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

State Innovation in Family Planning Services Project Agency

Ipsos Research Pvt. Ltd.
C-1 First floor
Opposite Indian oil building
Green park extension
New Delhi – 110016

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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 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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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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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.

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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.

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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 sterilization 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.

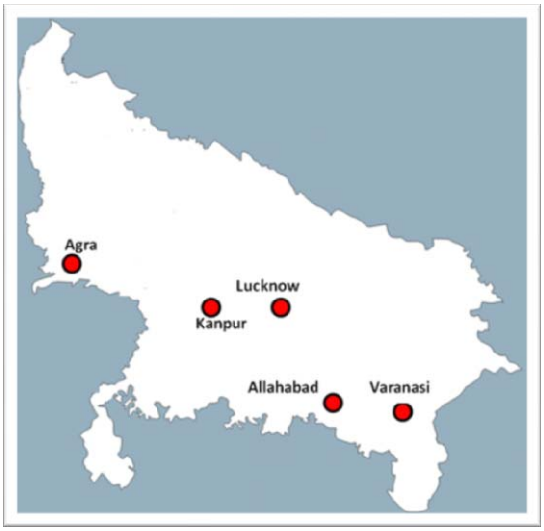
WOMEN BENEFICIARIES:

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

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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**

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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.

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FINDINGS OF THE END-LINE SURVEY

The findings of the survey are based on qualitative interactions with 28 participants and quantitative interviews with 398 randomly selected eligible women in the city of Varanasi. The beneficiary survey broadly consists of the following covered areas:

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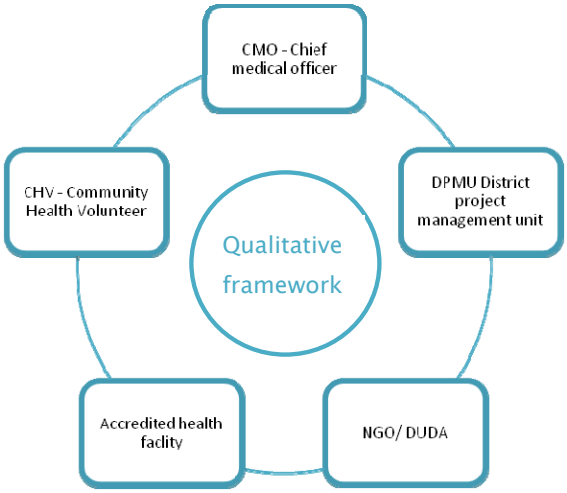
- Socio economic profile of eligible women
- Ante- Natal care services - Comparison of behavior during and before the project period
- Delivery and Post natal care - Checkups availed, Motivators for PNC and Advice given during PNC
- Family planning methods – awareness, source of information and usage
- 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 Varanasi
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 Varanasi 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), Varanasi 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 12 health facilities which are presently accredited with the Sambhav voucher scheme in Varanasi. 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 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 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 NGO. NGO was provided 1000 vouchers at the beginning of the project. Thereafter, vouchers were supplied as per demand. The NGO obtains the demand from the CHV's who monthly report the number of vouchers distribute and redeemed.

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 used for CHV selection in Varanasi 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. 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 DMPU 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 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. Also CHV's expressed the need for timely payments which was a growing concern amongst them.

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 when their suggestions were asked.

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 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 Varanasi , Pamphlets followed by Nautankis and Banners were the most effective mediums .

4.2 Socio Economic profile of the eligible women

The number of women who were interviewed in Varanasi is 398. The women were in the age group of 15-49 years. Around 38.1 percent of the respondents were in the age group of 25-29 years and 36.9 percent in the age group of 20-24 years. The percentage of forty and above age was less. Only 1.7 percent was in 40-44 years and 1.2 percent in 45-49 years.

Socio demographic spread of the respondents	
Age	Varanasi (%) N= 398

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15-19 years	1.2	
20-24 years	36.9	
25-29 years	38.1	
30-34 years	17.5	
35-39 years	4.2	
40-44 years	1.7	
45-49 years	1.2	
Mean age	26.0 years	
Education	**Self**	**Husband**
Illiterate/ No formal Education	34.6	31.4
School up to 4th class	3.2	5.0
School: 5th to 9th class	34.1	31.9
School: 9th to 12th class	20.8	23.8
Graduate	5.5	5.7
Post Graduate	1.5	2.0
Occupation	**Self**	**Husband**
Business/Shop/Office	0.2	16.58
Domestic work	5.2	7.79
Selling in street/market	0	0.2
House wife	91.4	0
Skilled worker	2.0	35.43
Daily Wage Earner	.05	37.44
Monthly Household income	**N=398**	
0-2000	5.28	
2001-5000	85.43	
5001-10,000	9.3	
10,001 - 15,000	0	

