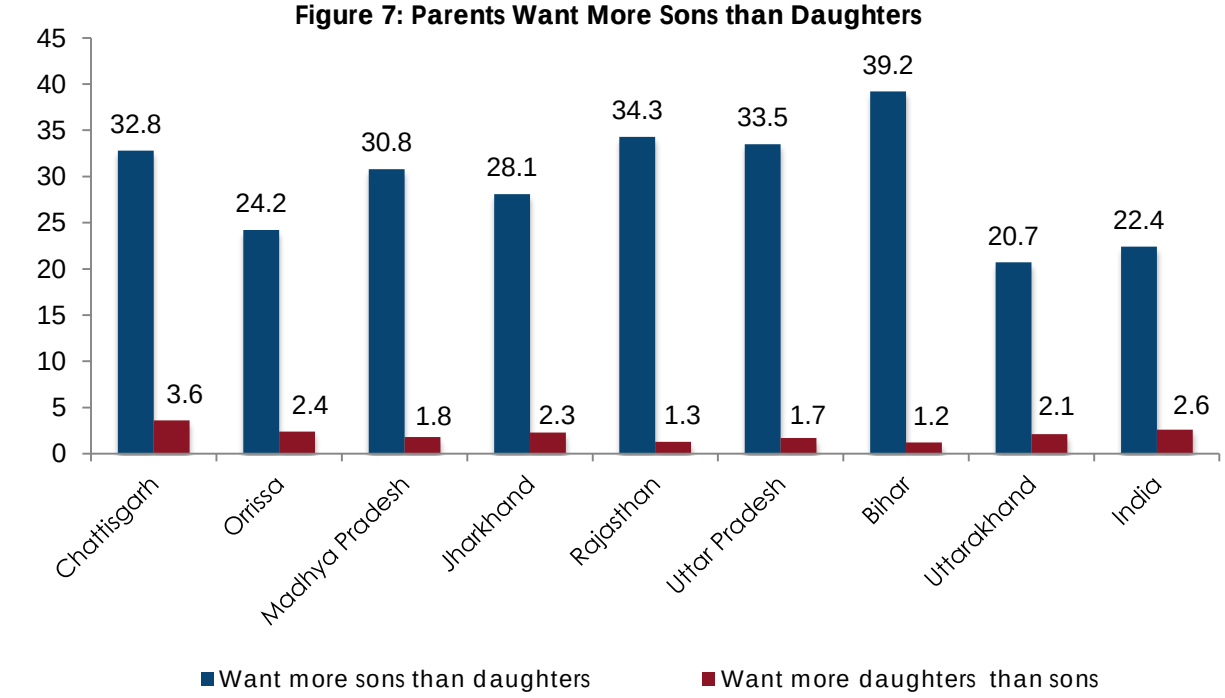


Figure 8: Desired TFR vs Actual TFR

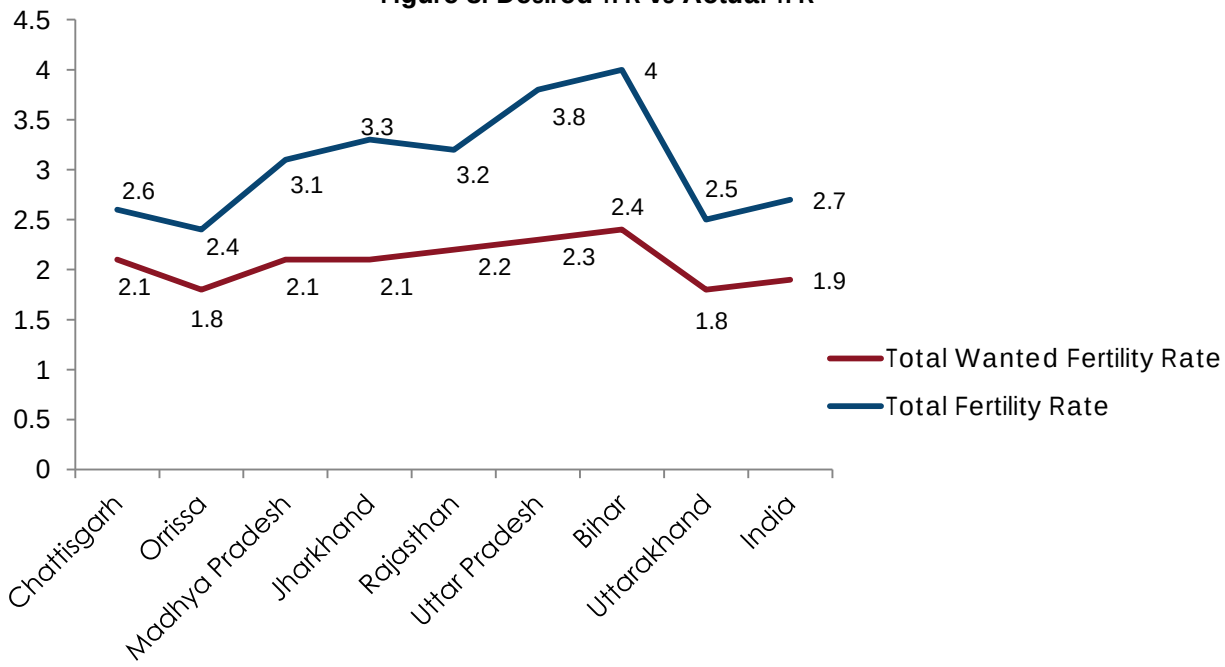


Table 1: Unmet Need for Contraceptives

States/ INDIA	Not Using any Modern FP Method	Unmet Need for Limiting Methods	Unmet Need for Spacing Methods	Total Unmet Need for FP
Jharkhand	62.0	14.3	16.2	30.5
Bihar	66.1	17.9	21.3	39.2
Orissa	56.0	12.4	10.8	23.2
Madhya Pradesh	43.0	8.6	13.8	22.4
Chhattisgarh	50.5	10.9	15.5	26.4
INDIA	52.7	9.3	5.3	14.6

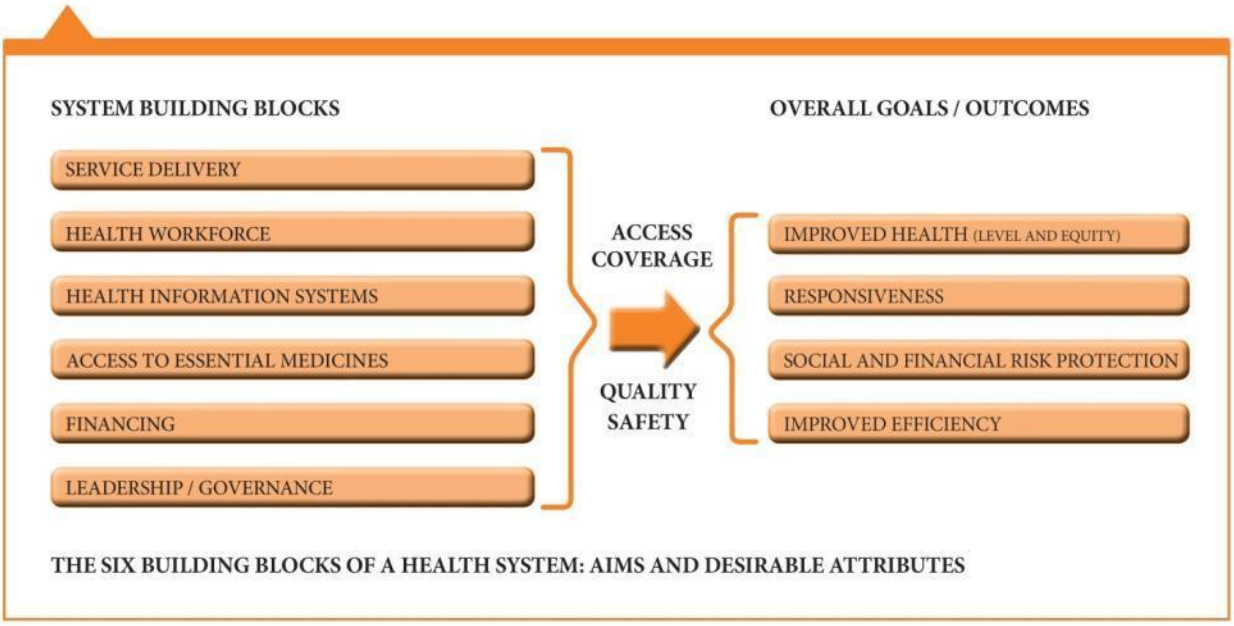
ANNEX F. COMPONENTS OF HEALTH SYSTEMS

What is a health system?

