END-LINE REPORT FOR EVALUATION OF SAMBHAV VOUCHER SCHEME – AGRA

State Innovation in Family Planning Services Project Agency

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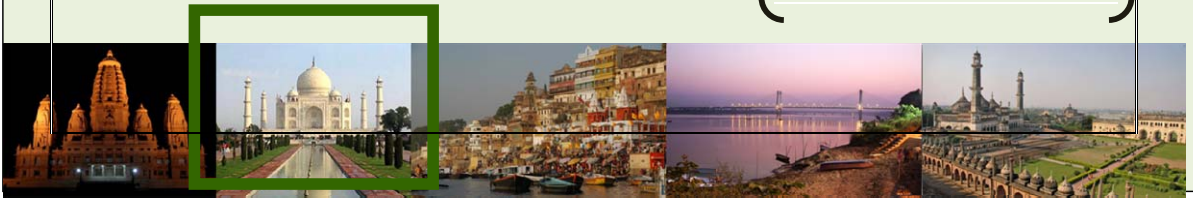

ACKNOWLEDGEMENT

The present Endline Study in the slums of KAVAL Cities of Uttar Pradesh has been assigned to Ipsos Research Private Ltd, New Delhi. We are thankful to Shri.Amit Kumar Ghosh , Executive Director , Shri B.K Jain, General Manager (R&E/ FPIS), SIFPSA, Ms.Savita Chauhan , General Manager (Private Sector) for providing us the opportunity to undertake this study .

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We are also thankful to all the Household heads and women respondents for giving their precious time during the data collection.

We would also like to thank all district coordinators and district monitoring officers who supported in the execution and analysis of the study by all means.

Ipsos Study Team

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Ipsos Study Team

ABBREVIATION

1. ANC - Antenatal Care
2. ANM - Auxiliary Nurse Midwife
3. ASHA - Accredited Social Health Activist
4. BPL - Below Poverty Line
5. CHV - Community Health Volunteer
6. CMO - Chief Medical Officer
7. DIFPSA - District Innovations in Family Planning Services Agency
8. DLHS - District-Level Household Survey
9. DPMU - District Project Management Unit
10. GoI - Government of India
11. FP - Family Planning
12. HLFFPT - Hindustan Latex Family Planning Promotion Trust
13. IFA - Iron-Folic Acid
14. IUCD - Intrauterine Contraceptive Device
15. MCH – Mother and Child Health
16. NFHS - National Family Health Survey
17. NGO - Non-Governmental Organization
18. PMU - Project Management Unit
19. PNC - Postnatal Care
20. PPP - Public-Private Partnership
21. RCH - Reproductive and Child Health
22. RTI - Reproductive Tract Infection
23. RSBY - Rashtriya Swasthya Bima Yojana
24. SIFPSA - State Innovations in Family Planning Services Agency
25. STI - Sexually Transmitted Infection
26. TT - Tetanus Toxoid
27. VMU - Voucher Management Unit

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1

INTRODUCTION

1.1. State Innovations Family Planning Services Project Agency(SIFPSPA) – An Overview

SIFPSPA is a registered society in Uttar Pradesh which was set up to implement and manage projects undertaken through Innovations in Family Planning Services (IFPS) Project Agreement. The IFPS Project Agreement came into being as a joint endeavour of Government of India and the United States Agency for International Development (USAID) on 30th September, 1992. The IFPS project was designed to serve as a catalyst for the Government of India in reorienting and revitalizing the country's family planning. The project structure envisaged that all activities would be implemented by SIFPSA. This society would help in the flow of funds from Government of India and help in involving both Government agencies as well as non-governmental sector in family planning service delivery. It would have flexibility to recruit experts from the private sector and also obtain Government officers on deputation. The society would be responsible for the day to day coordination and management of all project activities.

The main objective of SIFPSA is to facilitate, through innovative means and partnerships with government and other agencies, the goal of health for all by improving the quality, demand, access and delivery of family planning and Mother and Child Health (MCH) services and also improvement related to quality of life which includes the status of women.

The primary goal of the IFPS project is to assist the state of Uttar Pradesh in reducing the rate of population growth to a level consistent with its social and economic objectives. In 1992, when this project was conceived, the population of Uttar Pradesh was 140 million making it the largest state in India. Uttar Pradesh also had one of the poorer demographic social and economic profiles in India. In order to achieve the goal of reducing population, the way out was to make access to family planning services. It would be very effective if couples accept and use contraception on a broad scale in Uttar Pradesh.

Apart from it, the other goals were to increase the percentage of pregnant women receiving ante natal care (ANC) from 30 to 40 percent and the percentage of deliveries assisted by trained providers from 17 to 30 percent. It also aimed to expand immunization coverage of children.

In fact, population stabilization coupled with greater attention to reproductive and child health is the most challenging task before the state of Uttar Pradesh. In this context, SIFPSA has been playing a crucial and significant role to improve the quality and availability of Reproductive and Child Health (RCH) services both as a catalyst and as a funding agency.

Since 1994, SIFPSA has developed innovative models, piloting and replicating them and pioneering the involvement of the private sector in family planning in Uttar Pradesh. The major successful innovations of SIFPSA have been partnerships with private sector including NGOs, dairy cooperatives, Indigenous System of Medicine Practitioners (ISMPs), corporate sector, decentralized planning and implementation of RCH activities through District Action Plans (DAPs). It also developed a unique approach called Performance Based Disbursement System (PBDS).

Today, SIFPSA has gained an international acclaim for its innovative interventions and has set standards for working in the field of social development and RCH in particular.

1.2. Sambhav Voucher Scheme

According to the Census of India 2011[1], there has been an increase of 17.64 percent of population in the past decade. The state of Uttar Pradesh is found to be the most populated state with 16.49 percent of the total population of India. India is one of the countries of the world which agreed to achieve the United Nations Millennium Development Goals (MDGs) in 2000. The eight goals include improving maternal health and reduce child mortality. With the maternal mortality rate (MMR) of 212 [2]and Infant mortality rate (IMR) of 50[3] and increasing population, India is still lagging behind to achieve the goals of MDGs. It will not be able to achieve the goal by 2015 unless, it improves the health of the poor in the country.

[1] Government of India(2011) "Census of India"; Office of Registrar General, India
[2] Government of India(2011) "Maternal and Child Mortality and Total Fertility Rates"; Sample Registration System ,Office of Registrar General, India

To overcome this hurdle, the Indian government has adopted many initiatives to improve the access of poor to quality. One of the initiatives is the voucher scheme to increase access to reproductive, maternal, and child health services. The scheme is implemented through public private partnership approach. It is a collaborative effort between the public and private sectors with clear, mutually agreed on roles, shared objectives, and specified performance indicators[4].

On September 28, 2007, SIFPSA in collaboration with Hindustan Latex Family Planning Promotion Trust (HLFPT) initiated the pilot project of "Sambhav Voucher Scheme" in Kanpur. "Sambhav" is a Hindi term which means it is possible. It signifies that the poor families can also have access to high quality health services. The scheme is executed through PPP mode with funding support from USAID. The scheme is an initiative to provide health care services to below poverty line (BPL) families in slum areas as well as to control the rapidly growing population. Based on the positive outcomes in Kanpur, the scheme was further launched in Allahabad, Varanasi, Agra and Lucknow.