In Varanasi the education qualification of the respondents are almost at par with their husband. From the table, it can be seen that around more than 30 percent of the respondent and their husband were illiterate. They did not have any kind of formal qualification. About 34.1 percent of the respondents have attended upper primary class while 31.9 percent of their husband has qualification of upper primary class. Similarly, 20.8 percent of the women have secondary and senior secondary education and 23.8 percent of their husband has the same qualification. More than 5 percent of the respondent and their husband are graduates. However, only 1.5 of the respondent and 2 percent of husband were post graduates.

A large percentage of 91.4 of the women were housewives and did not work anywhere for earning. About 5.2 percent of the respondents were domestic helper and 2 percent were skilled labour. A mere

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0.5 percent was daily wage earner. In case of their husband, all of them are working for income. Around 37.4 percent of the respondent's husband was daily wage earner and 35.4 percent are skilled worker. While 16.5 percent of them are involved in business/shop/office, 7.7 percent of them work as domestic help.

The average monthly household income of the respondents was Rs. 2001-5000. About 9 percent of them have monthly income of Rs. 5000 and more and 5.2 percent have around Rs.2000 per month as household income. The economic condition of the slum dweller is bad and none of them have household income of more than Rs.10000 per month.

4.3 Ante – Natal care

To look at the trend of availing ANC services, 221 respondents were interviewed before the project and 326 during the project. About 91.8 percent availed registration service before the project and 95.4 percent during the project. Similarly, 0.4 percent of the respondents availed 1 physical examination before the project increased to 7.6 during the project. However, the 85.5 percent availing 3 physical examinations before the project decreased to 69.6 percent during the project.

~~But in case of TT injection, there was a decrease in not availing the injection service from 11.7 percent to 4.9 percent after the project has been implemented.~~ In case of TT Injections,~~Thus,~~ 89.2 percent availed 2 injections during the project as compared to 86.8 percent before the project started. After the scheme was started, there was an increase in the usage of IFA tablets by the respondents. Prior to the project, 14.9 percent of the respondents used 100 IFA tablets but after the project 19.6 percent of them are using it. Though a lot of beneficiaries mentioned IFA tablets not being available in AHCs.

	Varanasi	
ANC services	(N=221)	(N=326)
	Before Project Period	During Project Period
Registration	92	95
Physical examination		

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1 examination availed	0	8
2 examinations availed	4	18
3 examinations availed	86	70
TT Injection		
1 injection	1	5
2 injection	87	89
IFA tablets		
Less than 100	70	68
100	15	20
Counseling related to pregnancy	90	94
Advice on institutional delivery	89	92
Ultrasound	43	67
Blood test	58	74
Urine test	57	74

~~Percentage distribution of women availing ANC services during the program and before the programme period~~		
~~ANC services~~	~~Varanasi % (N=326)~~	~~Varanasi % (N=221)~~
	~~DURING PROJECT PERIOD~~	~~BEFORE PROJECT PERIOD~~
~~Registration~~		
~~Availed~~	~~95.4~~	~~91.8~~
~~Physical examination~~		

Not availed any examination	4.2	10.4
1 examination availed	7.6	0.4
2 examinations availed	18.1	3.6
3 examinations availed	69.6	85.5
TT Injection		
Not availed	4.9	11.7
1 injection	5.2	1.3
2 injection	89.2	86.8
IFA tablets		
Not availed	12.2	14.9
Less than 100	67.7	70.1
100	19.6	14.9
Counseling related to pregnancy		
Availed	94.1	90.5
Not availed	5.5	9.5
Advice on institutional delivery		
Availed	92.3	88.6
Not availed	7.3	11.3
Ultrasound		
Availed	66.5	43.4
Not availed	33.1	56.5
Blood test		
Availed	73.9	58.3
Not availed	25.7	41.6
Urine test		
Availed	73.9	57.0
Not availed	25.7	42.9

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A significant change could not be seen in availing counseling service for pregnancy related queries before or during the project. But an increasing trend can be seen in availing advisory services on institutional delivery during the project.

