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

State Innovation in Family Planning Services Project Agency

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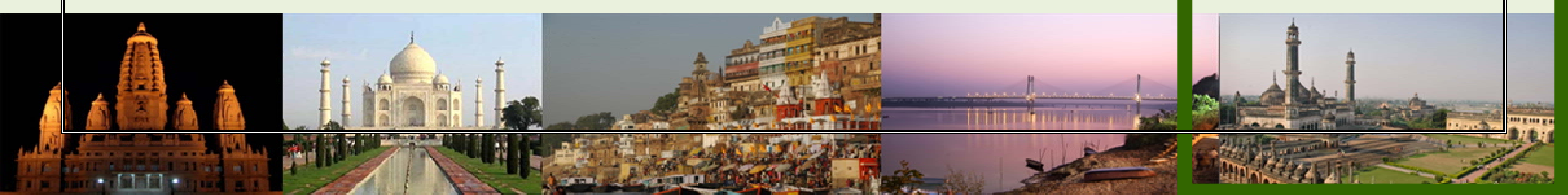

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Ipsos Study Team

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

CONTENTS

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.

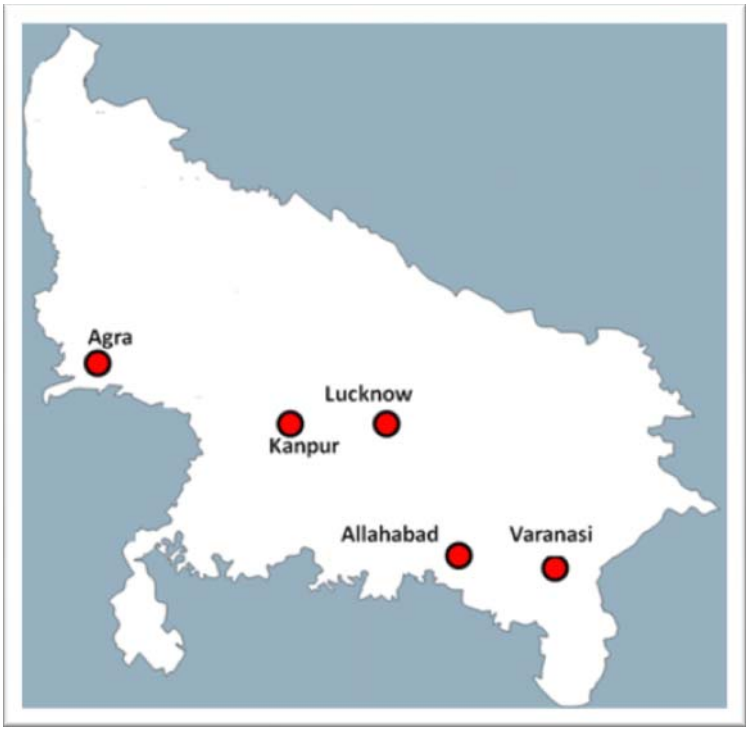
WOMEN BENEFICIARIES:

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 401 randomly selected eligible women in the city of Lucknow. The beneficiary survey broadly consists of the following covered areas:

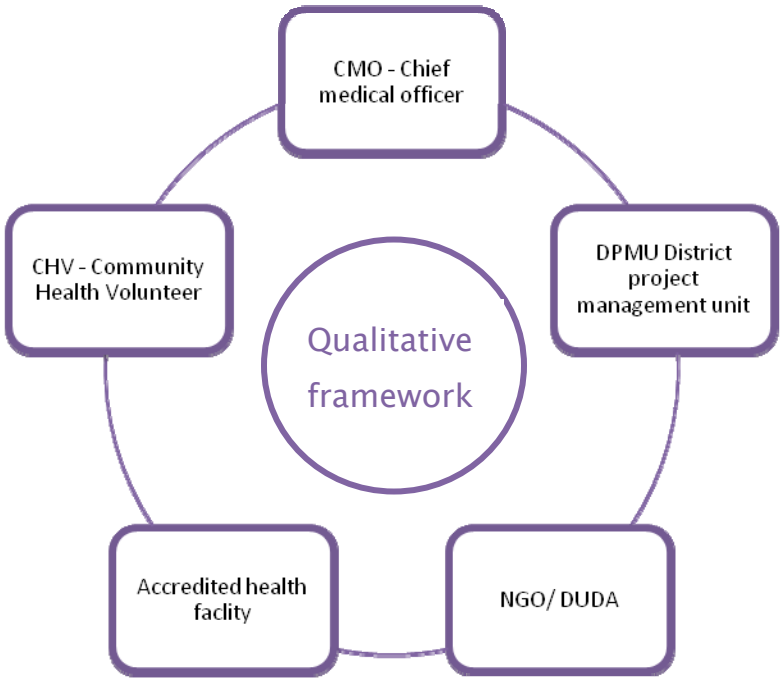
- Socio economic profile of eligible women
- Ante- Natal care services - Comparison of behavior during and before the project period
- Delivery and Post natal care - Checkups availed, Motivators for PNC and Advice given during PNC
- Family planning methods – awareness, source of information and usage
- 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 Lucknow
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 Lucknow 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), Lucknow 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 18 health facilities which are presently accredited with the Sambhav voucher scheme in Lucknow. The facility managers mentioned that they came to know about

