The Urban Reproductive Health Initiatives:
A Comparative Review of ISSU, NURHI, Tupange and the UHI

ExpandNet
Peter Fajans and Ruth Simmons
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**List of Acronyms /Abbreviations:**

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMUA</td>
<td>Social marketing brand of private health services in Kenya</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>APHIA+</td>
<td>AIDS, Population and Health Integrated Assistance Program (Kenya)</td>
</tr>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist (India)</td>
</tr>
<tr>
<td>AWC</td>
<td>Anganwadi Center (India)</td>
</tr>
<tr>
<td>AWWs</td>
<td>Anganwadi Workers (India)</td>
</tr>
<tr>
<td>BMGF</td>
<td>Bill and Melinda Gates Foundation</td>
</tr>
<tr>
<td>CARE CISSD</td>
<td>CARE India Solutions for Sustainable Development</td>
</tr>
<tr>
<td>CCPN</td>
<td>Centre for Communications Programs Nigeria</td>
</tr>
<tr>
<td>CHEW</td>
<td>Community Health Extension Worker</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer (India)</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>DEVCOMS</td>
<td>Development Communications Network: An NGO partner of NURHI</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DHMT</td>
<td>District Health Management Team (Kenya)</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
</tr>
<tr>
<td>DHISII</td>
<td>Kenya Department of Health Information System II</td>
</tr>
<tr>
<td>DMPA</td>
<td>Depot medroxyprogesterone acetate (DepoProvera)</td>
</tr>
<tr>
<td>DSRSE</td>
<td>Directorate of Reproductive Health and Child Survival (Senegal)</td>
</tr>
<tr>
<td>DWH</td>
<td>District Women’s Hospital (India)</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency contraception</td>
</tr>
<tr>
<td>FMOH</td>
<td>Nigeria Federal Ministry of Health</td>
</tr>
<tr>
<td>FOGSI</td>
<td>Federation of Obstetric and Gynaecological Societies of India</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FPPN</td>
<td>Family Planning Providers Network of Nigeria</td>
</tr>
<tr>
<td>FRHS</td>
<td>Foundation for Research in Health Systems (India)</td>
</tr>
<tr>
<td>FSD</td>
<td>Fixed Service Day (India)</td>
</tr>
<tr>
<td>GI</td>
<td>Bill and Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins University</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus infection and acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>HLFPPPT</td>
<td>Hindustan Latex Family Planning Promotion Trust (India)</td>
</tr>
<tr>
<td>ICDS</td>
<td>Integrated Child Development Services (India)</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>---------</td>
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</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IPC</td>
<td>Interpersonal Communication</td>
</tr>
<tr>
<td>IPM</td>
<td>Informed Push Model (Senegal)</td>
</tr>
<tr>
<td>ISSU</td>
<td>Senegal Urban Reproductive Health Initiative</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>JHPIEGO</td>
<td>Johns Hopkins Program for International Education in Gynecology and Obstetrics</td>
</tr>
<tr>
<td>JHU-CCP</td>
<td>Johns Hopkins University Center for Communications Programs</td>
</tr>
<tr>
<td>KEMSA</td>
<td>Kenya Medical Supplies Authority</td>
</tr>
<tr>
<td>KM</td>
<td>Kilometer</td>
</tr>
<tr>
<td>LARC</td>
<td>Long-acting reversible contraception</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area (Nigeria)</td>
</tr>
<tr>
<td>mCPR</td>
<td>Modern Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>ME</td>
<td>Marginal effect</td>
</tr>
<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>MLE</td>
<td>Measurement, Learning and Evaluation</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare (India)</td>
</tr>
<tr>
<td>MSI</td>
<td>Marie Stopes International</td>
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<tr>
<td>MSI-K</td>
<td>Marie Stopes International Kenya</td>
</tr>
<tr>
<td>MSION</td>
<td>Marie Stopes International Organization Nigeria</td>
</tr>
<tr>
<td>NACO</td>
<td>National AIDS Control Organization (India)</td>
</tr>
<tr>
<td>NCPD</td>
<td>National Council for Population and Development (Kenya)</td>
</tr>
<tr>
<td>NGO</td>
<td>Non governmental Organization</td>
</tr>
<tr>
<td>NHM</td>
<td>National Health Mission (India)</td>
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<tr>
<td>NURHI</td>
<td>Nigerian Urban Reproductive Health Initiative</td>
</tr>
<tr>
<td>NURHI 2</td>
<td>Nigerian Urban Reproductive Health Initiative, Phase 2</td>
</tr>
<tr>
<td>OCPs</td>
<td>Oral Contraceptives</td>
</tr>
<tr>
<td>PASS2020</td>
<td>Paquet Minimum to Maximize District Leadership and Performance in Senegal</td>
</tr>
<tr>
<td>PIP</td>
<td>Program Implementation Plan (India)</td>
</tr>
<tr>
<td>PMA2020</td>
<td>Performance Monitoring and Accountability 2020</td>
</tr>
<tr>
<td>PMV</td>
<td>Patent Medical Vendor (Nigeria)</td>
</tr>
<tr>
<td>PPIUD</td>
<td>Postpartum IUD</td>
</tr>
<tr>
<td>PPP</td>
<td>Private Public Partnership</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>PSS</td>
<td>Parivar Seva Sanstha, NGO (India)</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SDP</td>
<td>Service Delivery Point</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual Reproductive Health</td>
</tr>
<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>TCI</td>
<td>The Challenge Initiative</td>
</tr>
<tr>
<td>TSU</td>
<td>Technical Support Unit (India)</td>
</tr>
<tr>
<td>UHI</td>
<td>India Urban Reproductive Health Initiative</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UP</td>
<td>Uttar Pradesh, India</td>
</tr>
<tr>
<td>URHI</td>
<td>Urban Reproductive Health Initiative</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
</tbody>
</table>
PART I. INTRODUCTION

Chapter 1: Retrospective review of the Urban Reproductive Health Initiatives: objectives and methods

The Bill and Melinda Gates Foundation (BMGF) has invested major funding in the Urban Reproductive Health Initiatives (URHI) over the past six years, which supported implementation of a variety of efforts to increase demand for contraception among the urban poor in Africa and Asia, coupled with interventions to increase access to and the quality of care in urban public and private sector family planning services. The projects also included extensive advocacy efforts. An impact evaluation of the URHIs by the University of North Carolina’s Measurement Learning and Evaluation (MLE) project demonstrated that impressive increases in modern contraceptive prevalence and related outcomes were achieved in the cities in which they worked. However, many questions remained about which activities and approaches were most influential in producing these results and what could still be learned about moving towards sustainable scale up of the interventions. Much remained to be learned about how the processes of implementation and the interaction with the different contexts affected outcomes in each country, information that was not available through MLE monitoring and research activities.