Source: Adapted from World Health Organisation. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action* (pp. 2–4). Geneva: WHO.

A health system consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly-owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organisations; and occupational health and safety legislation. It includes inter-sectoral action by health staff, for example, encouraging the Ministry of Education to promote female education, a well-known determinant of better health.

WHO health system building blocks: To achieve their goals, all health systems have to carry out some basic functions, regardless of how they are organised: they have to provide services; develop health workers and other key resources; mobilise and allocate finances, and ensure health system leadership and governance.



- Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.
- A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).

- A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
- A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
- A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
- Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.

Health Systems: Key Concepts

- **Multiple, dynamic relationships**: A health system, like any other system, is a set of inter-connected parts that must function together to be effective. Changes in one area have repercussions elsewhere. Improvements in one area cannot be achieved without contributions from the others. Interaction between building blocks is essential for achieving better health outcomes.
- **Health system strengthening**: Is defined as improving these six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. It requires both technical and political knowledge and action.
- **Access and coverage**: Since notions of improved access and coverage lie at the heart of this WHO health system strengthening strategy, there has to be some common understanding of these terms.
- **Is progress being made?** A key concern of governments and others who invest in health systems is how to tell whether and when the desired improvements in health system performance are being achieved. Convincing indicators that can detect changes on the ground are needed.

Public Health System in India

Source: Planning Commission. 2011. *Evaluation Study of National Rural Health Mission (NRHM) in 7 States* (pp. 8–9). New Delhi: Planning Commission, GOI.

India being signatory to Alma Ata Declaration is committed to attaining Health for All through the primary healthcare approach. The ultimate objective of a healthcare delivery system is to ensure that the rich and poor are treated alike, poverty does not become disability and wealth is not an advantage towards accessibility of healthcare. In order to provide accessible, affordable and accountable healthcare system to all, especially underprivileged and vulnerable sections of the society, the NRHM has emphasised on improvement in healthcare infrastructure in demographically backward states and districts (NRHM, 2005). Thus, apart from increased budget, through the involvement of people in VHSCs, District Health Societies, RKS, etc. the emphasis is on improvement of basic health infrastructure with adequate supply of human resource, material, drugs, equipment, transport system, etc.

In the hierarchical healthcare system of the GOI, the DH is the apex body, which provides specialised healthcare to the people of a district on subsidised cost. Every district is expected to have at least one DH

but in some cases the Medical College Hospital or any other sub-divisional hospital also serves as DH, where such an institution is not established.

As per norms DHs and FRUs/CHCs ought to have critical inputs like adequately equipped operation theatres and laboratories, separate aseptic labour room, electricity in all parts of the hospital, availability of generator, overhead tank and pump facility, etc.; specialists like gynaecologist, surgeon, orthopaedician, obstetrician, paediatrician, anaesthesiologists, laboratory technicians, etc. and ready availability of all critical drugs/medicines, equipment, etc. Most of the DHs/FRUs are supposed to have direct linkage with the blood bank or blood storage facility. Since FRUs treat emergency cases they should be well equipped with adequate human resource, materials, drugs and kits.

CHCs are also FRUs where referral cases are sent from lower-level healthcare facilities. FRUs and CHCs take up referral cases from the lower healthcare establishments besides providing usual healthcare activities for the area of their operation.

The PHCs provide curative, preventive, and promotive health and family welfare services in the rural area for a population of about 30,000. For effective service delivery a PHC should have essential infrastructure, staff, equipment and supplies (MoHFW, 2007). Thus, a PHC should also have critical infrastructure like continuous water supply, electricity, labour room, laboratory, telephone, functional vehicle, etc. A PHC ought to have at least one medical officer, one laboratory technician and health assistants both male and female. Critical equipment that a PHC ought to have includes a functioning deep freezer, vaccine carrier, blood pressure instrument, autoclave and supply of contraceptives, normal delivery kit/labour room kit, essential obstetric kit, all vaccines, Iron and Folic Acid (IFA) tablets and Oral Rehydration Solution (ORS) packets. PHCs have the major responsibility of providing both preventive and curative healthcare services in the area. PHCs have limited facilities and expertise; hence they cannot provide complete obstetric care to women. Some of the upgraded PHCs and CHCs have been categorised as FRUs and these facilities have been provided with specialised equipment and kits to provide maternal healthcare, particularly Emergency Obstetric Care (EmOC). Emergency cases can be referred from the sub-centres and PHCs to these FRUs.

Components of the Health System: from the FP perspective

Looking at the State FP programme from the health systems building blocks point of view, the following are various aspects to consider in order identifying areas for improvement.

Component 1: Service Delivery

Service delivery needs to be ensured through:

Availability of free or low-cost condoms, oral contraceptive pills (OCPs) and emergency contraceptive pills (ECPs):

- With ASHAs/*Sahiyas* through the door-to-door delivery.
- At VHNDs.
- Through social marketing organisation depot holders.
- Through pharmacies selling premium and social-marketed brands.

- IUCD services provided by trained ANMs/nurses/doctors at the PHC, CHC, DH fixed-day services and camps.
- PPIUCD provided by trained ANMs/ nurses/doctors at select CHCs, FRUs and DH.
- Sterilisation services for males and females provided by trained surgeons at the CHC, DH fixed-day services and camps.

- Range of clinical FP services provided by private providers, franchised hospitals, trust-run facilities and corporate social responsibility initiatives.
- **Helpline**: JSK runs a Helpline (1800-11-6555) to provide reliable and accurate information on issues related to RCH. It specifically caters to adolescents, newly married and about to be married people from the high-focus states of Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand and Chhattisgarh.

Quality Assurance

Adapted from MoHFW. 2008. Quality Assurance for District Reproductive and Child Health Services in Public Health System, An Operational Manual. New Delhi: MoHFW, GOI.

Quality Assurance can be defined as a mechanism/process that contributes to defining, designing, assessing, monitoring, and improving the quality of healthcare (MoHFW, 2006).

Quality Assurance applies broadly to an entire cycle of assessment which extends beyond problem identification to:

- Verification of the problem.
- Identification of what is correctable.
- Initiation of interventions/improvements.
- Continual review to ensure that identified problems have been adequately corrected, quality of services improved and no further problems have been engendered in the process.

Nine elements of Quality of Care (UNFPA, 1999)

- Service environment: appropriate infrastructure, basic amenities, clients comfort, privacy etc.
- Client-provider interaction: the nature of information exchanged between them
- Informed decision making: availability of relevant information and service providers that facilitate informed choice by client.
- Integration of services: linkage of services and health institutions.
- Women's participation in management: women's participation in planning, implementation and monitoring of reproductive health services.
- Access to services: location, distance, timing of facility, affordability in terms of travel cost, loss of wages etc.
- Equipment and supplies: availability of equipment of standard specifications, their working condition, and availability of sufficient supplies.
- Professional standards and technical competence: Competence of the provider; availability of guidelines/protocols; established service standards.
- Continuity of care: Regular and effective client follow ups; management of side effects/complications; proper design and maintenance of MIS.

Steps for initiating Quality Assurance

- Constitution of the state and district QA Committees
- Finalisation of QA tools
- Pre-testing of QA tools

- TOT for master trainers from three districts
- Training of QAC members at the district level
- Training of medical officers and other functionaries of the identified institutions
- Organising QA visits
- Compilation of data on the basis of QA visits
- Monitoring of the quality improvements after the quality assessments

The following are the various state- and district-level structures and bodies to address quality assurance:

The State Quality Assurance cell has the following objectives

- Facilitate improvement of systems and process of service delivery in healthcare facilities as per standard technical protocol to meet laid down standards.
- Establish and develop quality management systems at the hospital level, leading to enhancement in service quality and quality certifications by QA cell.
- Implement and monitor quality of reproductive health services/MCH services at health facilities and consequently improve service quality by focusing on and addressing the gaps identified during assessment process.
- Undertake periodic assessment visits through state and district QA cell/committees using specific tools and based on gaps identified, guide service providers in addressing specific service quality elements and sub-elements.
- Undertake other GOI/state initiatives entrusted with QAC from time to time (e.g., Maternal Death Review–MDR, Mother and Child Tracking System–MCTS, etc.).

Structure of Quality Assurance cell in Jharkhand

Source: NRHM. 2011. Quality Assurance Cell, Structure and Terms of Reference, Jharkhand.,

At State Level

- Mission director (heads the cell)
- State QA Nodal Officer
- Full time consultants: MCH, FP, Managerial – Monitoring
- Data Entry Operator

Terms of Reference

Members of the state QA cell, medical legal advisor and other resource persons will operationalise the cell and all state programme officers and consultants to provide technical input and support. To assist the cell, a state working group consisting of technical experts from various organisations such as Rajendra Institute of Medical Sciences (RIMS), National Health Systems Resource Centre (NHSRC), Jhpiego, UNICEF, Public Health Foundation of India (PHFI) and others, has been constituted.