this scheme through the Media and through the representatives of the SIFPSA team. A team from DIFPSA 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. CHVs selected are those who are at least high school pass and residing in same slum. 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 DPMU, 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 weekly meetings with the AVM, AVC and VC and officers from DUDA. The CMO interacts with the DPMU representatives who maintain all the records such as cash book, ledger book and financial details.

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 DUDA. The DUDA obtains the demand from the CHV's who monthly report the number of vouchers distribute and redeemed. Voucher redemption is done by Voucher Management Unit (VMU)

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. 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 only criteria for CHV selection in Lucknow was that she should be from the same slum community.

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 40-60 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. This makes it difficult for implementing agency to sell SAMBHAV scheme to private nursing homes. Also, the longer wait duration among CHVs leads to attrition among them.

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, those in charge of the hospitals mentioned that under SAMBHAV voucher scheme, currently medicines are not being provided to the patients. Also, for the RTI/STI treatment, medicines for only 2-3 days are being provided. Another challenge mentioned by those in charge of the hospitals were low costs offered for caesarians. Doctors in current ACHs mentioned that current charges do not adequately cover for caesarians as they have to request outside help for anesthetists and also during caesarians a lot of medicines have to be asked for; cost for which are not currently covered under SAMBHAV vouchers.

On meeting the CHV's, it was brought up that following 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 wary of the scheme and assured benefits and they find it difficult to gain their trust. Also CHV's expressed the needs for timely payments. Also, CHVs requested that very often they incur cost towards transporting patients to health facilities. Currently, this money is not being reimbursed. A lot of CHVs we met also requested for reimbursement of call charges which they incur during the course of implementing SAMBHAV scheme.

4.1.4 Suggestions:

When asked about possible solutions and suggestions to these challenges, the CMO suggested that payments of CHV's should be increased. Timely payments will ensure motivated CHV's. CMO also suggested that the present rate the accredited facilities can be increased. This would in turn help them empanel more hospitals 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. These ideas were supported by DPMU and the NGO as well.

The facilities and CHV's also requested for increase in rate and salary respectively when asked about suggestions related to the scheme. The CHV's additionally mentioned need for transportation facility to the patients. 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 Innovations Suggested in the Implementation of the Scheme

Use of Information technology and mobile telephony is suggested to make implementation of scheme better.

Two main problems as per In charge of Accredited Health Facilities and CHVs encountered in smooth implementation of scheme are:

1. Time taken in verification of the vouchers
2. Delay in payment of CHVs which is primarily on account of extended verification period

Using mobile phone telephony and Information technology, CHVs remunerations could be transferred in their respective accounts using mobile payment methods; this would make transaction faster. Also, verification could be done using software scanners in mobile phone, which makes transfer of voucher images much faster than it is currently. This would in turn also help in making payment to CHVs faster.

A lot of CHVs in Lucknow mentioned transportation of beneficiaries as a major problem. SIFPSA could consider tying up with local government varsities for sharing their ambulance service at a nominal/no cost for ensuring comfortable transport of emergency cases to nearest Accredited Health Facility.

Similarly, SIFPSA could issue passes to CHVs to ensure that they can travel within limits of city on government transportation medium without incurring any extra cost.