The targeted population of the scheme is urban slum women in the age group of 15-49 years who are married and living with their husbands having children (in the age group 0-2 years) or are currently pregnant. The main objectives of the scheme are:

- Expand service coverage and meet individual, family and community level demand.
- Improve quality of and access to RCH services.
- Accreditation of private facilities for providing quality RCH and family planning services to the BPL families of urban slums.
- Expand service coverage and create Health Seeking Behaviour.
- Providing a choice of service providers available to the people for accessing services.
- Create and manage a voucher system for availing predetermined RCH services.
- Documenting and disseminating the process, lessons and learning.
  To identify linkages with other agencies for replicating and scaling-up this PPP model.

[4] IFPS technical Assistance Project(ITAP)(2012) "Sambhav: Vouchers Make High-Quality reproductive Health Services Possible for India's Poor", Report prepared for USAID India, Futures Group, Gurgaon, Haryana

Under the scheme, six vouchers for six different facilities were provided: ante-natal care — including three ANC checkups, iron tablets, TT injections, nutrition counselling and pathological services for pregnant women; delivery facilities — normal as well as caesarean; post-natal care, two checkups, including breastfeeding as well as family planning counselling; family planning facilities including male and female sterilisation and intra-uterine contraceptive device; checkups and treatment of reproductive tract and sexually transmitted infection including counselling of partner; and one general health check-up for any member of the family in a year.

The accredited hospitals and nursing homes provided free services to voucher holders, and then got their reimbursement through the implementing authority in each district. The scheme is implemented in each of the districts under the District Innovations Family Planning Services Project Agency (DIFPSA), which chose another implementation agency for the programme.

For Lucknow, Agra and Varanasi, the respective DIFPSA had chosen the District Urban Development Agency (DUDA) for the programme implementation; an NGO was chosen for Allahabad.

The implementing agencies, like DUDA, further employed Community Health Volunteers (CHV) for each slum, who were the field workers with the responsibility to track the beneficiaries and provide them the vouchers. They assisted them to the hospitals and private nursing homes. The volunteers got an incentive for each case they refer to the hospitals. For each case of ante-natal care, they got Rs 60 for each delivery and Rs 50 for family planning.

2

BACKGROUND AND CONTEXT TO RESEARCH

2.1 Research objectives

The voucher scheme was one form of public private partnership being initiated to increase coverage of RCH services by improving access of the economically poor households to the service delivery system. The scheme allowed targeting individuals for providing health subsidies directly. Vouchers were provided directly to poor families in slums through an NGO in each city.

2.1.1 The baseline study findings:

The baseline study was carried out in 4 cities of Uttar Pradesh namely Agra, Allahabad Lucknow and Varanasi, to estimate the baseline indicators related to the reproductive health among the slum dwellers. A sample survey among the slum dwellers was carried out in all four cities. The survey also included house-listing operation in the entire slum areas of the city to identify the beneficiaries.

During the baseline phase, house-listing operation was carried out in about 209 slums of Agra and 42 slums were randomly selected for sample survey using a statistical sampling design. All the households with an eligible woman were identified and about 20 households with an eligible woman were randomly selected from each of the selected slums. One woman from each household was interviewed in detail using the structured questionnaire. In case there was more than one eligible woman in the household, the youngest woman was interviewed during the main survey. The questionnaire contained the information related to the family planning and maternal and child health.

2.1.2 Expected outcome of the Voucher Scheme project:

Following were the expected outcome of the project to be measured during end line:

1. Increase in CPR by 4 percentage points annually by distributing sterilisation and IUCD voucher
2. ANC Services: Complete ANC services covering 3 check ups, 2 TT and 100 IFA for at-least 75% pregnant women
3. Delivery Services: ensuring 50% institutional delivery in the project area through voucher.
4. PNC Services: provide to at least 60% of delivery clients
5. RTI/STI: treatment of 10 percent infected eligible women.
6. Health check up: Free health consultation from qualified medical practitioner

2.2 Research Design

The primary research aimed at evaluating Sambhav voucher scheme across the beneficiaries and key stakeholders, in the selected 5 cities. The research techniques involved the use of both qualitative and quantitative method of data collection and analysis.

An iterative approach was followed for primary data collection where qualitative data collection and quantitative methods were used. Combination of these two methods and an iterative approach helped generate a richer data and understanding of preferences that emerge.

For instance the fieldwork was initiated with in-depth discussions and structured interviews pilot rounds for a day, which gave inputs for main qualitative and quantitative survey. Similarly the main research fieldwork was initiated with qualitative interactions with CMO, DPMU, NGO heads,

accredited facility owners/ managers and CHV's in each city followed by administering the structured questionnaire to women beneficiaries residing in the slums.

The qualitative methods used for collecting the data included in-depth interviews with key stakeholders like CMO, DPMU, NGO heads, Accredited facility owners/ managers and CHV's in each city .

Quantitative Methods helped to obtain the viewpoints of Women Beneficiaries on their current practices and reactions to all important aspects of the scheme.

Triangulation of findings from both approaches helped to get a holistic understanding and assessment of the scheme.

2.2.1 Target Groups:

The target group comprised of the key officials involved in the scheme at all levels of administration. For instance, officials at different hierarchy for instance (CMO) Chief Medical officer, Head of the District Project management unit (DPMU), Head of the NGO and Heads of the accredited facilities. Ground level workers (CHV's) were interviewed to obtain a holistic understanding and feedback on the scheme.

Women beneficiaries were interviewed to get the feedback from the demand perspective.

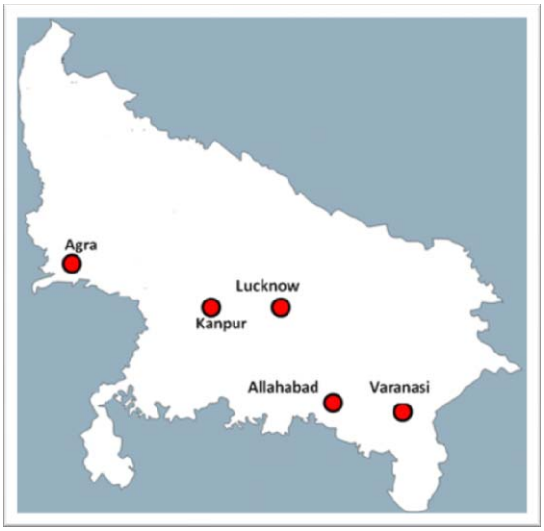
WOMEN BENEFICIARIES:

Women beneficiary, from project perspective were defined as those eligible women who were:

- In the age group 15-49 years ,
- Married,

- Living with husband ,
- Having a 0-5 years child.

2.2.2 Geographical Coverage



20 urban slums in each of the 5 KAVAL (Kanpur, Agra, Varanasi, Allahabad and Lucknow) cities were visited for the end-line round to meet the women beneficiaries. The slums were selected in consultation with the SIFPSA team.