State Quality Assurance Committee

Terms of Reference

- Adopt standard protocols in maternal health, child health and FP in tune with national guidelines.
- Ensure adequate dissemination and monitor the adherence to these standards through a set of quality indicators.

- Sensitise and orient health personnel involved in quality management on quality protocols and tools.
- Formulate strategies with timelines for quality improvement for all levels of facilities and outreach-based programmes.
- Provide technical and managerial guidance to programme officers at the state and in districts on implementation of measures for improving quality of services in the state.
- Develop and recommend joint field travel plan for undertaking QA visits to districts at regular intervals using checklists. Share the field visit feedback received from teams with all QAC members and recommend concrete measurable corrective actions with timeline for different levels.
- Review reports and recommendations of members, field observations of the district quality assurance committee (DQAC), and recommend corrective actions to the chair.
- Meet once every three months.

State Quality Assurance Working Group

Terms of Reference

- Prepare, adopt and ensure dissemination of Standard Operating Procedures (SOPs), guidelines and manuals for the facilities.
- Monthly meetings of the Working Group to review the reports being received from the districts. Members may ask for additional information from the district committees, if needed.
- Review reports of district-level committees received from the regional QAC and present the progress before the state QAC.
- Create a pool of district trainers for disseminating QA concepts, tools and methodology at district and sub-district levels.
- Make periodic visits to districts; evaluate the QA in districts using standard format and give necessary inputs to the regional/district QA teams.
- Visit both public and private accredited facilities (under PPP scheme) providing various health services in the state to ensure implementation of national standards and provide feedback for consideration during accreditation renewal process of facilities.
- Review (desk review/field visit, if required) cases of deaths/complications following sterilisation and cases of conception due to failure of sterilisation in the state.
- Review cases of maternal and infant deaths/any adverse outcomes in MNCH.
- Review and monitor quality of trainings under RCH II/National Disease Control Programmes (NDCP) organised at the state and district levels and undertake follow up of selected sample of trainees during field visits.

At Regional Level

Regional QA Unit is headed by the Regional Deputy Director (RDD). On a quarterly basis, the functioning and progress would be reviewed by the Divisional Commissioner.

- RDD – Chairperson
- Regional Quality Consultant – Convenor

- Members – one RCH Officer from each district of that particular region, one ACMO or medical officer in-charge (MOIC) from each district of that particular region, one NGO representative, development partners—UNICEF/Child in Need Institute (CINI)
- Divisional Commissioner to review functioning and progress of QA on a quarterly basis.

Terms of Reference for the Regional QA Unit

- Monitor health facilities and guiding district-level teams for ensuring quality healthcare services from that facility.
- Ensure adherence of treatment protocols on public health management and delivery of quality healthcare services focusing more on the medical colleges, DHs and FRUs.
- Planning, controlling, management of the medical staff, demography and bio-statistics, management of research in healthcare, epidemiology and community health and strategic management.
- Ensure proper functioning of the HMIS and also monitoring of medical records as prescribed.
- Management of health and related services within the medical colleges/hospital premises to achieve optimal care by providing staff for management and treatment of patients.
- Provide quality of care through M&E of services, development of protocols, supervision of staff and continuing education.
- Review cases of maternal and infant deaths and report from cases of adverse outcomes/complications in MNCH.
- Provide technical inputs to medical colleges/DHs/FRUs within the division to improve their functioning.

At District Level

The Quality Assurance Committee is made of up of the following positions:

- Civil Surgeon – Chairperson
- District Programme Manager – Convener
- ACMO – Member Secretary (Hospital Manager to assist)
- Members – District Gynaecologist and/or District Surgeon and/or District Anaesthetist and/or District Paediatrician; one NGO representative; District Nursing Head; District RCH Officer/Family Welfare
- District Programme Officer – TB, vector-borne diseases , blindness control and leprosy
- Deputy Programme Coordinator
- Technical Assistance – two health educators
- Secretarial Assistance – District M&E Officer
- Special Invitees – Representatives from development partners in the district

Terms of Reference for the Quality Assurance Committee

- Meet once every month.
- Develop half-yearly action plan of district for QA interventions (facility-wise planning for infrastructure strengthening, and strengthening of services at facility).

- Provide technical and managerial guidance to blocks on the implementation of action plan for improving the quality of services in the facilities.
- Monitor quality improvement of programme and track progress based on identified quality indicators at each facility level (sub-centres, PHCs, etc.). Also keep a check on whether the facilities are providing essential service package as per standards and protocols.
- Review cases of maternal and infant deaths and report from cases of adverse outcomes/complications in MNCH.
- Collect information on all hospitalisation cases related to complications following sterilisation as well as sterilisation failures.
- Process all cases of failure, complications requiring hospitalisation, and deaths following sterilisation for payment of compensation.
- Review all static institutions—government, and accredited private/NGOs and selected camps providing sterilisation and safe abortion services for quality of care as per the standards laid down, and recommend remedial actions for institutions not adhering to standards.
- Conduct medical audits of all maternal and infant deaths and deaths related to sterilisations from time to time and send reports to the state QAC office.
- Review and monitor the quality of trainings under RCH II/NDCP organised at the state and district level and undertake follow-up of selected sample of trainees during field visits.
- Review of different community-based interventions, implementation of schemes under MNCH.
- Plan QAC visits and make necessary preparations for visits to facilities and use the standardised QA checklists to conduct the assessment and debrief the MOIC of the facility, with guidance on what action needs to be taken.
- Compile findings during district-level visits and distribute the district summary report and discuss these at monthly meetings with medical officers. Forward the minutes of the monthly QAC meeting and actions to be taken to the concerned officials—regional and state QAC.
- Share the district visit reports with the state committee on monthly basis and initiate actions based on recommendations from state committee. To address the state-level actions, the district has to take the initiative and pursue the state authorities and follow up.
- Keep a record of follow up and actions taken so that these can be reviewed on subsequent visits to the facility.

Communication for Demand Generation and Behaviour Change

It is important that district- and block-level functionaries of health programmes have conceptual clarity of BCC, as most programme managers focus only on knowledge creation and awareness through IEC and not behaviour change. In order to achieve sustainable behaviour change, it is necessary to shift from awareness creation to a focus on changing behaviours. The messages below are very simple but highlight the difference between IEC and BCC.

IEC message on a pamphlet at PHC

Small Family, Happy Family

Adopt a contraceptive method today.

BCC message from an ASHA to a woman during a home visit

Now that your child is three months old, you need to choose a contraceptive method to delay the next child for three years. You can choose from a range of easy options that are easy to use and effective, and will ensure that you are healthy, your child receives all the required love and attention, you and your husband will have more time for each other and you can save up some money for the entire family. I will help you access your choice of contraceptive.

What is health behaviour?

Source: Soch Se Amal Tak-State Level Behaviour Change Communication (BCC) Planning Workshop. USAID supported IFPS Technical Assistance Project. 2010.

Behaviour is an action. For example, in Uttar Pradesh, 28 percent of rural women receive three ANC check-ups during pregnancy. The behaviour that requires promotion is receiving three ANC check-ups. It is not enough to simply tell every pregnant woman "go for three ANC check-ups." District- and block-level workers must follow up to see if the behavioural action occurred after the BCC inputs. One cannot assume that women will go for three ANC check-ups because they were asked to have three ANC check-ups. The main work in BCC is to make sure that the behavioural action occurs.

Behaviour is a specific action. Other health behaviours include *washing hands with soap after defecation, eating iron rich food daily, using modern FP methods*, and *taking iron tablets during pregnancy*. So, behaviours include small and big actions that can be carried out at the individual, household and community levels. Many a time it is difficult to carry out these actions. For example, if there is no transportation available in the village late at night, how can a pregnant woman have a hospital delivery? Therefore, it is important to identify the barriers to behaviour change.

What is Behaviour Change Communication?

It is important to build a common understanding of the term "Behaviour Change Communication." Behaviour Change Communication is a process that strategically uses a mix of communication media in order to motivate a targeted audience to adopt specific behaviours. BCC includes *all* the efforts undertaken to motivate people to adopt healthy behaviours. It includes use of TV and radio spots; posters and flip books; and most importantly interpersonal communication (IPC) and the community-based efforts of the ASHA, ANM, anganwadi worker (AWW), and medical officers.

Choose the channels that are most likely to reach the intended audience

Before you can decide what materials to produce, you must first decide what communication channels will best reach the intended audience. Health communicators have defined communication channels as modes of transmission that enable messages to be exchanged between "senders" and "receivers."