4.1.6 IEC Material Effectiveness

	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 Lucknow Banners followed by Brochures and Wall Paintings were relatively effective mediums as per CHVs . Pamphlets were also useful to an extent .

4.2 Socio Economic profile of the eligible women

In Lucknow, 401 respondents were interviewed to assess the voucher scheme. The women were in the age group of 15-49 years. The mean age of the respondents was 26.8 years. Around 35.6 percent of the respondents were in the age group of 25-29 years and 30.9 percent in the age group of 20-24 years. The percentage of forty and above age was less. Only 1.2 percent was in 40-44 years and 0.2 percent in 45-49 years.

Socio demographic spread of the respondents

Age	(%) N= 401	
15-19 years	2.49	
20-24 years	30.92	
25-29 years	35.66	
30-34 years	19.2	
35-39 years	10.22	
40-44 years	1.25	
45-49 years	0.25	
Mean age	26.83 years	
Education	**Self**	**Husband**
Illiterate/ No formal Education	47.88	41.15
School up to 4th class	4.99	9.23
School: 5th to 9th class	27.93	28.93
School: 9th to 12th class	14.46	16.96
Graduate	3.74	2.74
Post Graduate	1	1
Occupation	**Self**	**Husband**
Business/Shop/Office	0	9.48
Domestic work	4.74	0.25
Selling in street/market	0.25	7.98
House wife	91.52	0.25
Skilled worker	2	43.39
Daily Wage Earner	1	36.41
Others	0.25	1.5

Monthly Household income	N=401
0-2000	25.19
2001-5000	65.09
5001-10,000	6.98
10,001 - 15,000	2.75

The education level of respondents and their husband was found to be quite low. From the table, it can be seen that 47.8 percent of the respondent and 41.1 percent of their husband were illiterate. They did not have any kind of formal qualification. About 27.9 percent of the respondents have attended upper primary class and 28.9 percent of their husband has the same qualification. Likewise, 14.4 percent of the women and 16.9 percent of their husband have secondary and senior secondary education qualification. The percentage of graduates among the respondent was 3.7 and their husband was 2.7 percent.

A large percentage of 91.5 of the women were housewives and did not work anywhere for earning. About 4.7 percent of the respondents were domestic helper and 2 percent were skilled labour. A sheer 1 percent was daily wage earner. Around 43.3 percent of the respondent's husbands were skilled worker and 36.4 percent of them were daily wage earner. The percentage of those who have business/shop/office was 9.4 percent and selling things in market/street was 7.9 percent.

The monthly household income of the 65 percent of the respondents was Rs. 2001-5000. About 25 percent have Rs.0-2000 per month as household income and 6.9 percent of them have monthly income of Rs. 5001-10000. Only 2.7 percent of the respondents have household income of more than Rs.10000.

4.3 Ante – Natal care

From a total of 401 respondents, 300 availed ANC services during the project period while 254 availed the same 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 Lucknow.

During the project 92 percent of the respondent registered which increased from 82.6 percent before the project phase. The table shows that before the project was initiated 20 percent did not avail any physical examination service. After the project was implemented, it further reduced to 5.6 percent. Thus, availing the 3 physical examination increased from 70.4 percent to 81.6 percent.

ANC services	**(N=254)**	**(N= 300)**
	Before Project Period	**During Project Period**
Registration	83	92
Physical examination		
1 examination availed	4	4
2 examinations availed	6 (80%)	8 (94%)
3 examinations availed	70	82
TT Injection		
1 injection	4 (82%)	5 (93%)
2 injections	78	88
IFA tablets		
Less than 100	61 (76%)	73 (91%)

100	15	18
Counseling related to pregnancy	69	90
Advice on institutional delivery	71	90
Ultrasound	62	85
Blood test	75	92
Urine test	75	92

There was also an increase in availing services like TT injection and IFA tablets during the project. Around 88 percent availed 2 injections after the project as compared to 77.9 percent before the project started. There was also an increase in availing the counseling services related to pregnancy. It increased from 68.9 percent to 89.6 percent. Though a lot of beneficiaries mentioned IFA tablets not being available in AHCs. Similarly, 89.6 percent sought advice on institutional delivery which was 70.8 percent before the project started. There was also an increase in availing other ANCs services like ultrasound, blood test and urine test after the scheme was launched. About 85.3 availed ultrasound service, 92 percent got their blood and urine test done.