2.2.3 Programme Delivery indicators for the End-line survey

The indicators used in the end-line stage were kept in line with the baseline outcomes to have a clear comparison between the two time frames. The measureable indicators which were obtained from the baseline phase were:

- ANC services to pregnant women
  - % of pregnant women got registered

- % of currently pregnant women checked up
- % of currently pregnant women received TT
- % Of CPW received IFA

➢ Natal care to pregnant women
- % Of pregnant women got delivered at different institutions

➢ Post natal care services availed by new mothers
- % Of women availed PNC
- Advice for colostrum feeding
- Advice for proper baby care
- Advice for timely immunization
- Immunization of children
- Advice for spacing between child birth

➢ Awareness of RTI and STI symptoms

➢ Prevalence of RTI and STI

The information areas of the End-line study were:

1. HH details
2. Address
3. Head of the Household
4. Any women in the age group of 15-49 years
5. Number of children in age group 0-12 months
6. Number of children in age group 13-60 months

Beneficiary Interview

1. Demographic details- age, education, occupation, monthly HH income
2. For information related to all live births during project period (July 2011-June 2013)
    a. Information related to ANC registration, physical examination, counseling, TT injection, IFA tablets, advice on institutional delivery

3. Institutional delivery and PNC
    a. Counseling received on issues- breast feeding, immunization, family planning, etc.
    b. Number of PNC checkups availed
    c. Who advised to get a PNC checkup done
4. Family Planning
    a. Awareness of FP methods
    b. Source of information of the FP methods
    c. Are you or your husband currently using any FP method?
5. RTI/STI
    a. Awareness of symptoms
    b. Did they suffer from any of these symptoms
6. Awareness about voucher
    a. Source of awareness of any scheme where they can pay for health services through vouchers?
    b. What information was given to them regarding the voucher
    c. Did anyone visit their home for verification?
    d. Did anyone visit your home for confirmation once you had received the services?
    e. How would you rate the services received at the facility
    f. Were you satisfied with the services
    g. In your opinion should this service continue
    h. Any health care need that should be covered by this voucher?

3

SAMPLING METHODOLOGY

3.1 Sample size

As per the research design a sample of 2000 women and 100 CHV's formed the part of quantitative survey. In addition to this, formal discussion with 5 CMO's, one in each district, 5 DPMU heads and 5 NGO heads and 20 facility managers/owners, were completed as a part of qualitative interactions.

The grid below lists the total sample size achieved across segments.

Target Group	Spread	Target	Achieved
Women beneficiaries interviews	400 * 5	2000	2030
CMO	1 * 5	5	5
DPMU	1 * 5	5	5
NGO	1 * 5	5	5
Facility Heads	5 * 5	25	25
CHV's	20 * 5	100	100
Total		**2140**	**2170**

For CMO, DPMU, NGO and facility interviews, repeated attempts were made to schedule the interviews. The interviews were completed with cooperation of the Voucher management unit at each city. The interviews were conducted by experienced researchers of Ipsos.

3.2 Sampling Methodology

The sampling methodology for the selection of respondent in slums is explained below:

3.2.1 House listing – Contact sheet

For the purpose of selecting household in the slum; all the households in each slum were listed and numbered systematically. This was critical in identifying the eligible target audience and ascertain the proportion of eligible respondent's in the total population of the slum.

For selection of households, listing of all the dwelling units were carried out in following the steps as specified below:

(1) Correct identification of the boundaries of the slums,

(2) Preparation of the sketch maps of the slums,

(3) Numbering of all the structures within the four boundaries of the slums,

(4) Listing of dwelling units and

(5) Listing of all the households within each dwelling units in the slum.

The list of all the households in the slum thus constituted the sampling frame for the main survey for that specific slum. The listing operation consists of visiting the selected slum, recording of a description of every structure together with the names of heads of the households found in the structure and drawing of a location map as well as the lay out map of the structures in the slum.

The details that were recorded during the listing exercise were:

1. HH serial number
2. Name of the head of the household
3. Door number
4. Whether the HH has a women aged 15-49 years

5. Whether the women in the HH delivered a child between July 2011 and June 2013.
6. Whether there is any 0-5 years child in the HH
7. New serial number of the HH with eligible women beneficiary

At the listing stage, all the married women in the age group 15-49 years were listed and eligible women were bucketed. 20 eligible women respondents were asked to give their responses on a structured questionnaire which was prepared in consultation with the SIFPSA team.

3.2.2 Qualitative interactions

A total of 140 qualitative interactions were carried out in each city. The interview with the Chief Medical Officer, (CMO) of the district was scheduled with the help of the assistant Voucher coordinator of that district. The interviews with the DPMU and NGO head were also scheduled with the help of the voucher management unit of the district.

A list of all accredited facilities in the city was prepared with inputs from the divisional voucher management units in each city. The facilities were selected on the basis of number of vouchers redeemed by the beneficiaries. The facility list was aligned in a manner that the facility with maximum number of vouchers redeemed was at the top and the facility with the least number of vouchers redeemed was at the bottom of the list. Top 2 and Bottom 2 facilities were selected from the list. The remaining one facility was selected from the middle.

A total of 20 CHV interactions were completed in each city. 4 CHV's associated with each of the 5 selected accredited facilities were selected. In-depth discussions with the CHV's were conducted to understand the implementation of the scheme at the ground level.

The Qualitative interactions were helpful in understanding the following:

- Understanding of the processes adopted in selection of accredited nursing homes in the district;
- Measures taken to improve the quality of services provided in the accredited nursing homes;
- Satisfaction of accredited nursing homes providing the services through voucher scheme.
- Financial performance of the accredited nursing homes and assess the existing client load; and

- Responses from the accredited nursing homes on how to improve the functioning of voucher scheme.

4

FINDINGS OF THE END-LINE SURVEY

The findings of the survey are based on qualitative interactions with 28 participants and quantitative interviews with 405 randomly selected eligible women in the city of Agra. The beneficiary survey broadly consists of the following covered areas:

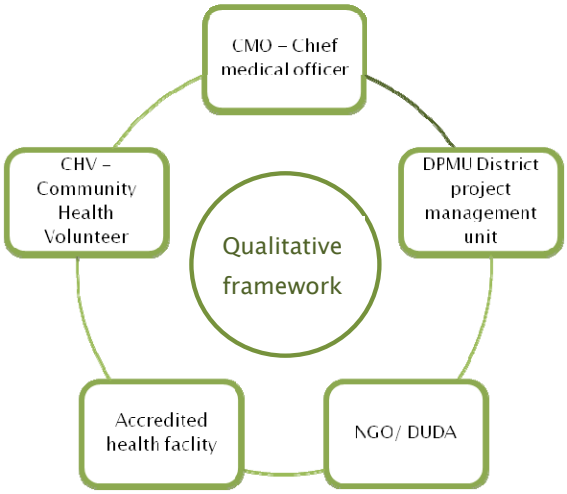
- Socio economic profile of eligible women
- Ante- Natal care services - Comparison of behavior during and before the project period
- Delivery and Post natal care - Checkups availed, Motivators for PNC and Advice given during PNC
- Family planning methods – awareness, source of information and usage
- RTI / STI- awareness and prevalence
- "Sambhav" Voucher related information

4.1 Qualitative findings

The qualitative interactions were spread across the following target groups:

1. **The CMO of the district**, who is involved at the level of supportive supervision towards the Sambhav voucher scheme.
2. **The DPMU (District project management unit) head,** which heads the voucher management unit at Agra
3. **The NGO head,** who is responsible for training and distribution of vouchers among the CHV's

4. **The Accredited Facility owners/managers,** who are responsible for redeeming and providing the health services against the vouchers.
5. **The CHV's,** who visit door to door to create awareness, identify beneficiaries, and distribute vouchers of the Sambhav scheme.