ExpandNet was requested by the Foundation to conduct a retrospective comparative review to address these and related questions in India, Kenya and Senegal, building on their knowledge gained through extensive association with each of these URHIs over the past several years, as well in Nigeria based upon more recent collaboration with NURHI. The purpose of such a review was to provide actionable recommendations to assist in facilitating rapid implementation and scale up in new urban areas in the four country settings and in neighboring countries within The Challenge Initiative (TCI).

In conducting this review ExpandNet was guided by the following learning questions:

- How did the URHIs design, implement, adapt and successfully scale up their interventions?
- To what extent do differences in context explain differences in results?
- What was the role of “process” in explaining success as viewed by URHI team members?
- How important was the use of a participatory approach involving key stakeholders, in particular government?
- How were data and results from monitoring used for decision-making?
- Was a systematic approach to sustainable scale up used?
- What was the process of scale up and its pace?
- How were the teams organized and how did the management of the consortiums facilitate success?
• What was the role of donor flexibility, and how did a learning environment encourage success?

The review was based on review and analysis of the following data:
• key baseline, mid-term and endline MLE population-based survey results from the four countries,
• data from MLE facility-based surveys,
• MLE multivariate analyses of the impact of interventions,
• URHI project reports, documents and publications and available URHI project M&E data,
• qualitative participant observation data gathered by ExpandNet over the previous years in working with the URHI teams,
• in-depth interviews conducted with key project staff (project managers, city coordinators) and other key stakeholders (district and national or state officials; consortium partners, etc.).

Using such a mixed-method approach in the analysis of the URHIs facilitates a contextual interpretation of the results and their determinants, which is essential for understanding how large-scale expansion can move forward. The complementarity of qualitative and quantitative data makes it possible to see how interventions interacted within the socio-cultural, political-administrative and institutional systems into which they were introduced and how effective scale-up strategies are contingent upon appropriate adaptation to new contexts.

A protocol for the review and initial guides for interviews with project directors, city managers and other project staff and for other stakeholders including government partners were developed based on previous experience with the project and in discussion with BMGF staff. The in-depth interviews were conducted by ExpandNet members either as individual or group conversations. Interviews were flexible, following new learning and insight and evolved over the process of data collection.

Analysis of the data was by means of triangulation and synthesis of MLE reports and presentations, project data and reports, ExpandNet’s prior knowledge of the projects gained through provision of technical support and extensive field visits, and in-depth interviews and conversations with URHI staff from India, Kenya, Nigeria and Senegal and key project stakeholders, conducted in late 2015 and the first quarter of 2016.

The information, data and data analyses utilized for this report included those up to July 10, 2016. After this date new information and data analyses are continuing to become available as MLE continues to conduct further impact analysis. However in the interest of finalizing the report as the TCI is commencing, this cutoff date was chosen.

A draft of this report was shared with BMGF staff, the URHI country Project Directors and other team members who were asked to review the draft and make comments and suggestions
concerning the accuracy of the findings and conclusions and to add any other relevant information or recommendations. Their comments were incorporated into the report.

Chapter 2: Background

The URHIs in India, Kenya, Nigeria and Senegal were initiated between 2009 and 2010 with a common focus on the urban poor. The overarching goal of each URHI, as initially conceptualized and stated in the project proposals, was to significantly increase contraceptive prevalence by pursuing the following five basic objectives (there were slight variations between countries):

- develop interventions for integrating quality family planning with maternal and newborn health, HIV/AIDS, and with the postpartum and post-abortion care services;
- improve access to quality family planning services for the urban poor in both the government and the private sectors;
- test novel public-private partnerships and innovative private sector approaches to increase access to and use of family planning by the urban poor;
- develop interventions for creating demand for and sustaining use of contraceptives among urban poor or marginalized populations; and
- increase government funding and financial mechanisms, as well as a supportive policy environment for ensuring access to family planning supplies and services for the urban poor.

In each country the project was initially implemented in a number of “core” cities but from the outset, scaling up to additional cities was planned as follows:

<table>
<thead>
<tr>
<th>Country</th>
<th>Core city/district (population rounded to the nearest 1000)</th>
<th>Scale-up city/district (population rounded to the nearest 1000)</th>
</tr>
</thead>
</table>
| India (Uttar Pradesh) | Agra (1,575,000)  
                           Alligarch (899,000)  
                           Allahabad (1,117,000)  
                           Gorakhpur (693,000)  | Bareilly (898,000)  
                               Farukhabad (276,000)  
                               Kanpur (2,772,000)  
                               Lucknow (2,887,000)  
                               Mathura (352,000)  
                               Moradabad (890,000)  
                               Varanasi (1,463,000)  |
| Kenya            | Mombasa (1,104,000)  
                           Nairobi (3,915,000)  
                           Kisumu (410,000)  | Kakamega (92,000)  
                               Machakos (150,000)  |
Scaling up began as soon as one year after initiation of implementation of interventions in India, in year three in Kenya and in the fourth year of the project in Nigeria. In Senegal it was decided early on to scale up the contraceptive logistics intervention, known as the Informed Push Model (IPM), within the regions of Dakar, Thies and Kaolack, as well as the broader ISSU model to two districts. In addition, three years into the project after expansion to an additional two cities and scaling up of the IPM were already underway, ISSU was asked by the Director of Dakar Medical region to add two additional districts to the project Diamniadio (pop. 12,000) and Rufisque (pop. 162,000) in order to help them achieve contraceptive results similar to the other districts.