The various types of communication channels are:

Interpersonal Channels which include one-to-one communication, such as provider to client, spouse to spouse, or peer to peer.

Community-based Channels which reach a community (a group of people within a distinct geographic area, such as a village or neighbourhood, or a group based on common interests or characteristics, such as ethnicity or occupational status). Forms of community communication are:

- Community-based media, such as local newspapers, local radio stations, bulletin boards, and posters.
- Community-based activities, such as health fairs, folk dramas, concerts, rallies, and parades.
- Community mobilisation, a participatory process of communities identifying and taking action on shared concerns.

Mass Media Channels which reach a large audience in a short period of time, including:

- Television
- Radio

- Newspapers
- Magazines
- Outdoor/Transit Advertising
- Newsletters
- Internet

To start developing a channel strategy, write down opportunities (or openings) for sending your message during a typical day in the life of your audience.

Research has demonstrated that a multichannel approach has a better chance of changing behaviour than a single channel approach (O'Sullivan, Yonkler, Morgan & Merritt, 2003). In addition, a multichannel approach, especially an approach that uses mass media, can achieve objectives more quickly. Using several channels enables you to reach more people and to reach people in different environments with more frequency. The combination of multiple channels also offers a synergy to the campaign and gives it more impact. It is important for the primary audience as well as for other secondary and influencing audiences, who will most likely be exposed to these same messages. This exposure will, in turn, help to reinforce in them the necessity of supporting the campaign.

Select a lead channel and supporting channels, with a rationale for each

- You must determine which channel will be the lead channel and which ones will serve as supporting channels. Just as a locomotive pulls the other cars on a train, the lead channel will be the "engine" that pulls the other channels with it. Answer the following questions:
    - Which channel will reach the largest proportion of the intended audience?
    - Which channel will fit the message brief most appropriately?
    - Which channel will achieve the greatest impact?

Although a mass medium may reach more people, it may not always make sense to choose it as a lead channel. Depending on the objective of your strategy, you may choose from one of the eight strategic communication tools.

Eight tools of strategic communication: Definitions and examples

1. **Advocacy:** a set of tools used to create a shift in public opinion and mobilise necessary resources and forces to support an issue, policy, or constituency.
2. **Advertising:** a set of tools to inform and persuade in a controlled setting through paid media, such as television, radio, billboards, newspapers, and magazines.
3. **Promotion:** a set of tools for providing added incentives to encourage the audience to think favourably about a desired behaviour or to take some intermediate action that will lead toward practice of the desired behaviour, such as coupons, free samples, contests, sweepstakes, and merchandising.
4. **IPC Enhancement:** a set of tools that can enhance personal interaction between clients and providers, including discussions within and outside the clinic. It includes not only training the information providers, but also enhancing the place where the communication takes place.
5. **Event Creation and Sponsorship:** developing and/or sponsoring events for the purpose of calling attention to and promoting a desired behaviour, such as a news conference, celebrity appearance, grand opening, parade, concert, award presentation, research presentation, or sporting event.

6. **Community Participation:** a set of tools for helping a community to actively support and facilitate the adoption of a desired behaviour.
7. **Publicity:** the use of nonpaid media communication to help build audience awareness and affect attitudes positively.
8. **Entertainment Vehicles**: Mediums such as television or radio programmes, folk dramas, songs, or games, provide entertainment combined with educational messages.

Intersectoral Convergence and Partnerships

Source: Adapted from National Programme Implementation Plan, RCH II, 2005.

Convergence is a process that facilitates different functionaries and community to work together for efficient service delivery and involves networking at highest levels and then percolating to different levels. There is a need to converge with critical sectors whose actions would lead to joint outcomes.

Benefits

- Saves time
- Helps build rapport
- Increases efficiency
- Reduces workload
- Facilitates sharing of ideas
- Leads to improved health status of the community

Intersectoral convergence envisaged with

- Department of Women and Child Development
- Panchayati Raj Institutions (PRIs)
- Department of Human Resource Development
- Department of Urban Development

What is needed for convergence?

- Leadership and willingness
- Policies
- Sharing common visions and perspective
- Defining roles and responsibilities
- Identifying strategies and activities
- Joint monitoring
- Taking remedial measures in case of coordination-related issues

Common issues between Health Department and Department of Women and Child Development

- Link MCH problems with FP

Synergy between ANMs, ASHAs, and AWWs

- FP Counselling

  - ANMs, AWWs and ASHAs can counsel women and men on contraceptive options based on the clients' life stage and desired family size.

- Convergence on VHNDs
  - ANMs and ASHAs can bring all pregnant women to anganwadi centre (AWC) and counsel of postpartum contraception and lactational amenorrhea method (LAM).
  - ASHAs and PRIs can facilitate couples to adopt FP methods.
- Declining sex ratios
  - Counsel women who have two or more girls.
  - AWWs/ASHAs/local women persuade women to have institutional delivery to reduce female infanticide.

How can PRIs be engaged?

- Monitoring and supervision of services related to FP (and functionaries).
- Sensitisation and orientation on women and reproductive health issues, child health issues, FP, gender, etc.
- Responsible for selection of ASHAs.
- Guiding the VHSCs.

Convergence with Education Department

- Inclusion of life skills education materials for formal and non-formal education.
- Involvement of various agencies and all zilla saksharata samitis in IEC activities, especially on delaying age at marriage and first child.
- Involving school teachers, health workers, and adolescents in awareness programmes.

Component 2. Health Workforce

Source: Source: Adapted from World Health Organisation. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva: WHO.

"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; are provided regular trainings and mentoring to upgrade their skills and knowledge for them to perform to their fullest; are provided a conducive work environment; and their financial needs and compensation are taken care of."

When district programme managers and block programme managers go on field visits they need to focus on the following:

- *Sahiyas* who counsel and provide condoms and pills, and refer clients for clinical services.
- ANM and LHVs who counsel and provide IUCD services.
- Nurses and doctors who have been trained in and provide IUCD, PPIUCD, tubectomy, non-scalpel vasectomy NSV, and Minilap services in a client-friendly manner.
- FP counsellors at selected facilities.

Various training programmes planned under NRHM for FP for these staff members are:

- TOT for IUCD 380A and 375 and training of medical officers, staff nurses, ANMs and LHVs.
- TOT for PPIUCD insertion and training of medical officers and staff nurses.
- TOT on laparoscopic sterilisation and training for service providers (gynaecologists /surgeons).
- TOT on Minilap and training for medical officers/MBBS students.
- TOT on NSV and training for medical officers.
- Contraceptive update trainings for health providers in the districts.
- IPC and community mobilisation training for FP for ASHAs, ANMs, block trainers teams (BTTs).
- Training in QA to state-, district- and block-level QACs.
- Orientation of district programme managers, block programme managers, and district programme committees in contraceptive update, programme management and supportive supervision.
- Orientation of RKSs, VHSCs, VHCs in importance of FP, motivating men in adopting methods and using untied funds for FP promotion.
- The district data managers, the district programme managers as well as block data managers need to be trained on checking and improving the quality of HMIS data. Such trainings have been provided by the centre through NHSRC at state level; however staff still requires training on improving data quality (HPP Baseline Assessment, 2012).

Component 3. Health Information Systems

Sources:

- World Health Organisation (WHO). 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* Geneva: WHO.
- MoHFW. 2011. HMIS Resource Persons' Manual, Volume IV. New Delhi: GOI.

Health Information System includes a well-functioning information system where data is entered, updated, compiled and analysed on a regular basis with little or no discrepancy. The HMIS is critical for the state and districts to ensure that services are being accessed, stocks are available at all delivery points, equipment for clinical services are available and of good quality, and to understand trends and occurrences based on which activities can be planned or problems addressed in a timely fashion. (WHO, 2007)

An important aspect of health information systems is supervision and feedback, which is crucial for health workers at all levels to realise the contribution of their efforts to the overall health scenario, areas for improvement or addressing issues like underperformance so that capacity building activities can be planned and implemented (See below section on supportive supervision).

The Health Management Information System (HMIS) data is a reliable source of routine data for use in programme monitoring and management support. Such data is available at the district and sub-district level. HMIS is the only available information source and an effective tool for decentralised district programme management. The following information related to FP is included in the HMIS (Sundararaman, 2011).