Unlike other cities (Agra, Allahabad, Kanpur and Varanasi), there was no significant increase in availing ANC service during the voucher scheme. The percentage of availing ANC services was already high before the scheme started.

4.3 Delivery and Post natal care (PNC)

Natal Care	Percent (End Line)
Place of delivery	**N=304**
Govt. Institutions	**40.13**
Private Institutions	**48.03**
Home	**11.18**
Other	

88.1%

42% from Vouchers

Close to 88% percent deliveries happened in either Government Institutions or Private Institutions . Share of Private Instituion deliveries (48 percent)_ was a little more than those at Governement Instituions .(40 percent)

4.3.1 Motivators for PNC

	Lucknow (%)
Husband	**45**
Relative/family member	**26**
Govt health worker	**22**
Media	**0**
One who delivered the baby	**5**
CHV	**25**
Private Doctor	**0**
Self motivated	**2**

They were motivated mostly by their husband that is 45.1 percent of them. Relative/friend/family member inspired 26 percent for PNC checkups. 22.1 percent by motivated by government health worker.

4.3.2 Advice given during PNC

During the PNC checkups, the mother were given advice on various aspects which include breast feeding, immunization, baby care, mother care, etc. More than 90 percent were advised for timely immunization related advice. Around 83.8 percent were given advice to on birth spacing which urban slum dwellers do not follow much. Baby care and mother care advice were also given to 73.1 percent and 57.4 percent of the respondents.

Advice given during PNC checkups	
Women who availed PNC services within two months	**58.9**
Type of PNC services	
Advice for proper baby care	**73.19**
Advice for timely immunization	**96.17**
Advice for spacing between child birth	**83.83**

72% From Vouchers.

4.4 Family Planning

Various kinds of initiatives have been taken up by the Indian government for family planning. All the respondents were interviewed about their awareness about the family planning methods. More than 90 percent of the respondents were aware about oral contraceptive, male condom, IUD/copper T, male and female sterilization. From the table it can be seen that awareness level among the respondents was quite high. The respondents were aware about all the methods available for family planning.

Awareness about the family planning methods	Lucknow (%)
	N=401
Oral contraceptive	**93**
Male condom	**99**
IUD/copper T	**96**
Male sterilization	**93**

Injectable	**34**

Despite the high awareness level among the respondents, the percentage of respondents who are currently using family planning method is low. Those who are at presently using family planning prefer IUD/Copper T. About 4.3 percent of them are using IUD's to prevent pregnancy. Female sterilization is also found to be adopted by 12.8 percent of the women. But none of them are using male sterilization.

FP Method	Current Users (%) Base Line	Current Users (%) End Line
Condom	22.6	26.1
Oral pill	5.2	5.9
IUD	1.3	4.3
Male Sterilization	0.3	-
Female Sterilization	18.9	12.8
CPR	**48.3**	**49.1**

4.5.1 Source of information for Family Planning

Relatives and friends was one of the main sources of information about oral contraceptive (61.7%) and female sterilization (54.7%). Media was also one of the important sources of information regarding female condom (60%), male sterilization (55.3%) and injectable (53.2%). Government health worker was also store house of information on the methods of family planning. About 57.4 percent of the respondents got to know about male condoms from their husband. Likewise, 46.8 percent got their awareness about female sterilization from chemist.

Source of information about the FP methods	Oral Contraceptive	Male Condom	Female Condom	IUD/ Copper T	Male Sterilization	Female Sterilization	Injectable
Husband	12.3	57.47	30	4.94	9.36	6.58	1.46
Chemist	1.34	0	0	0	0.27	46.84	0
Relative/Friend	61.76	23.29	20	45.71	37.97	54.74	32.12
Govt health worker	52.67	34.43	20	60.78	53.48	45.26	32.12
Media	56.15	44.56	60	49.35	55.35	15.26	53.28
Project Staff	0.27	0.51	0	0.78	0.27	0	0
CHV	6.42	4.3	0	19.74	12.3	6.58	13.14