All four projects included the expectation that results would be broadly disseminated, efforts be made to mobilize other resources where feasible, and to develop a toolkit of successful interventions with the longer term intent that URHI interventions would have broader relevance at the national and even regional level.

Each URHI was implemented by a consortium of organizations and other collaborating partners.

<table>
<thead>
<tr>
<th>Country</th>
<th>Lead Organization</th>
<th>Major Consortium Partners*</th>
</tr>
</thead>
<tbody>
<tr>
<td>India (Uttar Pradesh)</td>
<td>FHI 360, Project Director: Gita Pillai</td>
<td>Hindustan Latex Family Planning Promotion Trust (HLFPPT), Johns Hopkins University Center for Communication Programs (JHU-CCP), CARE/CISSD, Foundation for Research on Health Systems (FRHS), Kamala Nehru Memorial Hospital (KNMH), Parivar Seva Sanstha (PSS), Janani, IPAS, Institute of Reproductive Health, Georgetown University, as well as a large number of other UP and local NGOs.</td>
</tr>
<tr>
<td>Country</td>
<td>Implementing Organization</td>
<td>Core Partners</td>
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<td>-----------</td>
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<tr>
<td></td>
<td><em>Project Director:</em> Nelson Keyonzo</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>JHU-CCP</td>
<td>Center for Communication Programs Nigeria (CCPN), Association for Reproductive and Family Health (ARFH) were core partners, while Health Reform Foundation of Nigeria (HERFON), Development Communications Networks (DEVCOMS), Advocacy Nigeria, African Radio Drama Association (ARDA), The Futures Institute, USAID/SFH, Marie Stopes International Nigeria (MSION) were collaborating partners.</td>
</tr>
<tr>
<td></td>
<td><em>Project Director:</em> Mojisola Odeku</td>
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<tr>
<td></td>
<td><em>Project Director:</em> Cheikh Seck</td>
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</tr>
</tbody>
</table>

*With the exception of Kenya, some organizations listed partnered with the URHIs in the consortium for variable times, but not necessarily for the entire project.

The initial project year was devoted to extensive diagnostic assessments, formative research, fact-finding, planning and strategizing. Implementation of interventions began in the projects’ second year. After completing five years of implementation, the projects were given a no-cost extension for another year. In 2015 the UHI in Uttar Pradesh, India came to an end. Kenya was given an additional six-month bridge funding to prepare for The Challenge Initiative; the work in Nigeria was extended for another five years (NURHI 2), expanding to the city of Lagos and peri urban/rural areas of Kaduna and Oyo States. However activities in Abuja FCT and Benin City were discontinued. Senegal was given additional funds for one-year to extend the “paquet porteur” tested in Diamniadio and Rufisque to 23 districts in three regions (PASS2020).

An external evaluation, which included baseline, mid-term and endline surveys, was conducted by MLE, Carolina Population Center, North Carolina. The projects also conducted their own programmatic research studies during the course of implementation. Ongoing support with a special focus on scaling up was provided by ExpandNet beginning in 2010 in India, in 2012 in Kenya and Senegal and in 2015 in Nigeria.
Given the strong learning focus of the URHI, four annual meetings of all project teams were conducted to share results and learning.

PART II. OVERALL APPROACH OF THE URHIs

Chapter 3: Conceptualizing the URHIs

Using a holistic conceptual and programmatic approach

Reflecting the initial overall URHI project concept, the individual URHI projects all promoted the use of FP in a comprehensive or holistic manner, utilizing a participatory process, and targeting areas and people that are usually neglected - the urban poor. They implemented a broad range of different types of FP interventions including:

- advocacy with government and other stakeholders,
- demand creation efforts involving mass media, mid media and outreach
- social mobilization by community and religious leaders, and community based volunteer workers,
- development of IEC materials and job aids for information and counseling (to be used by providers and for clients), and
- a broad variety of efforts to improve access to and the quality of services in the public and the private sector, including improved contraceptive logistics, training in technical and interpersonal skills, supportive supervision, service integration and outreach activities.

These broad approaches to strengthening FP demand and services were set out in the original project guidance, and subsequently adapted and modified by each country team to address their local contexts, including local cultural and institutional settings, and identified needs on the part of community members and of services.

All four URHI teams felt a comprehensive approach that combined advocacy, demand generation, increasing access to and the quality of services in an integrated package was key to the successes that they achieved in meeting the needs of the urban poor and increasing modern contraceptive prevalence. In India the city managers underlined the importance of the UHI’s holistic approach by noting that after the project ended there were other projects/players implementing FP interventions throughout UP, but each of them was focused only on one component and that too in different cities. This, they argued, resulted in:
• absence of an integrated package (one project is focusing only on the private sector, another primarily on technical training, another one on DMPA, another one on interval IUCD, another on PPIUCD and so on).

• sub-optimal utilization of services because not all agencies are present in one geography, and given their singular focus on one aspect of the family planning program, other aspects remain unattended.

**Recommendations:**

3.1 Wherever feasible, a comprehensive, integrated package of interventions that combines advocacy with multi-pronged efforts to create demand for contraceptive use and to increase the availability and quality of family planning services in both the public and private sector should be promoted rather than more narrow interventions.

3.2 In the absence of comprehensive projects that integrate the critical components of family planning interventions, other agencies supporting FP in shared geographies should coordinate with one another to ensure that service utilization and demand generation activities are both present and mutually supportive to maximize impact.

**Working within the government framework and strengthening public sector systems**

**Working within the government framework:** A central determinant that staff from all four URHIs considered responsible for their success was that they worked within the basic government policy and programmatic framework. The activities and innovations they implemented were either consistent with established government policy, program frameworks and operational guidelines or at least not contrary to them. If relevant policies were not in place the interventions were in line with ongoing policy discussions and the results of policy and programmatic research. This congruence with the government frameworks was critical in engaging government as partners and gaining their support. The fact that the URHIs were focused on increasing contraceptive prevalence was a critical component in gaining government attention and support because such efforts make it possible to be in line with each country’s national and international commitments.