There was also an enormous increase in availing other services of ANCs like ultrasound, blood test and urine test after the scheme was launched. Around 66.5 percent availed ultrasound service, 73.9 percent got their blood and urine test done.

4.3.1 Place of availing ANC services

1. Registration, physical examination, TT and IFA tablets

Services availed from	Registration		Physical examination		TT Injection		IFA tablets	
	During	Before	During	Before	During	Before	During	Before
	N=267	N=203	N=311	N=198	N=308	N=195	N=285	N=188
Govt hospital	36.0	66.0	34.4	65.6	34.7	62.5	35.0	62.7
Private doctor / nursing home	3.8	6.9	3.8	7.5	4.5	7.1	4.9	5.3
Private hospital	9	23.1	9.9	22.2	9.4	23.5	6.3	24.4
Accredited health facility	48.8	0	49.2	0	46.7	0	49.4	0
Anganwadi/ ANM	0	3.45	5.1	4.0	0	5.6	0	5.8

Prior to project, the number of women who availed ANC services like registration, physical examination, TT injections and IFA tablets were 203,198, 195 and 188 respectively. Through the project 267 has done registration, 311 undertook physical examination, 308 took TT injections and 285 took IFA tablets. This shows that there is an increasing trend in availing ANC services among the women after the project initiated. Before the project started the respondents relied on government hospital for ANC services which reduced after the project. During the project, 48.8 percent registered, 49.2 percent undertook physical examination, 46.7 percent took TT injections and 49.4 percent took IFA tablets from the accredited health facility. Some percentage of the respondents was found to be availing ANC services from private hospital and private doctor or nursing home. For availing registration, TT injections and IFA tablets from Anganwadi/ANM was 0 during the project. But in case of physical examination, it increased from 4.0 percent to 5.1 percent during the project.

2. Counseling related to pregnancy and Institutional Delivery

Services availed from	Counseling related to	Counseling related to

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	pregnancy		institutional delivery	
	During	Before	During	Before
	N=307	N=200	N=301	N=196
Govt hospital	35.1	67	35.5	67.3
Private doctor / nursing home	4.2	6	4.3	5.6
Private hospital	8.7	21.5	8.6	19.9
Accredited health facility	49.1	0	48.8	0
Anganwadi/ ANM	0	5	0	6.1

Before the project, counseling related to pregnancy was availed by 200 respondents and 196 for institutional delivery. During the project, counseling for pregnancy was availed by 307 women and 301 for institutional delivery related queries. From the above table it is evident that 67 percent of the respondents visited government hospital for counseling related to pregnancy and institutional delivery. The percentage of availing such services from government hospital reduced to almost half during the project. For availing counseling services whether related to pregnancy or institutional delivery, none of them visited the accredited health facility. However, after the project started it increased to 49.1 percent and 48.8 percent for pregnancy and institutional delivery related counseling respectively. Also, the respondents stopped visiting Anganwadi/ANM for counseling during the project.

3. Tests- Ultrasound, Blood test and Urine test

Services availed from-	Ultrasound		Blood test		Urine test	
	During	Before	During	Before	During	Before
	N=217	N=150	N=241	N=129	N=241	N=126
Govt hospital	12.4	34.3	20.7	48.0	21.5	47.6
Private doctor / nursing home	2.7	8.3	2.4	6.2	2.9	7.1
Private hospital	37.7	55.2	26.1	44.9	24.4	43.6
Accredited health facility	46.0	0	50.2	0	50.6	0
Anganwadi/ ANM	0	0	0	0	0	0.7

In the pre project phase, 150 women got ultrasound done; 129 got blood test done and 126 got their urine tested. During the project, 217 of them availed ultrasound test; 241 availed blood test and 241 availed urine test. It is evident that none of them availed the test services from any of the accredited

health facility in the pre-project period. During the project, 46 percent availed ultrasound service; 50.2 percent got their blood test and 50.6 percent got their urine test done from the accredited health facility. This, in turn has reduced the percentage of women visiting private hospital for getting various test done. Earlier, 55.2 percent; 44.9 percent and 43.6 percent went to private hospital for getting their test done.

About 34.3 percent availed ultrasound test; 48 percent blood test and 47.6 percent got their urine test from government hospitals which decreased to almost half during the project. It is also evident that none of them visited Anganwadi/ANM for getting their test before or during the project except 0.7 for urine test before the project started.

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. The table shows that about 39 percent of the respondent did not visit anywhere for PNC checkups. About 39.7 percent of them visited only once and 19.3 percent twice for their PNC checkups. Only 0.7 percent of the respondents got their PNC checkups more than 3 times.