4.1.1 Planning and preparation

The CMO of Agra district is one of the key figures of the Sambhav voucher scheme. The involvement of the CMO is at the strategic level, where the responsibility is effective programme monitoring of the scheme. To assist the CMO, the DPMU (District Project Management Unit), Agra manages the day-to day operations involved in the implementation of voucher scheme. The NGO associated with the DPMU, DUDA (District Urban Development Authority), manages the distribution of vouchers and training of the CHV's. These are the key players in the scheme who are responsible for planning and preparatory activities.

At the implementation level, the accredited facility staff and the CHV's (Community health volunteers) are the major players. There are 5 health facilities which are presently accredited with the Sambhav voucher scheme in Agra. The facility managers mentioned that they came to know about this

scheme through the Media and through the VMU (Voucher management unit). A team from Lucknow visited their hospital for inspections and audits before they were empanelled.

The CHV's are the backbone of the scheme at the ground level. They are closely associated with the beneficiaries as well as the staff of voucher management system and act as an interface between them. They map all households in their slums and go house to house to identify beneficiaries of this scheme.

As mentioned by the CMO, Quarterly meetings with all the stakeholders of the system (DPMU, NGO, hospital representatives) help in sharing information about the challenges faced in the implementation of the scheme on ground.

The decisions related to scheme are taken after detailed meetings with the DPMU which happen every month. The CMO interacts with the DPMU representatives who maintain all the records such as cash book, ledger book and financial details. Crucial decisions like selection of the NGO were taken after consultation and recommendations from the DPMU at the beginning of the scheme.

4.1.2 Implementation – Roles and responsibilities,

The CMO being the strategic head provides supervisory guidance in effective implementation of the scheme. Head of the DPMU mentioned that their main responsibilities involve Analysis of fund processes, fund releases and budgeting. Apart from that, he is also involved in managing DPMU team, which coordinates with implementing partners, establish quality assurance systems, distributing the vouchers, facilitate communication efforts, promote continued participation of private service providers, reimburse the providers, and collect and analyze data for monitoring and evaluation purposes.

Voucher distribution as mentioned by the DPMU, is according to the demand from the NGO. The NGO obtains the demand from the CHV's who weekly report the number of vouchers distribute and redeemed. They also mentioned that in the past two years the voucher distribution process has been smooth and hassle free in their city.

The head of the DUDA, mentioned that their role is to ensure that the CHV's are adequately trained and receive sufficient vouchers for distribution by constantly informing the DPMU about the demand of vouchers. They mentioned that their major responsibilities include recruitment and payments of the CHV's and beneficiary verification on the field. The minimum criterion for a woman to become a

CHV is that she should be 8th pass and should not have a problem in accompanying a woman even at night. During the initial stages they recruited the Anganwadi workers as CHV's since they were a known face among the slum community. They organize events in the slums like saas-bahu show, community rallies and put up banners and pamphlets to assist the CHV to increase the awareness about the scheme.

The facility heads expressed that their main role is to provide the stated health facility services enlisted in the voucher scheme. The two major reasons why they consented for accreditation were:

- Regular influx of patients. One of the hospitals mentioned that they have recently started functioning and regular patient load will help them gain popularity among other clients also.
- Charity and public service opportunity. 3 out of 5 hospitals mentioned that this way they got a chance to do public service and help the poor and downtrodden

Apart from the CHV's, AVC's (Assistant voucher coordinators) also play an important role in the system. The hospitals mentioned that cases where the CHV's are unable to call an extremely critical patient, at that time the AVC's motivate and brings the patient to the facility.

On interaction with the CHV's, it was observed that they were well informed about their duties and responsibilities and mentioned going to about 40-50 households per week. They expressed that initially they were hesitant and had doubts as to why any private health facility would give out services for free. But later as they were trained they understood the scheme better.

4.1.3 Challenges

When asked about the challenges faced for effective implementation of the scheme, the CMO mentioned that Nursing homes which are accredited are working on low rates. It was also pointed out that not enough vouchers are being distributed to the extremely poor and downtrodden.

The DPMU expressed that the paper work and file management occupy most of their time and installation of software might be a step ahead for effective monitoring of the scheme. It was also pointed out a need for a larger team at the voucher management unit.

When asked about challenges, The NGO (DUDA) pointed out that one of the major reasons why some women do not go to the facility is that they do not have money for transportation, since they are extremely poor. The CHV's bring out such issues to them during their fortnightly meetings. These issues are then brought forth to DPMU during the monthly meetings.

At the accredited facility level the challenges were more managerial in nature. They mentioned that the patient load is more than what they had expected. The beds they had assigned for the scheme beneficiaries sometimes fall short. They also pointed out that in such situations they generally have to put extra manpower to reduce the patient load.

On meeting the CHV's, it was brought up that following up with patient is a major challenge as they say yes on the first home visit and then on the second visit they refuse to go to the facility. This is mainly because their elders do not allow them to go ahead. They also mentioned that without transportation facility the patients feel reluctant to spend money on their own. This invariably leads to refusals and it becomes difficult for the CHV's to counsel them. Another challenge quoted by the CHV's is that some women in the slums are vary of the scheme and assured benefits and they find it difficult to gain their trust.

4.1.4 Suggestions:

When asked about possible solutions and suggestions to these challenges, the CMO suggested that the present rate for CHV's and the accredited facilities can be increased. This would in turn help them empanel more hospitals, add more CHV's and thus ensure wider reach/ coverage of beneficiaries into the scheme. More hospitals would lead to better reach for the beneficiaries and more CHV's would help in getting more distribution of vouchers. She was happy with the way the scheme was working out in her district and recommends that it should continue.

As mentioned by the DPMU, the work load at the facility is increasing and too many voucher patients are visiting the facility during the given hours. Due to this, the facilities have expressed the need for increment in the rates. He suggested that the rates given to the accredited facilities are less and should be increased to avoid any kind of dropouts from the panel.

The DUDA expressed their support towards the scheme to continue and wished that the payments for CHV's are increased as they work very hard to increase the awareness in their slums.

The facilities expressed the need to increase the rates for each service. They mentioned that the rates are low and increment will be a good thing. Also there were no complaints about reimbursements. They said that the payments happened in time and they were satisfied with the present payment cycle.

15 out of 20 CHV's mentioned that they expect increase in their salary. They also suggested adding free medicines in the vouchers so that it becomes easy for them to earn patient's trust. They said that they were satisfied with the scheme as they receive more respect and admiration from their community and they expressed their wish to be associated with it longer.