**Strengthening the public sector system:** The public sector often has weak technical and managerial capacity, particularly at lower levels and this was the case in the four URHI geographies. It was therefore important to include interventions to strengthen their management capacities and their ability to implement specific interventions. Although this was not an explicit objective of the URHIs, all included efforts to build the capacity of the public sector system because in each context there were significant weaknesses, which affected the implementation of the URHI interventions. Because strengthening the public sector to implement family planning
services takes time this can initially produce tension with the objective of achieving rapid results. However, without such efforts sustainability and subsequent scale up are unattainable.

Building capacity to use data for the management of program implementation was an initial focus of the project. In addition to all four countries strengthening national and local capacity to use data for the management of contraceptive commodities, UHI, Tupange and NURHI explicitly worked with local health teams and officials to strengthen their capacity to use data for management of other aspects of their FP program as well. This was an important factor in increasing government’s attention to family planning services and outcomes and brought early support and eagerness to collaborate with the UHI from officials in UP. During scale up to Diamniadio and Rufisque, ISSU trained members of the District Health Management Team in the use of data for program purposes.

The four URHIs also realized that there were a range of more general technical capacities on the part of providers and facility staff that needed to be addressed in order to ensure that clients received good quality family planning services. For example, providers needed training and other supervision to have appropriate attitudes and strengthened interpersonal skills for not only family planning but the full range on MNCH services. Likewise improving infection prevention at facilities, ensuring privacy for clients and clean service areas and toilets cut across health services and other aspects of quality improvement needed to be addressed to meet standards for FP. These efforts are discussed later in the report under the specific interventions implemented by the projects.

Another approach to strengthening the public sector system was illustrated by the UHI efforts to assist health officials in UP to develop the annual Program Implementation Plan for FP under the National Health Mission (NHM). Funds to support the family planning program were available through the NHM but these often went unused and were returned to Delhi each year. By working closely with their district counterparts the UHI staff helped them apply appropriately for these family planning funds, which produced a substantial inflow of new resources to project districts. The main approach to supporting the health system in Senegal was ISSU’s introduction of the distribution of FP commodities through the Informed Push Model (IPM). The implementation of the IPM signaled the beginning of increasing contraceptive utilization in Senegal.

**Recommendations:**

3.3 Future projects should continue the practice of working closely within the public sector policy and program framework throughout all stages of the project because this creates the basis for government ownership and institutionalization.
3.4 Future projects should avoid a narrow focus on short-term contraceptive outcomes and instead recognize the importance of building the public sector’s capacity to implement quality family planning services.

3.5 Given that Ministries of Health often have relatively weak capacity to implement FP programs, it is important to include interventions to strengthen their management capacities, including their capability to use data for this purpose. Increased capacity for program implementation and management is critical for future scale up.

*Understanding the local context in designing the interventions*

All the projects were based on common broad parameters based on international evidence and global best practices. But in every country the team selected appropriate and feasible interventions needed to address the needs of the urban poor. The specific contextual dimensions were:

1. relevant geographic, socio-cultural and religious factors,
2. the health system with special emphasis on the family planning program (distribution of facilities, their available human resources, equipment, supplies and their level of functioning),
3. policy needs and realities,
4. available community resources.

Each country team initially undertook comprehensive baseline assessments, which included mapping, landscaping, and scoping exercises or studies and each developed a tailored set of interventions within the broad project framework. Some of these interventions were quite similar and others rather different, but all were designed to address the specific urban contexts where they were working. Even in individual countries, different cities needed differing approaches.

- For example, in Nigeria, the context in Abuja compared to Kaduna or Oyo was very different in terms of languages, diverse social norms, beliefs, predominate religion and social organization. Therefore, demand generation materials needed to be adapted accordingly. Likewise, different service delivery contexts and capacities required adaptation for the “local flavor” of each city. As NURHI 2 expands to Lagos, the presence of a powerful professional association of TBAs presents potential opportunities and constraints not relevant in other cities where NURHI initially worked.

- Similarly, working in the large urban slums of Nairobi with extensive movement and migration, more employment, and more youth required different approaches to working in Kisumu with its extremely high levels of HIV infection or in Mombasa with its population
which was primarily Muslim. Working in these contexts required extensive adaptation of the original package to produce locally effective interventions.

• The core cities in UP were more similar to each other, but even here different ethnic mixes and even the personalities of district health leaders required slightly tailored approaches. Cities with large Muslim communities required different approaches for entry through working with local religious leaders, for demand creation and for service delivery, as community attitudes toward FP and preferred methods were different than in Hindu communities. For example, Muslim women often chose post partum IUD instead of sterilization as a long acting method.

• Although there were no major differences among the cities in Senegal, the package of interventions had to be adjusted because of the more limited financial resources of some cities.

**Recommendations:**

3.6 Before seeking to replicate proven practices in new settings it is essential to assess whether and how they need to be adapted to the local context.

**Using data for decision-making**

A key characteristic of the URHIs was their strong commitment to the use of data from multiple sources in decision-making. This was critical at the stage of intervention design where URHIs used health service and other statistics, as well as information from available national surveys or special studies. In Nigeria the results of MLE baseline data were available to assist in the development of interventions, but this was not the case in the other countries. Reviews of health service statistics, operations research data and project monitoring were used on an ongoing basis to reflect on intervention progress. For example, in the case of the UHI in Uttar Pradesh this involved formal external reviews from population and health experts which were used to make ongoing project adjustments as well as ongoing evaluation inputs from the Foundation for Research on Health Systems (FRHS). The midterm evaluations provided important opportunities for the use of data to formally review and adjust interventions, based on MLE, as well as other available data sources. The Tupange project, for example, prepared a document with the critical questions facing the project, identifying for each both quantitative and qualitative data sources available that could provide relevant information as the basis for determining mid-course corrections. The use of data for decision-making was encouraged by BMGF’s strong support for flexibility and learning as the URHIs progressed.