Monthly Reporting—On a monthly basis the following information is provided by the HMIS:

1. **Number of NSV/ conventional vasectomy conducted**
   Total number of male sterilisation acceptors of NSV/Conventional Vasectomy conducted during the reporting month at the public and private health facilities.
   The date element for this indicator is collected from:
   - PHCs
   - CHCs
   - Sub-divisional hospitals/DHs
   - Other state-owned public institutions
   - Private hospitals

2. **Number of laparoscopic sterilisations conducted**
   Total number of female sterilisation acceptors of Laparoscopic Sterilisation conducted during the reporting month at the following facilities:
   - PHCs
   - CHCs
   - Sub-divisional hospitals/DHs
   - Other state-owned public institutions
   - Private hospitals

3. **Number of Mini-lap sterilisations conducted**
   Total number of female accepters of Mini-lap conducted during the reporting month at the following facilities:
   - PHCs
   - CHCs
   - Sub-divisional hospitals/DHs
   - Other state-owned public institutions
   - Private hospitals

4. **Number of Post-partum Sterilisations conducted**
   Total number of females who have undergone postpartum sterilisations during the reporting month at the following facilities:
   - PHCs
   - CHCs
   - Sub-divisional hospitals/DHs
   - Other state-owned public institutions
   - Private hospitals

5. **Number of IUD Insertions**
   Total number of cases of IUD Insertion during the reporting month at the following facilities:
   - Sub-centres
   - PHCs
   - CHCs
   - Sub-divisional hospitals/DHs
   - Other state-owned public institutions
   - Private hospitals

6. **Number of IUD removals**
   Total number of cases of IUD removals during the reporting month.

7. **Number of Oral Pills cycles distributed**

Total number of oral pill packets distributed during the reporting month (Distribution would mean, distribution to actual beneficiaries and NOT inventory transfer from one facility to another).

8. **Number of Condom pieces distributed**
   Total number of condom pieces distributed during the reporting month.

9. **Number of Centchroman (weekly) pills given**
   Total number of Centchroman (weekly) pills distributed during the reporting month.

10. **Number of Emergency Contraceptive Pills distributed**
    Total number of emergency contraceptive pills distributed during the reporting month.

11. **Quality in Sterilisation services**
    i. *Number of complications following sterilisation*
    Total number of cases of complication following NSV/conventional vasectomy reported in the facility during the reporting month for:
    - Male
    - Female

    ii. *Number of failures following sterilisation*
    Total number of cases of failure following NSV/conventional vasectomy reported in the facility during the reporting month for:
    - Male
    - Female

    iii. *Number of deaths following sterilisation*
    Total number of cases of death following NSV/conventional vasectomy reported in the facility during the reporting month for:
    - Male
    - Female

12. **Number of institutions having NSV trained doctors**
13. **Monthly inventory status**
    FP (in nos.) for example, number of condoms, oral pill cycles, IUDs, etc.
    i. IUD 380A
    ii. Condoms
    iii. OCPs
    iv. ECPs
    v. Tubal rings

Quarterly Reporting—On a quarterly basis the HMIS provides training information on the following:

Part B: Trainings Conducted

1. **Number of doctors trained in:**
   Total number of new general duty medical officers trained during the quarter on specific skills.
   - NSVs
   - Minilap
   - Laparoscopic sterilisation (for Specialists)
   - IUD

2. **Number of GNM/ANM/LHV trained in:**
   Total Number of General Nurse Midwife (GNM)/ANM/LHV trained in specific skills during the quarter
   - Intrauterine Device (IUD)
   - Contraceptive update training (CUT)

3. **State Programme Management Unit:**
   Total number of Programme Management Unit personnel given trainings in State Programme Management Unit, during the quarter, including:
   - Programme managers
   - Accounts/finance managers
   - Management information systems (MIS)/data managers

4. **District Programme Management Units:**
   Total number of Programme Management Unit personnel given trainings in District Programme Management Units, during the quarter, including:
   - Programme managers
   - Accounts/finance Managers
   - MIS/data managers

5. **Block Programme Management Units:**
   Total number of Programme Management Unit personnel given trainings in block programme management units (BPMUs), during the quarter, including:
   - Programme managers
   - Accounts/finance Managers
   - MIS/Data managers

Component 4. Access to Essential Medical Products and Services

Source: WHO. 2010. *Key Components of a well-functioning health system.* Geneva: WHO.

Universal access to healthcare is heavily dependent on access to affordable essential medicines, vaccines, diagnostics and health technologies of assured quality, which are used in a scientifically sound and cost-effective way. Economically, medical products are the second largest component of most health budgets (after salaries) and the largest component of private health expenditure in low- and middle-income countries. Key components of a functioning system are:

- A medical products regulatory system for marketing authorisation and safety monitoring, supported by relevant legislation, enforcement mechanisms, an inspectorate and access to a medical products quality control laboratory.

- National lists of essential medical products, national diagnostic and treatment protocols, and standardised equipment per levels of care, to guide procurement, reimbursement and training.
- A supply and distribution system to ensure universal access to essential medical products and health technologies through public and private channels, with focus on the poor and disadvantaged.
- A national medical products availability and price monitoring system.
- A national programme to promote rational prescribing.

As per the NRHM drug and supply policy, these are some of the recommendations:

- Effective implementation of programmes/schemes depends on timely procurement of drugs and equipment.
- Essential to strengthen procurement capacity at state level.
- Procurement MIS implemented by GOI to automate and overcome challenges of current procurement system.
- States to standardise and streamline procurement process.
- Place trained personnel.
- Develop standard documents and specifications.
- Establish transparent procurement systems.
- Complete all pending procurement at the earliest.

Component 5. Financing

Source: WHO. 2010. *Key components of a Well-functioning Health System.* Geneva: WHO

Health financing can be a key policy instrument to improve health and reduce health inequalities if its primary objective is to facilitate universal coverage by removing financial barriers to access, and preventing financial hardship and catastrophic expenditure. The following can facilitate these outcomes:

- A system to raise sufficient funds for health fairly.
- A system to pool financial resources across population groups to share financial risks.
- A financing governance system supported by relevant legislation, financial audit and public expenditure reviews, and clear operational rules to ensure efficient use of funds.

The FP programme is funded centrally under NRHM and each year the state budgets for a certain sum for FP related activities under the State PIP, which is approved by the centre based on cumulative achievements of the previous year, money spent and unspent, need for expanded services, etc. Some of the areas that the district programme managers and block programme managers should monitor are:

- Transfer of funds approved in the financial year from the state to the districts and from the district to blocks.
- Utilisation of the Record of Proceedings (ROP) funds for district-level activities as planned in the DHAPs.
- Fund allocation for all relevant aspects of programming i.e. BCC activities, procurement of supplies and equipment, running costs of centres, etc.

- Utilisation of untied funds at the sub-centre, PHC and CHC levels in consultation with the RKS and VHSC.
- Availability of timely and complete compensation for clinical FP services. The compensation includes:
    - For FP clinical services there is a provision of compensation for daily wages, insurance for cases of failure of procedure or death.
        - **GOI Scheme to compensate acceptors of sterilisation for Loss of Wages:** With a view to encourage people to adopt permanent methods of FP, GOI has been implementing a Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilisation for the loss of wages for the day on which he/she attended the medical facility to undergo sterilisation. The scheme has since been revised in 2007 and details are provided below:
            - In Public (government) Facilities[2] compensation for the acceptor is as follows: Vasectomy—Rs.1100 and Tubectomy—Rs.600.
        - The **Family Planning Insurance Scheme** is one of the initiatives launched in November, 2005. The benefit under the policy is as follows:
            - Death following sterilisation in hospital (inclusive of death during process of sterilisation operation) or within seven days from the date of discharge from the hospital—Rs. 2 lakh.
            - Death following sterilisation within 8–30 days from the date of discharge from the hospital—Rs. 50,000
            - Failure of sterilisation—Rs. 30,000.
            - Cost of treatment up to 60 days arising out of complication following sterilisation operation (inclusive of complication during process of sterilisation operation) from the date of discharge—actual not exceeding Rs. 25,000.
            - Indemnity insurance per doctor/facility but not more than four cases in a year— up to Rs. 2 lakh per claim.