4.1.5 IEC Material Effectiveness

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	All	Lucknow	Kanpur	Agra	Allahabad	Varanasi
Banners/Posters	30%	56%	100%	14%	33%	21%
Pamphlets	37%	6%	0%	44%	45%	41%
Brochures	17%	25%	0%	42%	0%	0%
Wall Paintings	2%	13%	0%	0%	3%	0%
Nautanki	14%	0%	0%	0%	18%	38%
Puppet Show	0%	0%	0%	0%	0%	0%
Audio/Video	0%	0%	0%	0%	0%	0%

Overall, Pamphlets followed by Banners and Brochures were relatively more effective medium as per CHVs. Though Nautankis and Wall Paintings were also useful to an extent but their zone of effectiveness was highly limited.

In Agra , Pamphlets followed by Brochures and Banners were the only effective mediums .

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4.2 Socio Economic profile of the eligible women

In Agra, a total of 405 respondents in the age group of 15-49 years were interviewed. The mean age of the respondents is 25.8 years. A large percentage (41.4) of the respondents was in the age group of 25-29 years. A nominal proportion of 0.4 percent of the respondents was in the age group of 45-49 years of age.

Socio demographic spread of the respondents		
Age	Agra (%) N= 405	
15-19 years	2.2	
20-24 years	35.0	
25-29 years	41.4	
30-34 years	14.8	
35-39 years	4.9	
40-44 years	0.9	
45-49 years	0.4	
Mean age	25.8 years	
Education	**Self**	**Husband**
Illiterate/ No formal Education	47.4	30.6
School up to 4th class	4.9	3.7
School: 5th to 9th class	31.3	36.5
School: 9th to 12th class	11.8	23.4
Graduate	2.9	5.1
Post Graduate	1.4	0.4
Occupation	**Self**	**Husband**
Business/Shop/Office	0.4	15.5
Domestic work	0.9	1.2
Selling in street/market	0.7	3.2
House wife	94.0	0.2
Skilled worker	0.2	23.2
Daily Wage Earner	2.9	53.0
Monthly Household income	**N=405**	
0-2000	18.0	
2000-5000	63.7	
5001-10,000	15.8	
10,001 - 15,000	2.4	

Nearly half of the respondents (47.4%) were illiterate and did not receive formal education. 31.3 percent of the respondents have attended upper primary classes while 11.8 percent have secondary and higher secondary education. Only 2.9 percent and 1.4 percent of the respondents were graduates and post graduate. As compared to the respondents, the percentage of illiteracy of the respondent's husband was lower with 30.6 percent. Among the respondent's husband, 36.5 percent have received formal education till the upper primary classes. Unlike the respondents, the percentage of post graduates among the husband is low. Only 0.4 percent of the respondent's husbands are post graduates. This shows that majority of the respondents and their husbands were not well qualified.

From the above table, it is evident that 94.0 percent of the respondents are housewives which mean that they are economically dependent on their husband. 2.9 percent of the respondents are daily wage earner. A large percentage of 53.0 of the respondent's husband are wage earner and 23.2 percent are skilled worker.15.5 percent of the respondent's husband having business or shops. While 63.7 percent of the household earn Rs.2000-5000 per month, only 2.4 percent have a monthly earning of Rs.10,001-15000. Around 18 percent the total respondents have a household income of Rs.0-2000 in a month. From occupational and income structure of the respondents, we can say that the socio-economic condition of majority of the respondents are not good.

4.3 Ante – Natal care

Out of 322 respondents who delivered a child during the project period, 2945 (i.e.91.6%) availed ANC services. This percentage was 83.6% amongst 239 beneficiaries who also availed ANC services before the project was launched. This shows that there is an increasing in availing ANC services by pregnant women after the voucher scheme started in the area.

In reference to different aspects of ante natal care- largely there is an increase in those reported to have availed services such as physical examination, counseling related to pregnancy, advice related to institutional delivery, ultra sound, blood test and urine test. From the below table, it shows that before the project was initiated 25.1 percent did not avail any physical examination service. After the project was implemented, it reduced to 9.9 percent. we can see that Similarly, availing the 3 physical examination increased from 56.0 percent to 65.2 percent. But in case of TT injection, there was a decrease in availing the 2 injection service from 80.7 percent to 76.4 percent after the project has been implemented. However, 13.6 percent availed 1 injection after the project as compared to 5.8 percent.

ANC services	(N=239)	(N=294)
	Before Project Period	During Project Period
Registration	84	92
	Physical examination	

1 examination availed	8	9
2 examinations availed	11	6
3 examinations availed	56	65
TT Injection		
1 injection	6	14
2 injection	81	76
IFA tablets		
Less than 100	51	54
100	15	17
Counseling related to pregnancy	58	71
Advice on institutional delivery	57	47
Ultrasound	63	72
Blood test	66	88
Urine test	64	86

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Percentage distribution of women availing ANC services during the program and before the programme period		
ANC services	Agra % (N=322)	Agra % (N=239)
	DURING PROJECT PERIOD	BEFORE PROJECT PERIOD
Registration		

Percentage distribution of women availing ANC services during the program and before the programme period		
ANC services	Agra % (N=322)	Agra % (N=239)
	DURING PROJECT PERIOD	BEFORE PROJECT PERIOD
Availed	91.6	83.6
Physical examination		
Not availed any examination	9.9	25.1
1 examination availed	8.7	7.9
2 examinations availed	15.5	10.8
3 examinations availed	65.2	56.0
TT Injection		
Not availed	8.7	13.3
1 injection	13.6	5.8
2 injection	76.4	80.7
IFA tablets		
Not availed	28.5	34.3
Less than 100	53.7	51.0
100	17.0	14.6
Counseling related to pregnancy		
Availed	70.8	57.7
Not availed	28.5	42.2
Advice on institutional delivery		
Availed	71.7	56.9
Not availed	27.6	43.1
Ultrasound		
Availed	87.5	62.7
Not availed	11.8	37.2
Blood test		
Availed	87.8	65.6
Not availed	11.4	34.3
Urine test		
Availed	86.3	65.6
Not availed	13.0	34.3

After the scheme was started, there was an increase in the usage of IFA tablets by the respondents. Though a lot of beneficiaries mentioned IFA tablets not being available in AHCs. There was also an enormous increase in availing the counseling services related to pregnancy. It increased from 57.7 percent to 70.8 percent. Likewise, advice was sought from experts on institutional delivery. Around 71

percent of the women sought advice under the services provided by the scheme which was 56.9 percent before the initiative took place. Availing other services of ANCs like ultrasound, blood test and urine test also sharply increased after the scheme has been launched.

The above table depicts a positive impact of the scheme on the lives of women in the urban areas especially the poor which were the primary target group for the scheme. It can be thus stated that the access of urban poor to quality health services had increased since the implementation of the voucher scheme. It has also helped in improving the maternal and child health during and after pregnancy.