**Recommendations:**
3.7 The use of data in the design and initial adaptation of interventions, as well as in an ongoing process of monitoring their implementation and making necessary changes, including during scaling up is essential for success.

3.8 Under the TCI support for databased decision-making, learning and flexibility should be continued.

*Working with participatory processes*

Building on a widely confirmed principle from the development literature, the URHIs used a highly participatory process of decision-making, receiving input from government, a range of service delivery partners, religious leaders and other stakeholders.

- In Nigeria, the design of the three major intervention domains – advocacy, service delivery, and demand generation- and the design of strategies and specific interventions within them was a very participatory process involving a wide range of stakeholders. Not only did it consist of the project technical experts and counterparts from Federal, State and LGAs (Local Government Areas- an administrative unit), the Ministry of Health, but also other stakeholders and partners - NGOs working in FP/RH, civil societies, religious, community and traditional leaders - all of whom provided important inputs. The NURHI team saw this as ensuring that every activity was developed with a client oriented or “consumer lens”. This was important in reaching consensus on activities that were relevant, acceptable to communities and could succeed. It also set the stage for strengthened community buy-in and ownership of activities. “This is good practice” the NURHI team said, “this is what made our NURHI interventions more effective. It changed how we did things”.

- A similar participatory approach was used in Senegal, under the leadership of the Directorate of Reproductive Health and Child Survival (DSRSE). The political context was very conducive, as shown by the declaration from the Head of State in favor of family planning, in preparation for the London Summit in 2012. The project worked since the beginning with the Ministry of Health, the governors and prefects, the municipalities, consortium partners, and the community as represented by religious leaders and women’s groups. The design period of the project coincided with the preparatory phase by the Ministry of Health of the National Family Planning Accelerating Plan 2012-2015, which was a widely participatory exercise. Throughout its implementation phase the project was used as “demonstration” on how to create congruence between supply and demand-creation activities for family planning information and services in poor urban settings, while securing the support from religious leaders and the wider community.
• In Kenya, Tupange started with internal group meetings to discuss how to address priority areas. They took lessons and experience from the ongoing Jhpiego project APHIA+ in rural areas and considered how to adapt these for urban areas, visited facilities and assessed gaps in equipment, supplies, commodities, provider knowledge and skills etc. They developed work plans and then brought in government partners to discuss and refine planning for specific activities. The initial engagement with city governments led to the development of Memorandum of Understanding to guide future collaboration.

• In India, the UHI also utilized a very participatory process in initiating the project and in the initial design of the interventions. The government of Uttar Pradesh was involved from the beginning in discussion on and determination of which cities were to be included in the initial core and the latter scale up cities. Project leadership consulted with key government officials on their implementation strategies and sought their advice on activities to focus on to ensure congruence with government policies and operational plans. Following further discussion and refinement of plans for interventions with the consortium partners, the UHI leadership sought feedback from government partners.

**Recommendations:**

3.9 Involve a wide range of stakeholders from the beginning of the project, including the intended beneficiaries, who can support the design and later the implementation and the scale up of the interventions.

3.10 Involvement of community, traditional and religious leaders from the outset should be continued where relevant.

3.11 Seeking guidance from and encouraging substantial involvement of government from the onset of the project must be a key component of a participatory process.

**Chapter 4: Advocating with government and ensuring government involvement**

For the most part, the URHI projects were not advocating for major policy change. In India, Kenya and Nigeria formal FP policies were in place but they were not being fully implemented. All three countries had prior histories of stronger national FP programs than those currently. Although appropriate high-level policies remained (or had been updated in Ministries), political priorities had changed and resource allocations had greatly diminished. Even donor priorities had turned from FP to HIV/AIDS and to reducing maternal mortality and to a lesser extent improving infant and child health. However, this has begun to change as there are more advocacy activities
related to FP2020 and governments are being reminded of their verbal commitments to increase support for FP.

Senegal had extensive policy constraints regarding the provision of FP in both the public and private sectors. Advocacy consisted in seeking to change the family planning policy environment to ensure:

- a greater level of financial and qualified human resource;
- regulations so that the private sector could have the same commodities as the public sector and
- that the pharmacies could enlarge the range of family planning methods that could be provided without prescription, at least for DMPA.

ISSU sought to establish evidence for advocacy through its evaluation of the supply of family planning through pharmacies. However because the evidence only became available at the end of the project, it is essential that PASS2020 continues advocacy regarding pharmacies.

**Early emphasis on advocacy**

For three of the URHI teams (India being the exception) early advocacy with national governments was an important starting point. This began with informing key government leaders/stakeholders that the project was coming well in advance of actual interventions and included substantial advocacy on the importance of FP for achieving maternal health and the links with population issues. The relationship between FP, quality life and fertility on the one hand and poverty and development on the other was a major theme.

- In Nigeria, NURHI had a technical team for advocacy that worked with stakeholders to develop an advocacy strategy, but there were also many early one-on-one interactions with government officials. A key advocacy strategy was to create the multi-stakeholder Advocacy Core Groups in each State which, after training, played a central role in advocacy with government (they often included key government officials e.g. the FP or RH Coordinators, respected individuals in the communities, FP advocates and champions and sometimes the wives of high level officials) and representatives of other civil society groups. Another important advocacy effort was forming Budget Tracking Teams with relevant government officials to track the existence of FP budget line items and expenditures at multiple levels of government. The availability of this data supported continuing advocacy efforts to mobilize financial resources to support activities.

- In Kenya, Tupange’s early advocacy with government was carried out primarily by the team leadership and by the city managers. A key strength of Tupange’s advocacy efforts was that National Council on Population and Development (NCPD) was a member of the Tupange consortium. Given its official advocacy role with government and other stakeholders for FP
and population issues NCPD’s participation in the Tupange consortium greatly facilitated the project’s advocacy work. NCPD is smaller than the MOH and thus easier to work with. Key individuals from the FP/RH Department in the MOH were consulted and involved in discussions, but the Ministry was not a direct partner.