Number of PNC checkups availed	Varanasi (%)
	N=423
No Visit	39.7
1 Visit	39.7
2 Visits	19.3
3 Visits	0.7
More Than 3 Visits	0.5

Natal Care	Percent (End Line)
Place of delivery	N = 339
Govt. Institutions	27.73

75.1%

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Pvt. Institutions	47.49
Home	24.78
Other	-

54% from Vouchers

Majority of the deliveries happened in either Government or Private Institutions i.e. close to 75 percent .

4.4.14.3.1 Motivators for PNC

Out of the total sample, 240~~148~~ of the respondents got their PNC checkup done. They were motivated mostly by government health worker that is 38.3 percent of them. Around 29.1 percent were motivated by the one who delivered the baby and 24.5 percent were inspired by relatives or friend or family member. About 23.7 percent of the respondents were motivated by their husband for PNC .CHV motivated 13.7 percent of the respondents for PNC. Only 4.1 percent were self-motivated. A nominal percent of 0.4 percent were found to be motivated by media for PNC checkups.

~~Who motivated for PNC~~	Varanasi (%)~~N=148~~
	N = 240
Husband ~~Husband~~	24~~23.7~~
Relative/family member ~~Relative / friend/ family member~~	25~~24.5~~
Govt health worker ~~Govt health worker~~	38~~38.3~~
Media~~Media(TV/radio/ newspaper)~~	0~~0.4~~
One who delivered the baby ~~The one who delivered the baby~~	29~~29.1~~
CHV~~Community health volunteer~~	14~~13.7~~
Private Doctor~~Self motivated~~	0~~4.17~~
Self motivated	4

4.4.24.3.2 Advice given during PNC

During the PNC checkups, the mothers were given advice on various aspects which include breast feeding, immunization, baby care, mother care, etc. Out of 398, only 240~~148~~ of the respondents went for PNC checkups. More than 99 percent of the women were given advice on ~~breast feeding upto 6~~

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months, immunization advice, timely immunization, baby and mother care advice. Similarly, 98.7 percent were advised on birth spacing and 96.2 percent of the respondents were advised to give top feed after 6 months.breast feeding & timely immunization. Advice for spacing between child birth was done for 98.75 percent of the women .

Services~~Advice given during PNC checkups~~	Percent (End Line) (N = 240)~~N=148~~
Women who availed PNC services within two months~~Breast feeding up to 6 months~~	60.3~~99.5~~
Type of PNC services~~Immunization advice~~	~~99.5~~
Advice for proper baby care~~Timely immunization~~	99.58~~99.5~~
Advice for timely immunization~~Baby care advice~~	99.58~~99.5~~
Advice for spacing between child birth~~Advice to give top feed after 6 months~~	98.75~~96.2~~
~~Advice on birth spacing~~	~~98.7~~
~~Mother care~~	~~99.1~~

47% from Vouch

~~4.5~~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 99 percent of the respondents were aware about oral contraceptive, male condom and IUD/copper T. It was also found that 98.9 percent of them were aware about male ~~and female~~ sterilization. ~~However, awareness about female condom was found to be very low (i.e.1.5%).~~ 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~~Awareness about the family planning methods~~	Varanasi (%)~~N=405~~
~~Oral contraceptive~~	N=398~~99.75~~
Oral contraceptive~~Male condom~~	100~~99.5~~
Male condom~~Female condom~~	99~~1.51~~
IUD/copper T~~IUD/copper T~~	99~~99.2~~
Male sterilization~~Male sterilization~~	99~~98.9~~
Injectable~~Female sterilization~~	~~98.9~~
~~Injectables~~	~~52.5~~

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Despite the high awareness level among the respondents, the percentage of respondents who are currently using family planning method is low. About 20 percent of them are using condom to prevent pregnancy. Female sterilization is also found to be adopted by 12.6 percent of the women and IUD/Copper T by 11.146 percent of women. But none of them are using male sterilization and female condom for family planning.