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4.3.1 Place of availing ANC services

0. Registration, physical examination, TT and IFA tablets

Services availed from-	Registration		Physical examination		TT Injections		IFA Tablets	
	During	Before	During	Before	During	Before	During	Before
	N=295	N=200	N=288	N=179	N=290	N=207	N=228	N=157
Govt hospital	10.8	31	11.8	30.1	11.7	27.0	10.9	29.9
Private doctor/ nursing home	3.3	7	3.4	5.5	2.7	7.2	1.7	2.5
Private hospital	33.5	53.5	31.6	60.8	32.4	48.7	31.5	47.7
Accredited health facility	49.4	0	52.7	0	45.8	0	44.3	0
Anganwadi/ ANM	0	8.5	0	2.7	6.5	16.9	0	16.5

Before the implementation of the project, the number of women who availed ANC services like registration, physical examination, TT injections and IFA tablets were 200, 179, 207 and 157 respectively. However, during the project 295 has done registration, 288 undertook physical examination, 290 took TT injections and 228 took IFA tablets. This shows that there is an increasing trend in availing ANC services among the women. About 49 percent registered, 52 percent undertook physical examination, 45 percent took TT injections and 44 percent took IFA tablets from the accredited health facility. It is interesting to note that most of the women preferred private hospitals for availing ANC services before the project which is somewhat reduced after the beginning of the

project. A small number of the women were dependent on Anganwadi/ANM for ANC services before the project started. But none of them visited Anganwadi/ANM after the project except for 6.5 percent of them for TT injections.

0. Counseling related to pregnancy and Institutional Delivery

Services availed from-	Counseling related to pregnancy		Counseling related to Institutional delivery	
	During	Before	During	Before
	N=228	N=138	N=231	N=136
Govt hospital	8.7	24.6	7.3	27.2
Private doctor / nursing home	0.8	2.1	0.4	2.2
Private hospital	28.0	56.5	29.4	56.6
Accredited health facility	59.2	0	59.3	0
Anganwadi/ ANM	2.6	14.4	3.0	13.9

Counseling related to pregnancy as well as institutional delivery is of critical importance as far as ANC is concerned. In counseling related to pregnancy 138 women who availed this service before the project was interviewed and 228 during the project. To understand the same 136 people who were pregnant before the project were quizzed and 231 were observed during the project. In both the cases, after the project started the number of respondents visiting accredited health facility rose to 59 percent for both pregnancy and institutional related counseling. Before the project, for counseling for pregnancy and institutional related issues, most of the women preferred private hospital. However, the percentage reduced to 28 percent and 29.4 percent for pregnancy counseling and institutional counseling respectively. 24.6 percent visited government hospital before the project but only 8.7 percent during the project for pregnancy related counseling. Similarly, around 27 percent used to visit government hospitals for institutional counseling which reduced to 7.3 during the project.

0. Tests- Ultrasound, Blood test and Urine test

Services availed from-	Ultrasound		Blood tests		Urine test	
	During	Before	During	Before	During	Before

	N=282	N=150	N=283	N=157	N=278	N=152
Govt hospital	10.2	22	10.6	26.7	10.7	27.6
Private doctor / nursing home	3.5	4.6	3.8	7.6	3.9	7.2
Private hospital	35.4	73.3	32.5	65.6	32.0	64.4
Accredited health facility	50.3	0	51.9	0	51.8	0
Anganwadi/ ANM	0	0	0	0	0	0.6

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Before the project started, 150 of the women got ultrasound test; 157 got blood test done and 152 got their urine tested. On the same lines, 282 of them availed ultrasound test; 283 blood test and 278 urine test during the project. During the project, half the women started availing test services from the accredited health facility. This, in turn has reduced the percentage of women visiting private hospital before the project for getting their ultrasound, blood and urine test done. Initially, 73.3 percent; 65.6 percent and 64.4 percent relied on the private hospital for getting their test done. About 20-25 percent of the women were availing test services from government hospitals which decreased to around 10 percent during the project. It is also evident that none of them visited Anganwadi/ANM for getting their test before or during the project.

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4.4 Delivery and Post natal care (PNC)

Post natal care covers the core care that every healthy woman and healthy baby should be offered during the first 6-8 weeks after the birth. Although for most women and babies the postnatal period is uncomplicated, care during this period needs to address any deviation from expected recovery after birth.

Majority of the deliveries happened in Private Institutions i.e. about 70 percent . Home Deliveries accounted for about 20 percent .However, from the table it is evident that 63.9 percent of the respondents did not visit for PNC checkups which are essential for a healthy mother and child. Only 9 per cent received the prescribed two PNCs. Out of the total women interviewed, only one fourth of them went for a single visit for PNC checkups while a mere 0 .7 percent went for more than 3 visits for checkups. It can be said that PNC are neglected by the urban poor women.

Natal Care	Percent (End Line)
Place of delivery	N =327
Government Institutions	10.09
Private Institutions	68.5
Home	21.41

768.59 %

49% from Vouchers.

~~Number of Post Natal checkups availed~~	~~Agra (%)~~
	~~N=405~~
~~No Visit~~	~~63.9~~
~~1 Visit~~	~~25.6~~
~~2 Visits~~	~~8.6~~
~~3 Visits~~	~~0.9~~
~~More Than 3 Visits~~	~~0.7~~

4.4.1 Motivators for PNC

Those who availed PNC are found to be motivated mostly by the one who delivered the baby and by relatives, friends and family members. It is also seen that government health workers play an important role in motivating the women to go for PNC checkups. Around 254 percent of the respondents were motivated by the government health workers to avail the services provided for PNC. The husbands of the respondents did not have a significant role in motivating their wives to go for PNC checkups. Only 18.4 percent of the respondents were encouraged by their husband to go for PNC checkups. Community health volunteer has also motivated 21.9 percent of the respondents to avail the services provided for PNC. Only a nominal number of women were encouraged by private doctor to go for PNC checkups. Though a small proportion, 13 per cent of women said that they sought PNC basis recognizing the need for the same and not necessarily through external motivation.

	Agra (%)
Husband	~~18N=146~~
Relative/family member ~~Husband~~	3218.4

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Govt health worker Chemist	250.6
MediaRelative / friend/ family member	332.1
One who delivered the baby Govt health worker	3424.6
CHVMedia(TV/radio/ newspaper)	223.4
Private DoctorThe one who delivered the baby	134.2
Self motivatedCommunity health volunteer	1321.9
Husband Private Doctor	180.6
Self motivated	13.0

4.4.2 Advice given during PNC

	Agra (%)
Women who availed PNC services within two months	36.06N=146
Type of PNC services Breast feeding up to 6 months	90.4
Advice for proper baby care Immunization advice	86.386.9
Advice for timely immunization Timely immunization	86.9984.2
Advice for spacing between child birth Baby care advice	76.0386.3
Advice to give top feed after 6 months	84.9
Advice on birth spacing	76.0
Mother care	71.9

54%

FromFrom Vouchers.