[2] Source – Annual Report – MOHFW 2010-11

Component 6. Leadership/Governance

Source: WHO. 2010. *Key Components of a Well-functioning Health System.* Geneva: WHO

Each country's specific context and history shapes the way leadership and governance is exercised, but common ingredients of good practice in leadership and governance can be identified. These include:

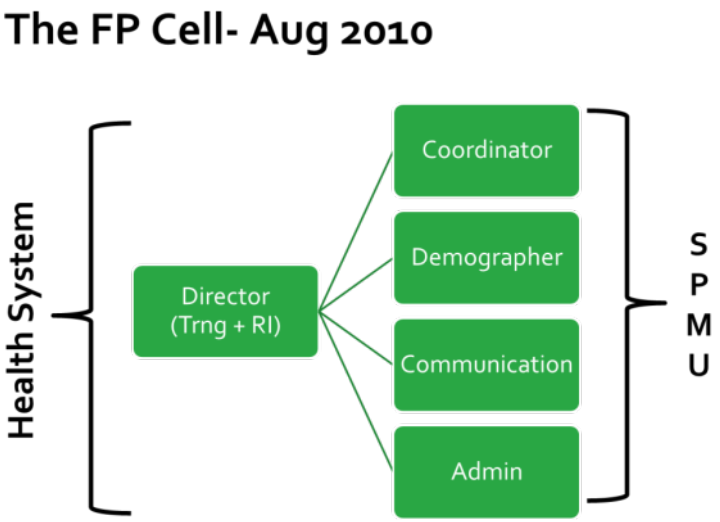
- Ensuring that health authorities take responsibility for steering the entire health sector (not merely public sector service delivery); and for dealing with future challenges (including unanticipated events or disasters) as well as with current problems.
- Defining, through transparent and inclusive processes, national health policies, strategy and plan that set a clear direction for the health sector, with:
    - A formulation of the country's commitment to high-level policy goals (health equity, people-centredness, sound public health policies, effective and accountable governance).
    - A strategy for translating these policy goals into its implications for financing, human resources, pharmaceuticals, technology, infrastructure and service delivery, with relevant guidelines, plans and targets.
    - Mechanisms for accountability and adaptation to evolving needs.
- Effective regulation through a combination of guidelines, mandates, and incentives, backed up by legal measures and enforcement mechanisms.
- Effective policy dialogue with other sectors.
- Mechanisms and institutional arrangements to channel donor funding and align it to country priorities.

At the state level

Source: Adapted from Khalko, Gunjan. "Implementing the Family Planning strategy: Progress, Achievements, and Challenges." Health Policy Project presentation. Institute of Public Health Auditorium, Ranchi, Jharkhand. April 11, 2013.

Jharkhand has an FP cell that is housed within the health directorate with the members of the cell also a part of the State Program Management Unit. The mandate of the FP cell is to:

- Oversee the implementation of all approved FP activities at the state/district level.
- Streamline the programme's financial and administrative process:
    - Identify unspent money; monitor utilisation reports; review and streamline flow of funds, develop processes to minimise lapse.
- Periodic situational review—impact, indicators and gaps.
- Strengthening of M&E process.
- Strengthening the IEC/BCC and integrating them with all FP services and activities.
- Review of existing training material for comprehension and applicability; documenting best practices and lessons learned.
- Clinical and non-clinical quality assurance.



The FP cell is also supported by the **FP task force** which was set up with assistance from the Innovations in Family Planning Services (IFPS) Technical Assistance Project (ITAP) in 2009. The objective of the task force is to review the state FP programme, identify key priorities, provide direction to the establishment of FP cell and review and provide direction to the development of FP strategy for the state. The task force, currently comprised of ITAP, JHPIEGO, Institute of Reproductive Health, A to Z, Population Foundation of India (PFI), Population Services International (PSI), UNICEF and Vistaar. The task force is chaired by the MD, NRHM and officials from DoHFW.

The ITAP project provided assistance to DoHFW to constitute the task force and coordinated the initial meetings and the discussions. After the project ended, the FP cell coordinated the task force and has been proactively engaged by the DoHFW for programme planning, state review missions and other FP-related activities. The task force meets on a quarterly basis to review FP HMIS data, QA data and other issues to arrive at programmatic action. Most task force members also provide technical assistance to the FP cell and district and sub-district functionaries, as and when, required.

At the **Sub-district level** the mechanism for governance is through community participation initiatives such as the RKS and the VHSCs that are entrusted with ensuring good governance of the FP programme at the community level.

a. Rogi Kalyan Samiti (Patient Welfare Committee)

Source: Summarised from MoHFW. 2011. *Model Accounting Handbook for Rogi Kalyan Samitis*. New Delhi: GOI.

For efficient management of health institutions, NRHM in 2005, proposed the RKS at the sub-district level. This initiative was introduced to bring in community ownership into running rural hospitals and health centres and also bring in accountability and responsibility.

- Basic structure: registered society set up in DHs/Sub-DHs, CHCs/FRUs.
- Composition: People's representatives (Members of Legislative Assembly/Members of Parliament), health officials, including ayurveda, yoga, naturopathy, unani, siddha, and homeopathy doctor (AYUSH) doctors, local district officials, leading members of community, CHC/FRU In-charge, representative of Indian Medical Association (IMA), members of local bodies and PRI representative, leading donors.

- Functions:
    - Identifying problems faced by patients in facility.
    - Acquiring equipment, furniture, ambulance (through purchase, donation, loans from banks etc.).
    - Expanding hospital building subject to guidelines by the state government.
    - Arranging for maintenance of hospital building.
    - Improving boarding/lodging for patients and attendants.
    - Partnership with private sector for support services—cleaning, laundry etc.
    - Encouraging community participation in maintenance and upkeep of hospital.
- Governing Body: with district magistrate (DM) as the chairperson, to meet at least once in every quarter.
- Executive Body: with Medical Superintendent of hospital as chairperson and senior medical officer of DH as member secretary to meet once every month.
- Roles:
    - Review Out-patient Department and In-patient Department service performance of hospital in last one month and service delivery targets for next month.
    - Review outreach work performed and planned.
    - Consider reports of monitoring committee for remedial action.

Implementation of Citizens Charter

CHCs and PHCS are supposed to display the citizen charter, which provides a framework to enable citizens to know what services are available at the facility; how patients/ clients can avail the services; and how the complaints regarding services/ denial will be addressed. National Rural Health Mission, A summary of Entitlements and mechanisms for community participation and ownership for community leaders. NRHM 2006.

"The objectives of the charter are:

- To make available medical treatment and the related facilities for citizens
- To provide appropriate advice, treatment and support that would help cure the ailment to the extent medically possible
- To ensure that treatment is best on well considered judgement, is timely, and comprehensive and with the consent of the citizen being treated.
- To ensure just awareness of the nature if the ailment, progress of treatment, suration of the treatment, impact on lives and
- To redress any grievances in this regard"

Monitoring Committee could be constituted by the Governing Body to visit hospital wards and collect patient feedback. Committee to send monthly monitoring report to DM and Chairperson of the Zilla Parishad.

- Community involvement and community empowerment.
- Community involvement in planning, implementation of health programmes critical for success.

- Community involvement leads to increased accountability, transparency.
- Better community participation leads to need-based planning and guaranteed programme success.
- Types of guidelines, funds and fund managers.
- Flexi-funds available at different levels.
- Management of flexi-funds at the sub-centre.
- Untied fund for VHSC—Guidelines.

Village Health and Sanitation Committees

Source: NRHM, Community Participation for Jharkhand State. 2008

Under the NRHM, the VHSCs are responsible for the Village Health Plans. This committee is formed at the level of the revenue village. With inputs from the Public Health Resource Network, the national guidelines were modified and adapted by NRHM, Jharkhand, as follows.

National Guidelines	Jharkhand modifications
Composition and Mandate • At least 50 percent members should be women. • Due representation of every hamlet within revenue village. • ANMs, anganwadi workers (AWWs), school teachers (government employees and honorarium paid staff members). • Representation from self-help groups (SHGs) or other development related community-based organisations (CBOs). • ASHA to be a member and mandatory to make her the member secretary. • Ensure needs of disadvantaged sections (STs, SCs, OBCs) are reflected. • Members to be residents of the village.	**Composition and Mandate** • Members above 18 years. • At least two office bearers should be women. • Part of one of the PRI Standing Committees. • All PRI members of the village to be members. • Representation of all areas and ethnic groups.
Intent and Purpose • Active participation of the community. • Focus on core health issues through people's participation. • Involvement of PRI in decision making and meeting Indian Public Health Standards (IPHS). • Ensure accountability, transparency and quality service provision. • Maintain register recording significant activities undertaken (may come from household survey and data supplemented from ANM, AWW, ASHA registers). • Maintain record of money received and expenditure for periodic review by health	**Intent and Purpose** • Ensure community participation in assessing health needs, planning and monitoring of health activities. • Fund-raising and fund management where necessary. • Create demand for health services. • Promote healthy and hygienic habits in the community. • Ensure gender equity and women's empowerment.

department representative and the panchayat body. Block-level Panchayat Samiti reviews functioning and progress of VHSCs. District Mission in its meetings periodically collects information on the functioning of VHSCs and issues guidelines to improve their functioning.	
Management of Untied Funds at Village Health and Sanitation Committees ● Total amount of untied funds: Rs. 10000 per annum ● Fund transfer from Block Programme Management Unit to VHSC's bank account ● Bank account in the name of VHSC. ● Joint signatories: *Sahiya* and President/treasurer of VHSC ● *Sahiya saathi* to collect the cheque and deposit in the account. ● Bank records to be collected and submitted by *Sahiya Saathi* or *Sahiya.* ● Report submission: Statement of Expenditure and Utilisation Certificates on quarterly basis. ● Reports and vouchers to be submitted to Block Accounts Manager by 28th of every month for verification and certification. **Decision making process at the VHSC** ● Needs Assessment: Formulation of Village Health Plan. ● VHSC monthly meeting. ● Quorum: Minimum of 50 percent members (11-21) to be present when decisions are made and passed, but presence not restricted to members only. **Use of Untied Funds by the Village Health and Sanitation Committee** ● As revolving funds for families in emergency and special circumstances. ● Cleanliness and environmental sanitation drives. ● Anganwadi activities which promote healthy eating habits among children. ● Increasing awareness on health issues. ● Meeting expenses of Village Health and Nutrition Day (VHND) (maximum Rs. 200 per month) related to IEC/BCC activities. ● Emergency transportation to nearest facility.	