- In India, the UHI leadership advocated with the Ministry of Health and Family Welfare (MoHFW) in Delhi, but the major focus of advocacy was at the state level in Lucknow where UHI staff played a strong advocacy role with State level officials. Each city team leader in turn interacted closely with local government and health officials advocating for FP in general and UHI activities specifically. A great deal of time passed sitting on benches outside of office doors before access/entry could be gained. “It took time to know which doors to knock on”. The Nigeria team reported the same phenomenon, but it was easier for them at the central level because the Project Manager had previously been a high level, respected official in the FMOH.

- In Senegal, the ISSU project team advocated extensively with members of the Ministry of Health at the national, regional and district levels as well as with prefects, governors and local “collectivities”. In addition, non-governmental organizations addressed advocacy as well, for example the association of journalists working on population health and development, the National Association of Midwives, ENDA Santé and the Population and Islam Network (RIP). The association of journalists focused on project visibility and the diffusion at the national level of the results that were being obtained, while the midwives association advocated for greater provision of qualified personnel and the quality of services. Within the context of the maternal mortality reduction campaign and progress towards ensuring universal coverage of basic services, ENDA Santé placed specific governance bodies at the national and sub-national level (observatories) with a view to advocate for improved access and quality of FP for all women. RIP’s advocacy focused on the role of religious leaders and the involvement of men. ISSU also published an advocacy magazine promoting the project entitled “Parlons FP” or “Let’s talk FP” which was targeted stakeholders and decision-makers.

One of the major successes of this advocacy was to allow the creation of a social franchise system, which until then was unknown in Senegal, as well as the contraceptive logistics system “Informed Push Model” and the special approach for the recruitment of additional midwives. Evidence of the considerable influence of the ISSU project on government can be seen in the fact that the ministry subsequently chose to set a national objective of a 15 percentage point increase in contraceptive prevalence based on what was accomplished in the project.
Using Maternal Health as an entry point for family planning

In each country reducing maternal mortality and more generally improving MNCH was a priority area for the governments/ministries of health. There was political support for achieving the targets set for the Millennium Development Goals 4 and 5. Therefore, promoting FP as a key to reducing maternal mortality and improving infant and child health was an important entry point for the URHIs. Because FP can be sensitive in all four countries the URHIs soon learned that an emphasis on reducing maternal and child mortality would gain entry to households, which helped the teams to build trust and credibility that made it possible to introduce the topic of family planning later on.

At the same time policy makers at higher levels often did not recognize or emphasize the key connection between FP and MNCH, or between FP and poverty and economic development. This strong linkage was also not understood by community members, community leaders or providers.

Recommendations:

4.1 Information about the linkages between use of FP and maternal and child health, as well as more generally with poverty reduction and the new Sustainable Development Goals should be part of demand generation and advocacy at all levels.

Advocacy for family planning with the media

Advocacy with the media played an important role in the URHIs. Stories in news media can contribute to changing social norms, and create indirect advocacy with government to provide more and higher quality services. The projects in Kenya, Nigeria and Senegal worked extensively with journalists and the press on advocacy for family planning issues and on dissemination of information about the projects. This included training workshops for newspaper journalists to increase their understanding of issues related to FP and to build their interest and capacity to report on these issues. They also closely monitored the press for favorable articles about the project and family planning more generally. They invited journalists to attend workshops and events so as to create community interest and dialogue on FP and by extension to create advocacy with local government. As a result of such work with the media, reporting on family planning topics greatly increased in the project cities and raised visibility for the URHIs in local mass media. However it is not clear to what extant these activities directly led to changes in government attitudes or actions.

In India, similar activities were originally planned as part of the UHI, but were dropped as press coverage of FP was already good and it was considered not to be a high impact strategy worthy of investment.
**Advocacy at multiple levels of government**

All the URHIs emphasized advocacy, but the teams nonetheless concluded that there would have been a need for even more advocacy both for increased attention and focus on FP issues in their own right as well as a key health and development concerns.

URHI leadership felt that advocacy with government requires working at all levels of government, including district/country, state and national levels. They argued that as implementation occurs at the subnational level, it is easy to lose sight of national level issues which are critical for institutionalization of interventions and for working later in other states, regions, counties. This is especially true when the national level does not have direct responsibility for implementation of health activities as in India, Nigeria and more recently in Kenya. However, involving the national level is critical for institutionalization, and it has the “moral authority” for other states to be encouraged to adopt them. Potential strategies for addressing this issue include working in more than one state from the outset, or to either establish or work with an existing national technical advisory group, as NURHI has been doing as part of their institutionalization strategy. This need for multi-level advocacy is particularly important when working in countries with highly decentralized systems. Where decentralization is a major feature of government structure, it becomes critical to have strong advocacy not only at the national level, but also with local district or county governments. This is needed to ensure that they consider family planning a health and development priority, allocating sufficient budgets, but also emphasizing attention to the importance of implementation of quality services that reach those in need.

**Recommendations:**

4.2 Advocacy must go beyond a general focus on the importance of FP to an emphasis on the implementation of existing policies, the creation of government budget lines at national and local levels and for allocation of government funding to buy contraceptive commodities and to support FP program implementation. In India substantial funding for FP is already available through the National Health Mission budget, but local government officials need support to successfully access these funds.

4.3 Governments in new geographies may not consider FP a political priority and not one that they are interested in “buying into”. This means considerable advocacy groundwork will be needed before these governments will invest significant amounts of funds in FP. Making a close link between FP, teenage pregnancy, and maternal and infant mortality will facilitate such advocacy.
4.4 Involving government in the design and implementation of interventions is important to get their buy-in and to build ownership for sustainability.

**Ensuring government involvement**

In Uttar Pradesh, the state government was involved in selection of cities and provided guidelines for the UHI strategies, and in that sense there was some degree of government involvement from the outset. In recruitment of staff UHI also chose quite a number of people with good connections and previous experience working with government.