During the PNC checkups, the mother were given advice on various aspects which include breast feeding, immunization, infant care, mother care, etc. Out of 405, only 146 of the respondents went for PNC checkups. 90.4 percent received advice on breast feed for six months and 84.9 percent were given advice to give top feed after 6 months. Immunization advice was given to 86.9 percent and 84.2 percent of the women for timely immunization86.3 percent women received advice for proper baby care , 87 percent received advice for timely immunization and 76 percent received advice for spacing between child birth . Important to note that cent percent coverage of key issues to be covered during PNC was still lacking and underscores need for strengthening especially with advice on birth spacing.

4.5 Family Planning

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Rapid population growth has been one of the main concerns of the planners of independent India. Since independence, the government of India has been constantly trying to formulate and execute policies related to family planning. The various family planning methods which is being used in India includes oral contraceptive, male condom, female condom, IUD/Copper T, male and female sterilisation and injectables.

Awareness about the family planning methods	~~N=405~~
~~Oral contraceptive~~	N=40599.5
Oral contraceptive~~Male condom~~	10099.5
Male condom~~Female condom~~	1006.4
IUD/copper T~~IUD/copper T~~	9999.2
Male sterilization~~Male sterilisation~~	8989.1
Injectable~~Female sterilisation~~	8799.0
~~Injectables~~	~~86.6~~

From the above table, it is obvious that almost all the respondents were aware about oral contraceptive, male condom & , IUD/Copper T ~~and female sterilisation.~~ More than 80 percent of the respondents were also aware about male sterilisation and injectables. ~~However, only 6.4 percent were aware about female condom which can be used for family planning.~~

FP Method	Current Users (%) Base Line	Current Users (%) End Line
Condom	17.7	14.2
Oral pill	1.8	1.9
IUD	0.4	.64
Male Sterilization	0.4	.2
Female Sterilization	30.8	34.45

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CPR	51.1	51.4

Despite the high awareness level among the respondents, the percentage of respondents who are currently using family planning method is low. About 14.25.4 percent of them are using condom to prevent pregnancy. Female sterilisation is also found to be adopted by 34.456.2 percent of the women. But none of them are using female condom for family planning.

4.5.1 Source of information for Family Planning

The most common source of information regarding family planning is the government health workers, relatives or friends and media. It is through government health workers, the respondents got the information regarding IUD/Copper T (52.9); male sterilisation (54.0%) and female sterilisation (57.8%). Relatives and friends also play a significant role in sharing the information for family planning. As it is evident from the below table, 64.7 percent of the women got the information about oral contraceptive from their relatives and friends. Similarly, relatives and friends were the source of information for male condoms (52.1%), female condoms (46.1%), IUD/Copper T (52.7%), female sterilisation (51.1%) and injectable (46.1%). Media is one of the important sources of information.

Source of information about the FP methods	Oral Contraceptive	Male Condom	Female Condom	IUD/ Copper T	Male Sterilisation	Female Sterilisation	Injectables
	N=403	**N=403**	**N=26**	**N=402**	**N=361**	**N=401**	**N=351**
Husband	16.6	56.8	30.7	10.9	17.4	20.7	11.9
Chemist	0.9	1.2	0	2.2	3.3	2.9	1.7
Relative/Friend	64.7	52.1	46.1	52.7	45.9	51.1	46.1
Govt health worker	53.3	49.1	38.4	52.9	54.0	57.8	51
Media	48.6	49.6	30.7	49.5	52.0	47.1	37.0
Project Staff	1.7	0.5	7.6	1.2	1.6	1.5	0.8
CHV	36.	34.9	26.9	37.3	39.3	37.4	37.0

Around 48 percent got awareness about oral contraceptive; 52 percent about male sterilisation and 47.1 percent about female sterilisation through media. It is noteworthy that the husband was the main source of information for using male condom (56.8%) as a method. However, the husband did not share much information about other methods of family planning.

4.6 RTI/ STI (Reproductive tract infections and sexually transmitted infections)

The women beneficiaries were checked about their awareness regarding RTI and STI. It was worth noting that 85.9 percent of the total 405 women were aware about it. Only 14.0 were not aware about RTI and STI.

	N= 405
Aware	85.9
Not aware	14.0

Symptoms of diseases	Awareness	Suffered	Undergone treatment
White-discharge	97.6	34.57	82
Pain during urination	98.0	19.01	85.7
Itching	97.2	13.58	96.4
Open sores	99.6	2.96	75.4
Pain in Lower Abdomen	95.3	15.56	73.4
Secretion from Partners Genitals	71.4	0.49	64.2
Pain during Intercourse	79.7	1.23	58

Awareness seems to be quite high in all symptoms . It is above 90 percent in most cases except 'Secretion from Partners Genitals' and 'Pain During Intercourse' where it is just above 70 percent . When we look at those who suffered , suffering was maximum in 'White Discharge' followed by 'Pain during Urination' and 'Pain in lower Abdomen' . Similarly woman who have undergone treatment are also highest in 'Pain during Urination' , 'Itching' & 'Open Sores' .

Out of 405 respondents, 34.5 percent of them reported to suffering from white discharge and 19.0 percent reported to be suffering from burning sensation during urination. About 15 percent of the women reported of pain in their lower abdomen and 13.5 percent said they were suffering from itching. Only a nominal 0.4 percent reported of symptom of secretion from partner's genitals.

Percentage of women who reported suffering from RTI/STI symptoms	N= 405
White discharge	34.5

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Burning sensation during urination	19.0
Itching	13.5
Open sores	2.9
Boils	3.4
Pain in lower abdomen	15.5
Secretion from partners genitals	0.4
Pain during intercourse	1.2

Out of 405 respondents, 34.5 percent of them reported to suffering from white discharge and 19.0 percent reported to be suffering from burning sensation during urination. About 15 percent of the women reported of pain in their lower abdomen and 13.5 percent said they were suffering from itching. Only a nominal 0.4 percent reported of symptom of secretion from partner's genitals.

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	N= 405
Diagnosed with symptoms	26.4
Availed checkup for the symptoms related to RTI/STI	
N= 107	
Yes	37.3
No	62.6

Around 26 percent of the women reported to be suffering from RTI/STI symptoms during the interviews. Out of which only 32.3 percent has availed checkup for the symptoms related to RTI/STI. Majority of the women i.e. 62.6 percent of the respondents did not go for checkup for their suffering related to RTI/STI.

4.6 Sambhav Voucher related information

Out of total 405 Women respondents in Agra city, 176 women were such who were pregnant during the project and had availed the Sambhav voucher for one or other services provided under the scheme. The table below shows percentage use of each voucher by these women. These women were quizzed about their feedback on the scheme and related information.

Voucher for service:	N= 1517~~6~~ (%)
ANC	98.01~~85.8~~

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Institutional delivery	92.3767.0
PNC	92.7747.1
RTI/ STI treatment	94.1219.3
FP services	97.522.73

A good proportion of 85.8 percent of the respondents availed ANC service under the voucher scheme. Next to ANC service the most commonly availed services were institutional delivery(67%) and PNC(47.1%). About 19.3 also availed RTI/STi treatment.

.4.6.1 Source of information

Source of information regarding the voucher:	N=176
Base: All AwareC H V	16296.0
C H V ANM	96.020
ANM Neighbor	02.2
Neighbor Health worker	2.271.7
Others	1.7

The main source of information about the scheme was the CHV working in the community. About 96 percent of the respondents got the information about the voucher scheme from CHV. Neighbor and health workers were also helpful in spreading awareness about the scheme.