ANNEX G: SUPPORTIVE SUPERVISION

Source: Adapted from The Population Council. 2010. *Facilitating Provision of Client Centered Family Planning Services through Supportive Supervision: A Guide for Human Resource Management*. Pakistan: Population Council (p. 19, 22, 25, 26).

Supervision is the activity carried out by supervisors to oversee the productivity and progress of employees. It is a function that leads to better coordination and helping others accomplish the mission, aims and the objectives of a programme or organisation. The main mission of the health system is to care for the clients in a manner that fully satisfies the client. Listening is more important than speaking and taking and providing feedback is very essential for improving performance.

Definition of Supervision

"A way of ensuring staff competence, effectiveness, and efficiency through observation, discussion, support and guidance" (McMahon, 1992, p 472). In short, supervision is a way to ensure that staff are performing to the best of their abilities the tasks assigned to them and achieving the results with the least amount of resources. Supervisors achieve this by guiding and supporting their staff.

Following points are important to remember about supervision:

- Supervision is a process not a task.
- A supervisor must show appreciation and encourage the supervisee.
- Supervisor should keep away from two words—inspection and checking.
- A good supervisor must always be accessible and approachable.
- A good supervisor must show patience.

Supervisors should:

- Know what their staff are supposed to do.
- Ensure that the staff are well trained for the job.
- Ensure that the staff are provided facilities to do the job.
- Ensure that their problems are solved.
- Ensure that their work is appreciated and recognised.
- Do's:
- Show appreciation and encouragement. Pick the positive points and anything for which the supervisees can be praised (for example a neat and clean *Sahiya* health house).
- Listen attentively to the supervisee's problems.
- Show respect.
- Provide on-the-spot guidance.
- Encourage the supervisees to identify problems and also solutions.
    - Clearly talk about what is expected from the staff. (task clarification).

Don'ts:

- Supervision should not be carried out in a manner that is:
    - Autocratic: Checking or inspecting things in an authoritative manner according to the whim of the supervisor.
    - Superficial: Not going into the depth of finding out what is working and what is not working.
    - One time visits: Irregular, visits conducted infrequently.
    - Checklist oriented: Checking things according to a checklist and not in an in-depth manner.
    - One-way: Discouraging inputs from the supervisee.

Supervisors must never:

- Scold a supervisee in the presence of others that includes family members or clients.
- Show favouritism towards certain employees.
- Blame an employee for their own mistakes.
- Unnecessarily focus on the personal matters of employees, especially if the supervisee is not interested in discussing these matters.
- Gossip with one employee about another.
- Discourage initiative by being overly critical.
- Constantly highlight the negative aspects.
- Make unfair comparisons between employees.
- Become inaccessible to employees, for instance, by infrequently visiting supervisees.
- Deny appreciation even on occasions when it is due.
- Fail to highlight achievement to higher ups/higher authorities such as District Coordinator of the National Programme.

Role of a Supervisor:

- Be a Leader (inspire, persuade and take along supervisees being innovative, think up new ideas and collaborative work with others).
- Be a Planner (creatively develop joint plans with the lady health visitor's (LHV) for achieving programme goals).
- Be a Problem Solver.
- Be an Organiser (get things organised through good planning).
- Be a Coordinator and Controller (work as a team and at times be assertive).
- Be a Communicator (be articulate and clear-headed).
- Be a Diplomat (be able to handle sensitive issues delicately without being hurtful).
- Be a Motivator (inspire a passion to work optimally).
- Be a Counsellor (provide good advice).

- Be a Reward Administrator (shower appreciation appropriately).
- Be a Change Agent (think innovatively out of the box).
- Be a Coach (guide and help).
- Be a Team Builder (take everyone along and work collaboratively).
- Be a Conflict Manager (tactfully resolve conflicts).
- Be an Advocate for Supervisee's rights and needs.

Attributes of a Supervisor

- Listen patiently.
- Persevere and not loose temper.
- Empathise.
- Be sensitive.
- Handle grievances appropriately.
- Maintain discipline.
- Have good negotiation skills.
- Be a good teacher.
- Manage time effectively.
- Maintain trust.
- Be fair and impartial.

ANNEX H: MANAGER'S TOOL

What is the Manager's Tool*?*

The USAID-funded Health Policy Project supported the state to develop the *Manager's Tool* as an aid for health managers to check critical aspects of the health system during their field visits to health facilities, to note their observations and the issues discussed and resolved together with health centre staff. The tool also serves as a means to address issues in quality assurance (QA) meetings and family planning (FP)- related trainings.

This tool is useful for managers at all levels. State-level managers may include members of the FP cell and state programme managers. District-level managers may include: district programme managers; civil surgeons; additional chief medical officers (ACMOs); reproductive and child health (RCH) officers; district programme coordinators; district programme officers; information, education and communication (IEC) officers; and district data officers. Block managers may include programme managers, data managers, and development officers.

Managers use this monitoring tool to inform decisionmakers of progress being made in each block or district, and identify the issues that need to be addressed to strengthen the health system and improve health service delivery.

Managers should use separate tools for each district.

The tool has the following sections, each of which corresponds to functions that district- and block-level healthcare managers typically engage in or are responsible for.

a) Details of each block
b) Sub-centre visit
c) Primary health centre visit
d) Community health centre visit
e) Family planning camps
f) Trainings
g) Contraceptive updates
h) Private hospitals accredited
i) Empanelment of doctors
j) Community monitoring meetings
k) Quality assurance meetings
l) Transport and referral
m) Meetings at state level
n) Meetings at district level

Manager's Tool *Basics*

For each section in the *Manager's Tool,* add the details in the top portion under 1, 2, 3, 4, or 5 rows. Continue using the same row to add other details.

SubCentre Visit					
No.	Date	Sub Centre	Block	Village	In-charge
1	12-Dec-12	Bano	Bano	NA	Dr. Minz
2					

The example here is of a visit to the sub-centre in Bano block of Simdega district in Jharkhand, and the details about basic infrastructure are filled in the first row, in the next section

		Electricty/telephone	Toilet facility	Water supply	ANM Staying	ANM Trained	Male Health Worker	Contractual Safai Karmachari to assist ANM
1	2	1	1	2	2	1	2	2
2								
3								

Step 1

When the State/District/Block Programme Manager visits a health facility or a meeting, first s/he informs the facility level staff that the visit's purpose is to understand the functioning of the centre or meeting, which aspects are doing well, which areas need strengthening. S'he assures the staff that this is neither a test nor a record for punitive action. Rather, the purpose of this visit is to improve the overall health system and health service delivery to the community and to jointly, arrive at possible solutions to address existing issues. Invite one person to show you around, and share relevant documents. S/he may ask questions to add in the *Manager's Tool*, the required information but only exactly what is asked for, rather than delving into the details of why things are done a certain way. Also, ask the health facility staff to give a few minutes (not more than 15–20 minutes) to share and discuss things 30–40 minutes, after making observations.

Step 2

The manager records the observations as '1' (for present or yes), and '2' (for (absent or no). For example, during a sub-centre visit, under the equipment and supplies section, record information on whether electricity and telephone is present or absent. Similarly for water supply, auxiliary nurse midwife (ANM) staying at the centre, whether the ANMs are trained as suggested by the Indian Public Health Standards (IPHS), and record the information as above.

In addition to recording observations, the manager asks the staff to share relevant documents and notes this information. For example, the manager can request the supply register to verify whether all the sections are current and complete. The register is checked against the available stock of supplies to see if it matches. No feedback is given at the recording stage—the manager waits to ask questions about why it is or is not updated. Comments are made during the follow-up discussion.