For NURHI a major factor in success with ensuring government involvement was that the Project Director had been a senior highly respected national MOH official and had excellent connections with government officials at the state and national level. This helped to facilitate government interest and involvement in the NURHI project. Likewise in Kenya Tupange’s Project Director had a great deal of experience working with high level government officials and a very strong network of contacts. This was important in quickly obtaining the necessary official permission and agreements with government required to begin implementation.

Remarkable evidence of government involvement and appreciation of the project comes from Senegal where the Minister of Health pleaded strongly in a filmed statement for sustaining ISSU interventions at the end of the project. Similarly in Uttar Pradesh, the Director of the National Health Mission requested continuation of the UHI for at least one or two years, given that the government was just then beginning to implement its urban health and family planning program and he felt the UHI experience could provide critical support in this effort.

Ensuring the involvement of government and multiple stakeholders can be time consuming and difficult, but in the long term is critical for sustainability and future expansion. High-level government interest builds the potential to get additional resources. However, creating a strong sense among government that they “own” the project is difficult to obtain and involves not only maintaining close relationships with government counterparts, but a willingness on the part of the project team to “step back” and hand over the “baby”. This is not easy and not the usual pattern in project implementation in most countries. Donors and technical assistance organizations want to see rapid results and resource teams typically think they can do this best and most efficiently by closely managing, if not implementing, activities themselves. The risk is that government ownership of activities is not created. The ISSU team learned this lesson as they moved to two additional districts, Diamniadio and Rufisque, in the last two years of the project. Here they realized the importance of shifting towards much stronger involvement of the district authorities than in the previous districts.
A senior NCPD staff person in Kenya pointed out that having a government team member to introduce project interventions in new counties will be critical in Kenya - an NGO will not get the same respect, interest, or buy-in.

Recommendations:

4.5 As discussed above in Chapter 3, involving government in the design and implementation of interventions is important to get their buy in, build ownership for sustainability and for future scale up. Creating government ownership from the beginning is a key strategy to facilitate later scale up and sustainability of the interventions.

4.6 A key lesson for the TCI is to involve key government counterparts as members/leaders of implementing consortiums and to select senior project staff with strong connections to government.

4.7 It is essential to encourage local level government officials to take greater initiative in coordinating and synchronizing the efforts of diverse agencies at the county or district and local level. If coordination meetings or other similar efforts are initiated by them, then the system might become more efficient and efforts would become more sustainable.

PART III. INTERVENTIONS TO STRENGTHEN DEMAND AND SERVICE DELIVERY

As previously discussed the URHI objectives called for advocacy with government, efforts to build and sustain demand for family planning and contraceptive use, together with efforts to strengthen access to and the quality of family planning and related services. Advocacy with government was discussed earlier and in this section the report will focus on interventions to create demand and to strengthen family planning service delivery in the public and private sectors.

Chapter 5: Demand generation

In the four countries, successful demand creation utilized a mix of mass media and interpersonal approaches. This focused not just on providing information about contraceptive methods, but also more generally on increasing motivation and reducing barriers to use. Particularly important were efforts to address the prevailing myths and misconceptions, fears of method side effects and other related community beliefs. Addressing community norms and creating a willingness to
discuss family planning openly in communities was also important. Community based workers and community activities with leaders played an important role in providing information, as well as addressing norms. Efforts to increase spousal communication were also essential, as men, particularly in the African URHI countries were often gatekeepers for FP and contraceptive use.

**Community religious and other leaders:** Efforts to involve community leaders and particularly community religious leaders in areas where the predominant religious orientation was not initially supportive to family planning, was critical to gaining entry into communities. Endorsement of FP by local religious leaders was also essential to gain the support of community social mobilizers, community health workers (CHWs), and providers, in addition to developing supportive attitudes towards FP among community members. This was particularly important in Muslim communities. For example, an important religious leader in the city of Zaria became an advocate for FP, which was a milestone in the success of the NURHI activities in the city. NURHI also facilitated the setting up of an Interfaith platform for Muslims and Christians to interact and understand the importance of family planning based on their faiths, thereby supporting FP uptake at the community level. Similarly in Senegal one of the Imams became such a strong advocate that he is now playing a key role in the follow-on PASS2020 project. Reaching Catholic and some fundamentalist Christian leaders in Nigeria and Kenya was also important. For example in Nairobi Tupange worked with a number of Christian leaders who became FP champions in their communities, informing their congregations of upcoming activities and making their churches available as sites for outreaches. NCPD Kenya official stated that Tupange had not only played a key role in helping to get religious leaders on board, but that this was critical to their success.

The four URHIs developed (or borrowed from other sources, including sister projects) materials based on the Quran, which clarified the supportive position of Islam for FP and highlighted the support for birth spacing in the Quran. For example, the UHI and Tupange adapted materials previously developed in Senegal. The Islamic perspectives advocacy handbook on RH/FP developed in Nigeria was used as a key resource by Senegal in designing their intervention. The URHIs worked with religious Muslim leaders at the national, state, and local levels to gain their support and favorable interpretations of religious texts, also conducted workshops and trainings with local Muslim leaders. Subsequent talks held by these trained religious leaders on the topic of family planning in their mosques, on the radio or within their communities opened doors to discussion and acceptance and had a significant impact on approval of FP and child spacing among men. The UHI also explicitly selected Muslim community health workers and counselors to serve these communities.

In Kenya, trainings were held for chiefs of communities who are linked to local government and who also are important community gatekeepers for family planning. The curriculum is included in the Tupange toolkit. Subsequently, they worked to incorporate family planning as part of the
job descriptions of chiefs and District Officers during their community meetings (known as Chief’s “barazas”). This work was notable as exposure to community events was significantly related to women’s adoption of contraception in Kenya in the MLE endline survey.

**Community health workers and social mobilizers:** The four URHI projects all relied on some form of volunteer workers to meet with community members, most often with women of reproductive age, to provide them with information about family planning and contraceptive methods, and to motivate them to access services. In each country these workers were somewhat different in nature depending on the types of existing community health workers (CHWs) in the health system.