FP Method	Current Users (%) Base Line	Current Users (%) End Line
Condom	10.7	20.2
Oral pill	4.3	5.29
IUD	4.6	11.14
Male Sterilization	1.1	0
Female Sterilization	30	12.69
CPR	50.7	49.32

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4.5.1 Source of information for Family Planning

Media was the major source of information about IUD/copper T(63.5%), male sterilization (68.7%), female sterilization (66.7%) and injectables (54%). Relatives and friends has also been an important source of information about oral contraceptive (60.4%), IUD/copper T (58.4%), male sterilization (54.5%), female sterilization (57.6%) and injectables(44%). Husband has been the dominant source of information on male condom. About 68.1 percent of the respondents got the information on male condom from their husband. From the table it can be seen that government health worker has also spread the knowledge about oral contraceptive, IUD/copper T, male/female sterilization and injectables. Only small number women got information on various family planning methods from CHV.

Source of information about the FP methods	Oral Contraceptive	Male Condom	Female Condom	IUD/Copper T	Male Sterilization	Female Sterilization	Injectable
	N=397	**N=396**	**N=6**	**N=395**	**N=394**	**N=394**	**N=209**
Husband	22.9	68.1	33.3	18.9	17.2	17.0	11.4
Chemist	1.0	1.5	0	3.8	3.0	2.5	1.9
Relative/Friend	60.4	45.4	33.3	58.4	54.5	57.6	44.0
Govt health worker	46.3	39.3	50	54.1	47.7	48.9	31.5
Media	52.1	59.6	33.3	63.5	68.7	66.7	54.0
Project Staff	1.2	1.5	0	2.2	2.5	2.5	0.9
CHV	20.4	17.1	0	28.8	19.5	24.8	13.8

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

~~The awareness about RTI/STI was high among the respondents. More than three fourth of the respondents were aware about RTI/STI. Yet, 24.2 percent of the total women were not aware about these kinds of infections.~~

	~~N= 398~~
~~Aware~~	~~75.8~~
~~Not aware~~	~~24.2~~

~~There was certain percentage of women who were suffering from RTI/STI symptoms. About 24.3 percent were suffering from white discharge, 9.3 percent from pain in lower abdomen, 7.2 percent from burning sensation during urination and 4.2 percent reported pain during intercourse. Only 1.2 suffered from boils and 1 percent reported of secretion from partner's genitals. A mere 0.2 percent suffered from open sores.~~

~~Percentage of women who reported suffering from RTI/STI symptoms~~	~~N= 398~~
~~White discharge~~	~~24.3~~
~~Burning sensation during urination~~	~~7.2~~
~~Itching~~	~~3.5~~
~~Open sores~~	~~0.2~~
~~Boils~~	~~1.2~~
~~Pain in lower abdomen~~	~~9.3~~
~~Secretion from partners genitals~~	~~1.0~~
~~Pain during intercourse~~	~~4.2~~

Symptoms of diseases	Awareness	Suffered (percent)	Undergone treatment
White-discharge	98	24.37	50
Pain during urination	97	7.29	48
Itching	97	3.52	30
Open sores	92.7	0.25	15

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Pain in Lower Abdomen	95.4	9.3	21
Secretion from Partners Genitals	92	1.01	10
Pain during Intercourse	94	4.27	5

Awareness levels are above 90 percent in all symptoms . It is around 97 percent in 'Pain during Urination' & 'Itching' . Sufferings were highest in 'White Discharge'(24 percent) . Close to 50 percent woman underwent treatment in 'White Discharge' & 'Pain During Urination' . ~~Out of the total sample of 398 respondents, 31.4 percent of the women were diagnosed with RTI/STI symptoms. Majority of the women did not avail checkup for the symptoms related to RTI/STI. Around 63.2 percent of them did not get any treatment for same.~~

	~~N= 398~~
~~Diagnosed with symptoms~~	~~31.41~~
~~Availed checkup for the symptoms related to RTI/STI~~	
~~N= 125~~	
~~Yes~~	~~36.8~~
~~No~~	~~63.2~~

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4.6 Sambhav Voucher related information

Out of the total 398 respondents, 197 of them used voucher to avail various services related to pregnancy. Majority of the percentage (99.35~~78.1~~%) availed ANC services. About 85.23~~44.6~~ percent availed institutional delivery service and 95.59~~34.5~~ used voucher to avail FP services. Similarly 95.16~~31.4~~ percent used it for PNC services while 70.37~~27.4~~ percent for RTI/STI treatment.