4.6.2 What was the information received

Information received	Agra (%)
	N=176
Get free delivery	28.9
Free checkup during pregnancy	30.6
Free treatment	27.8
Free Tests	16.4
All facility is free	5.6

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Free family planning services	3.9
Free medicine	3.4
Free Health services	2.2

The women were mostly informed about free checkups during pregnancy (30.6%), free delivery (28.9%) and free treatment (27.8%) which was to be provided through the voucher scheme. Around 16 percent of the respondents were informed about free testing facility as well as 5.6 percent received the information that all the facility for pregnancy will be free of cost.

4.6.3 Did anyone visit for verification?

When the project started, 51.1 of the respondents said that officials implementing the scheme visited for their verification but 48.8 denied that anybody has visited them for verification for the scheme. This reinforces the need for strengthening the verification system to ensure scheme benefits the neediest and credibility of process ensured. Out of 90 respondents, 53.3 percent responded that verification was done only once while 36.6 percent says that it was done twice. Only 1.1 percent said that verification was done thrice and 5.5 percent told that verification was done more than thrice.

Did anyone visit for verification	Agra (%)
	N=176
Yes	51.1
No	48.8
Number of times verification done	**N=90**
Once	53.3
Twice	36.6
Thrice	1.1
More than 3 times	5.5

4.6.4 Overall satisfaction with the services provided at the accredited health facility

A total 176 women responded on the question about their satisfaction with the accredited health facility, A large percentage (77.2%) of the respondents were extremely satisfied with the accredited facility while only 19.8 percent were somewhat satisfied with the services. A mere 0.5 were not so much satisfied with the accredited facility and 1.1 percent were not at all satisfied. 71.5 percent of the

women claimed that they had recommended about the voucher scheme to their family, friends and relatives.

Overall satisfaction with accredited facility	N=176
Used ANY Vouchers~~Extremely Satisfied~~	173~~77.2~~
Top 2 Box Satisfaction~~Somewhat Satisfied~~	~~19.8~~97.11
Top Box (Extremely Satisfied)~~Not Sure~~	76.88~~1.1~~
~~Not So Much Satisfied~~	~~0.5~~
~~Not at all satisfied~~	~~1.1~~
Did you recommend the voucher to someone	**N=176**
Yes	72.25~~1.5~~
No	27.75~~8.4~~
Should the voucher scheme continue	**N=176**
Yes	96.539
No	3.47~~1~~

The voucher scheme has high level of acceptability among the urban slum dwellers. Among 176 respondents who used this voucher in Agra, 96.539 would like the scheme to be continued so that they have an access to quality health services.

In terms of satisfaction, scheme has come a long way from where it started. CHVs mentioned that initially beneficiaries used to suspect the scheme motives and also veracity of the scheme objectives. It was hard to believe for most urban slum based women and their relatives that facilities could be availed without incurring any cost. Also, beneficiaries were reluctant to enter private clinics as most beneficiaries felt that these facilities charged a lot for their services. There was also reluctance among beneficiaries from entering these facilities as these facilities were in past in-accessible to most of the slum dwellers and beneficiaries mentioned being self-conscious in entering these facilities.

In Agra, 97% of beneficiaries we met mentioned being satisfied by the facilities provided by the accredited health facilities.

In retrospect, beneficiary satisfaction is a function of CHV involvement in the treatment process. The more involved a CHV is in day to day correspondence between accredited health facilities;

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especially during initial days; more chances of beneficiary feeling secure and confident in availing benefits from health facility.

Those who were dissatisfied mentioned their dissatisfaction stemming from the fact that accredited health facilities referred Caesarian to other hospitals which essentially did not treat patients with same level of sensitivity as in case of accredited health facility. Another source of dissatisfaction rooted from the fact that cost of medicines were not covered and also among those who availed RTI/STI counseling mentioned that medicines for only first 2-3 days was covered in the scheme and thereafter when they visited AHF, In charge referred them to a chemist who charged for the medicines.

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SUMMARY AND CONCLUSION

SIFPSA had taken an initiative of providing quality RCH services to the urban slum dwellers by introducing voucher Project Scheme in five cities of Uttar Pradesh. The present end-line survey was aimed to evaluate the scheme to see if the programme objectives were met and if the activities conducted achieve project outcomes. .

The stakeholders at various facets of the scheme were met and the scheme was understood at implementation level. At the ground level, beneficiaries of the scheme were met their responses were captured.

After the quantitative interactions it can be concluded that at the ground level the scheme has received a good response. The average number of women, who availed any ANC service before the project started, had increased during the project period. The number of women who availed any checkup has increased considerably as compared to figures obtained during the baseline survey. Women are now more informed about the need for Institutional delivery, PNC, RTI/STI and family planning. It was also observed that they have recommended the voucher scheme to their relatives and friends.

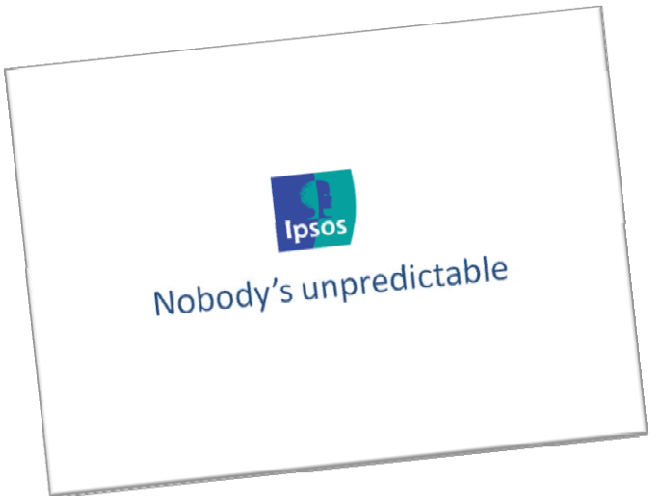
At the implementation level, all the processes involved for the smooth functioning of the scheme have been followed. It was observed that rights from the CMO to the CHV, each stakeholder/s were clear about their roles and responsibilities. They were outspoken and open about the challenges faced during the project period and how these challenges can be met in future. The CHV's who are the backbone of the system at the ground have expressed that they have noticed change in the mindset of people from what it was two years ago. The health facilities have mentioned that the patient load had been increasing since the initial phase of the programme.

The scheme in all respects has benefitted the city of Agra and its slum dwellers who have given a very good response for continuing the scheme further. We recommend the scheme should continue to improve the MCH level in the urban slums of Agra.

A few of the recommendations based on interaction with stakeholders are as follows,

1. Increase the rates for essential services provided by the accredited health facilities like Ultrasound, C- sections, delivery etc.
2. Empanel more hospitals / nursing homes in the system
3. Salary increment for the CHV's can be considered for maintaining motivation in them.

Integrating the above in the implementation phase will further strengthen the scheme and help achieve desired outcomes.



Thanks,

Ipsos Public Affairs Team

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