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

Symptoms of diseases (N = 840)	Awareness	Suffered (percent)	Undergone treatment
White-discharge	98.7	35.41	77.4
Pain during urination	98.9	20.95	79.2
Itching	97.2	15.96	43.4
Open sores	93.4	2.74	20
Pain in Lower Abdomen	94.3	18.95	97
Secretion from Partners Genitals	91.0	0.25	90
Pain during Intercourse	94.7	2.49	98

In Lucknow, we observed quite high awareness for most of the symptoms. While one third of respondents mentioned suffering from white-discharge; 15.96% mentioned suffering from itching and 18.95% mentioned suffering from pain in lower abdomen. High treatment rate for 'pain in lower abdomen', 'secretion from partner glands' and 'pain during intercourse'.

4.6 Sambhav Voucher related information

Out of the total 401 respondents, 167 of them used voucher to avail various services related to pregnancy. About 94.23 percent availed ANC services; 89 percent availed institutional delivery service and 82.2 percent used voucher to avail PNC services. Similarly, 68.18 percent used it for FP services while 46.55 percent for RTI/STI treatment.

Voucher for service:	
ANC	94.23
Institutional delivery	88.73
PNC	86.23
RTI/ STI treatment	46.55
FP services	68.18

Source of information

Source of information regarding the voucher:	N=184
C H V	95.81
ANM	1.2
Neighbor	1.8
Others	1.2

The respondents were aware about the initiative called Sambhav Voucher Scheme. Around 167 out of 401 were aware about the voucher scheme. The main source of information about the scheme is the CHV who is one of the stakeholders in the scheme. About 95 percent of the respondents got the information about the voucher scheme from CHV. ANM and neighbor also helped in spreading awareness about the scheme to 1 percent of the respondents.

What was the information received

The women were mostly informed about free delivery (44.9%); free treatment (35.9%); free tests (29.3%) and free checkup during pregnancy (13.1%). Which are provided through the voucher scheme. Around 7 percent of the respondents were informed that all facility is free under the voucher scheme. Only 2 percent of the respondents were informed about good treatment, free immunization services and free medicine which can be availed from the voucher scheme.

Information received	Lucknow (%)
	N=167
Get free delivery	44.91
Free treatment	35.93
Free tests	29.34
Free checkup during pregnancy	13.17
All facility is free	7.18
Free copper T apply	5.99
Free family planning services	4.19
Good treatment	2.99
Free immunization services	2.4
Free medicine	2.4

Out of the total of 167 who availed the voucher scheme, 76.6 percent said that officials visited them for verification but 23.3 percent denied it. Majority of the respondents said that verification was done only one time. 23.4 percent claimed that verification was done twice. Only 3 percent said that verification was done thrice or more than thrice.

Did anyone visit for verification?

Did anyone visit for verification	Lucknow (%)
	N=167
Yes	76.65
No	23.35
Number of times verification done	**N=128**
Once	67.97
Twice	23.44

Thrice	3.13
More than 3 times	3.91

Out of the total of 167 who availed the voucher scheme, 76.6 percent said that officials visited them for verification but 23.3 percent said that no one visited for verification. Majority of the respondents said that verification was done one time. About 23.4 percent claimed that verification was done twice. Only 3 percent said that verification was done thrice or more than thrice.

Overall satisfaction with the services provided at the accredited health facility

The overall satisfaction with accredited facility was quite high in Lucknow. About 91 percent of the respondents were extremely satisfied and 7.7 percent was somewhat satisfied with the accredited facility. On the basis of their access to quality health services, 65.2 percent of the respondents would recommend the voucher scheme to someone.

Overall satisfaction with accredited facility	
Used ANY Vouchers	*161*
Top 2 Box Satisfaction	99.37
Top Box (Extremely Satisfied)	91.3
Recommending the voucher to someone	**N=161**
Yes	65.84
No	34.16
Should the voucher scheme continue	**N=161**
Yes	95.65
No	4.35

About 95 percent of the respondents opined that the voucher scheme should be continued. The voucher scheme has enabled them to have access to quality health facility. So they would like to avail the facilities under scheme and help others to avail the same.

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 Lucknow, 99% 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; 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.

5

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 Lucknow 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 Lucknow.

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 C-sections
2. Timely release of salary of the CHV's and reimbursement of transport costs incurred by them.
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