SubCentre Visit							
No.	Date	Sub Centre	Block	Village	In-charge		LEGEND
1	12-Dec-12	Bano	Bano	NA	Dr. Minz		Present/ Yes= 1
2							Absent/ No= 2
3							Reason in words
4							
5							

No.	Labour Room hygenic	Electricty/telephone	Toilet facility	Water supply	ANM Staging	ANM Trained	Male Health Worker
1	2	1	1	2	2	1	2

Step 3

When all the sections are filled out, the manager meets with the key staff to, discuss things that are going well, that need strengthening andgather more information on the health facility and its functioning. Begin with a discussion on all the positive aspects observed during the visit. S/he can then look at all the areas marked '2' and discuss all these issues with the relevant staff in a group discussion.

This is a good opportunity for the entire staff to look at the positives and negatives, the resources they have and those that they can maximise; recognise and accept the issues or problem areas; and think together about options to address the issues at hand and find innovative solutions.

Step 4

No.	Key issues Disucssed	With	Solutions Offered	Next Steps		
				Action	Who is responsible	Due date for action
1	ANM not staying; MIS incomplete and not qulaity	Dr. Minz	ANM is not from block- so not possible to stay; BPM to receive training by DPM during next visit	ANM issue to be raised with ACMO/CS; BPM to receive training by DPM during next visit	DPM	Jan 2nd week

The next step is to develop specific actions with both a timeframe and assigned responsibility to address particular issues. Be realistic with timelines and responsibilities to assure that problems are addressed in a timely fashion and that the relevant people are informed about the needs, requirements, and changes.

The manager may also assign some responsibility to himself/herself. Some issues do not have an obvious solution, and may require a human resource or policy decision from the district or state. In this case the manager adopts the appropriate chain of command, communicates with the responsible person, and keeps the relevant staff informed of communication and follow up for all policy actions.

For example, a manager may learn that the supply of emergency contraceptive pills (ECPs) has been depleted for the last three months. Since ECPs are procured at the centre and contracted out to a

manufacturer, if the manufacturer has delayed supply to the state or the district, the sub-centre staff cannot be held responsible. In such a case, the district programme manager should inform the state programme manager, the state FP cell, or the procurement officer to remedy the problem—or short-term solutions can be explored. One option is to check whether unused or excess ECP stocks exist in other districts, facilities, or in the state repository and can be shared with the sub-centre. Simultaneously, take steps to ensure that clients are advised to use ECPs available in the private sector.

Step 5

The manager should thank the health facility staff for their time, and sharing their ideas and thoughts for improvement. Wherever relevant the manager should commend the staff for the good work they are doing towards improving the health of the community. The manager should also inform them about the next visit.

By following the five steps mentioned above, program managers can ensure the following:

1. The staff does not get a sense of approval or disapproval of their functioning, and do not get defensive or biased right in the beginning. This way they may not tend to influence the remaining parts of your visit/presence.
2. In cases where the centre is under-staffed or has irregular supplies, and the staff feel that they are dealing with many problems, they start in a negative mode and come up with a long list of complaints at the onset of the visit. This may also take up a lot of time. In such cases the staff members fail to see the positives, placing too much importance on the problems, without focusing on coming up with solutions.
3. In some cases, the meetings with the staff also have a positive team building effect, helping the entire team look at their strengths, weaknesses and also the opportunities available.
4. The visits also help the staff recognise that the managers or 'bosses' are not just interested in fault finding, but are genuinely interested in bringing a positive change. This acts as a motivating factor, and in the long run the staff tend to respect the managers and are responsive to future requests.
5. Setting realistic action points and timelines, and sharing responsibilities encourages the team to enhance its working in the given restricted resource settings available to them.
6. In order to assess areas of strengthening required by the staff, the managers need to: provide examples of innovative solutions that they can apply to other centres or districts; take opportunities to appreciate people who are doing commendable work; and iron out any pending issues in a timely fashion.

ANNEX I: PRE AND POST TRAINING TEST

Print these forms for each participant. The same form will be used in the pre and post-test.

Pre Test ☐ Post Test ☐

Name: _____

Date: _____

Designation: _ Block/District/State: _____

# of years of experience in health sector : _____

Contact Number: _____

Write the correct answer (*a/b/c/d /e*) in the next column	Answer
1. The four stages of the Policy process are- Problem Identification, Policy Development, Policy Implementation and Policy M & E a. True b. False	
2. The National Population Policy 2000 aimed to reach a TFR of 2.1 by the year: a. 2010 b. 2015 c. 2020 d. 2050	
3. Health is a state subject: states are responsible to implement the health programs and policies established by Government of India a. True b. False	
4. The population of India is so large that a. Every 3rd person is an Indian b. Every 6th person is an Indian c. Every 10th person is an Indian d. Every 16th person is an Indian e. None of the above	
5. According to the 12th Five year Plan a. Achieve a total fertility rate (TFR) of 2.1 by 2017 b. focus is on promotion of spacing and Post-partum contraception c. intensify training of service providers in FP d. deploying private providers e. all of the above	
6. According to the Annual Health Survey (2010-11) Jharkhand's family planning data is: a. TFR is 3.1; varies from 2.4 in urban areas to 3.3 in rural areas b. TFR is 2.1; varies from 2.1 in urban areas to 3.1 in rural areas c. None of the above	
7. The most adopted contraceptive method in Jharkhand is a. Female Sterilisation b. NSV	

Write the correct answer (*a/b/c/d /e*) in the next column	Answer
c. Condoms d. Emergency Contraceptive Pill	
8. The six building blocks health systems are service delivery, health workforce, health information systems, access to essential medicines, financing and leader ship and governance a. True b. False	
9. Free or low-cost condoms, oral contraceptive pills (OCPs) and emergency contraceptive pills (ECPs) are available: a. With ASHAs/Sahiyas through the door-to-door delivery. b. At VHNDs. c. Through social marketing organisation depot holders. d. Through pharmacies selling premium and social-marketed brands. e. All of the above	
10. Quality Assurance (QA) is defined by MOHFW, 2006 as: a. a mechanism/process that contributes to defining and designing the quality of health care. b. a mechanism/process that contributes to assessing and monitoring the quality of health care. c. a mechanism/process that contributes to defining, designing, assessing, monitoring, and improving the quality of health care. d. None of the above	
11. At the District level the DQAC should meet at least a. Twice a month b. Once a month c. Once a quarter d. Once a year e. Anytime, as required	
12. IEC BCC should be planned for a. Mass media b. Community level display and activities c. Health facility level display and activities d. Interpersonal Communication e. All of the above	
13. Jharkhand has an FP Cell, housed within the health directorate, is mandated oversee the implementation of all approved FP activities at the state/district level a. True b. False	
14. Data quality can be ensured by a. compare the data with other survey data that is available b. compare the data with previous month data c. discussions with program managers on data elements and indicators that are found to be unreliable, unrealistic d. Visit facilities, blocks and HMIS office to check data e. All of the above	
15. Ensuring data quality means a. Data correctness b. Data consistency c. Data Linkages established between related indicators d. None of the above e. All of the above	
16. According to McMahon (1992), Supportive Supervision is *"A way of ensuring staff*	

Write the correct answer (*a/b/c/d /e*) in the next column	Answer
competence, effectiveness, and efficiency through observation, discussion, support and guidance". a. True b. False	
17. A good supervisor should: a. Show appreciation and encouragement. b. Listen attentively to supervisee's problems, encourage in identifying supervisee's problems and identifying solutions. c. Show respect. d. Provide on-the-spot guidance. e. All of the above.	
18. In India's public family planning program these are the contraceptive choices available: a. Sterilisation, condoms, oral contraceptive pills, emergency contraceptive pills, and Copper T (or IUCD) b. Sterilisation, condoms, implants, injectables, pills, and diaphragms c. Sterilisation, condoms, oral contraceptive pills, implants, and Copper T (or IUCD) d. All of the above combinations	
19. The main supply side issues w.r.t. family planning program are: a. Fewer contraceptives in the basket b. Inadequate supply, especially to the last mile c. Supply chain management d. Option a. and c. e. All of the above	
20. The main demand side issues w.r.t. family planning program are: a. Improper counselling of men and women about family planning choices b. Focus on sterilisation is high from the ASHAs (community health workers) c. Range of myths and misconceptions among health workers about certain FP methods d. Option a. and b. e. All of the above	

For more information, contact:

Health Policy Project
Futures Group
One Thomas Circle NW, Suite 200
Washington, DC 20005
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@futuresgroup.com
www.healthpolicyproject.com