Voucher for service:	N=197
ANC	99.3578.1
Institutional delivery	85.2344.6
PNC	95.1631.4
RTI/ STI treatment	70.3727.4
FP services	95.5934.5

Source of information

Source of information regarding the voucher:	VaranasiN=197
Base: All AwareC H V	26799.5
C H V ANM	99.490.5
ANM Neighbor	00
Neighbor Health worker	00
Others	0.51

The main source of information about the scheme is the CHV who are working at the grassroot level. 99.5 percent of the respondents got the information about the voucher scheme from CHV. CHV has been actively carrying out their responsibilities in implementing the scheme. A nominal 0.5 percent got their information from ANM.

What was the information received

Information received	Varanasi (%)
	N=174
Free checkup during pregnancy	54.3
Get free delivery	37.0
Free treatment	15.7
Free family planning services	13.7
Free Medicine	9.1
Free Tests	8.6
Free cooper T apply	1.5

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Free immunization services	1.0
Free health services	0.5

174 respondents have received information related to the voucher scheme. The most common information which the women received about the voucher scheme were free checkup during pregnancy(54.3 %); get free delivery(37.0%); free treatment(15.7%) and free family planning services(13.7%). Around 9.1 percent of the respondents were informed about free medicine while 8.6 percent received the information about free tests. But only around 1 percent were aware about free copper T and free immunization services.

Did anyone visit for verification?

For the implementation of the voucher scheme officials were sent for the verification of the target group. The respondents were questioned whether any verification was done or not.

Did anyone visit for verification	N=197
Yes	90.8
No	9.1
Number of times verification done	**N=179**
Once	59.7
Twice	34.0
Thrice	2.7
More than 3 times	2.2

About 90 percent out of 197 responded positively that officials visited them for verification. But 59.7 percent of 179 said that their verification was done only once. Verification was done twice for 34 percent of the respondent. Around 2 percent of them claimed that verification was done thrice or more.

Overall satisfaction with the services provided at the accredited health facility

Around 90 percent of the total 197 respondents were extremely satisfied with accredited health facility. Only a nominal 0.5 percent was not satisfied with the services provided by the accredited health centre. Based on the satisfied service provided by the voucher scheme, 56.3 percent of the

respondents would recommend the voucher scheme to their friends and relatives. Yet, 43.6 percent said that they would not recommend the scheme to anyone.

Overall satisfaction with accredited facility	~~N=197~~
Used ANY Vouchers~~Extremely Satisfied~~	*197*~~90.3~~
Top 2 Box Satisfaction~~Somewhat Satisfied~~	98.99~~8.6~~
Top Box (Extremely Satisfied)~~Not Sure~~	90.36~~0.5~~
~~Not So Much Satisfied~~	~~0~~
~~Not at all satisfied~~	~~0.5~~
Recommending the voucher to someone:	**N=197**
Yes	56.3
No	43.6
Should the voucher scheme continue	**N=197**
Yes	95.4
No	4.5

~~Around 90 percent of the total 197 respondents were extremely satisfied with accredited health facility. Only a nominal 0.5 percent was not satisfied with the services provided by the accredited health centre. Based on the satisfied service provided by the voucher scheme, 56.3 percent of the respondents would recommend the voucher scheme to their friends and relatives. Yet, 43.6 percent said that they would not recommend the scheme to anyone.~~

About 95.4 percent of the respondents were satisfied with the services provided by the voucher scheme and they want the scheme to continue. Only 4.5 percent said that the voucher scheme should not be continued.

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.

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In Varanasi, 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.

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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 Varanasi 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 Varanasi.

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. 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.

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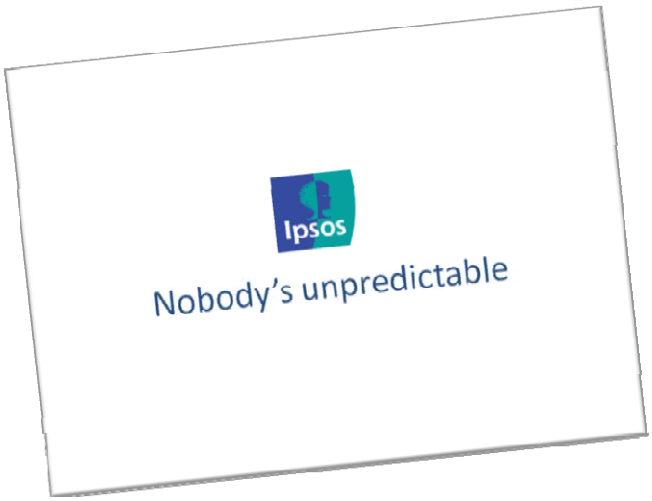

Thanks,

Ipsos Public Affairs Team

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