- In Kenya, there was a history of community based distribution (CBD) of contraceptives by CHWs going back to the 1980s but this had subsequently stopped. The Tupange project undertook to revitalize CBD by training a sub-group of CHWs already working in communities as part of the National Community Health Program. For each group of 50 CHWs a sub-group of ten, including both men and women, were selected by the MOH community health focal persons and given more comprehensive FP training. In addition to providing information and advice, they distributed condoms and oral contraceptives to women and men and facilitated “linked” referrals of women for clinical FP services, as well as conducting tracking and referral of post-partum mothers for FP. They also took part in regular community meetings on FP and assisted in motivating communities to attend outreach and in-reach activities implemented by the project. A key lesson learned by Tupange was that they needed to provide more in-depth training on FP and to train more of the CHWs to facilitate coverage of all households, given the added workload of providing FP services. Tupange worked with the National Community Health Program to develop a new national FP training curriculum for CHWs so that they had sufficient knowledge and skills to provide information, OCPs and condoms and make referrals. This was important as it enabled other partners supporting CHWs to train them on FP as well.

- In Uttar Pradesh, the UHI worked with existing NGOs to hire and train and mentor Urban ASHAs to work for the project with at least one posted in each city slum serving approximately 400 households. ASHAs are the standard female CHWs working with the national rural health services providing a broad range of community health services. When the UHI started, ASHAs did not yet exist in the urban areas, although there were plans to introduce them once the planned Urban Health Mission was approved. The UHI modeled their Urban ASHA on the GOI urban ASHA guidelines, with the exception that their tasks were primarily focused on providing FP information and advice and promoting the use of public and private FP services, as well as facility-based delivery, through routine household visits and other community activities. They also distributed free condoms and oral contraceptives and escorted women to facilities for ANC, delivery, post partum and newborn
care and FP services. In addition at the request of government they also supported other programs such as pulse polio days, vitamin A distribution and DOTs TB care. They received additional training and financial compensation for these extra activities. In the scale up cities where funds were not available to hire sufficient Urban ASHAs to cover all of the slums, the UHI worked with the government Anganwadi Workers (AWWs) from the Integrated Child Development Service (Ministry of Women and Child Development) to develop their capacity to inform and counsel pregnant and lactating women on family planning. Subsequently the UHI promoted collaboration between Urban ASHAs and AWWs in all of the cities and developed FP training materials for AWW to complement the government curriculum and resources.

- In Senegal, proactive demand creation for family planning through household visits was newly introduced by ISSU. In the project most community-based interventions were implemented directly by two consortium-partner organizations in charge of the demand-creation domain, in coordination with the city managers in each district. These consortium-partner organizations are local/national NGOs that have been active in promoting health as an important element of social and economic development for several decades. They were responsible for hiring the community health workers, directly or through sub-contracting with other community-based actors, for the implementation of household and community-level activities.

In Diamniadio and Rufisque, this activity was assigned to two of the relais (CHWs) attached to each of the health posts to avoid any sub-contracting. Relais exist in all districts in Senegal and are routinely used by various programs to support health interventions with a community mobilization component. Household visits focused on family planning represented a critical need identified in the diagnostic assessment in Rufisque and Diamniadio. Such visits consisted of preparatory contacts with the households to schedule a time convenient for the woman to receive the relais, followed by the household visit itself during which the worker focused on family planning education within the broader context of maternal and child health. When appropriate, women were referred to the health post or the special family planning service day and if needed the worker subsequently made follow-up visits. Relais received special training for this activity from the district, with technical backing from ISSU and were paid $1 compensation for each visit.

- In Nigeria, there are a variety of community health workers who are associated with different health programs and projects. However when NURHI began, none of them were specifically focusing on family planning. NURHI developed a new type of volunteer worker, known as a social mobilizer. These were young men and women (18-35 years old), typically artisans such as barbers, hairdressers or others interacting with broad segments of the community. NURHI benefitted from reaching the flow of people that patronized these people in their
various trade and work places. The social mobilizers were equipped with promotional and information materials and trained to promote the use of family planning to men and women at their workplaces, during community meetings and key life events such as weddings, naming ceremonies and graduation parties. As scaling up proceeds, in the addition to the NURHI motivators, other community volunteers working on different development initiatives will be trained and engaged to promote FP and distribute IEC materials.

A key difference among the countries was that in India and Kenya the CHWs played important roles in both generating demand through providing information and advice and in providing contraceptives and facilitating access to services. In contrast the work of the NURHI social mobilizers focused only on demand creation. In Nigeria condoms and OCPs are readily available from pharmacies, small drug shops or kiosks in or near where the urban poor live, so it was not critical for the social mobilizers to provide condoms or OCPs. The same was true for India and Kenya, but nonetheless the ASHA or CHWs provided free contraceptives for those that could not afford to buy them. In Senegal community-based distribution of OCPs was tested in one area.

Data from the midterm and endline MLE surveys in the four URHIs showed that contact with CHWs in Kenya and Uttar Pradesh was significantly related to contraceptive use, while attendance at community level events, including contact with CHWs or social mobilizers was also related to contraceptive use in Senegal and Nigeria. However, in all of the countries the rates of contact with CHWs or social mobilizers and attendance at such events by women interviewed were considerably lower than hoped for. There is a need for mechanisms to facilitate or ensure that CHWs or social mobilizers visit or contact all of the poor women in their communities whether to provide information and counseling or to mobilize participation in community level events promoting FP. The tendency can be for community workers to visit just the better off, better educated, easier to work with households. The poorest, uneducated or illiterate and most marginalized women and their partners are most likely to need accurate information about FP and assistance in accessing services- but they are often least likely to be contacted by community volunteers without efforts regularly spot check coverage and hold the worker and her supervisor accountable.

**Recommendations:**

5.1 It is important to involve religious and other community leaders from the beginning in developing and implementing demand generation activities. Supporting materials are available on the NURHI, ISSU and UHI websites and should be used/adapted as needed for other settings in the future TCI.

5.2 Training modules for CHWs will be an important component of TCI toolkits. The principles will be similar across countries but each will need adaptation to country specific social, cultural, and health system contexts.
5.3 In new geographies, TCI should seek to build upon existing CHWs and engage them to provide FP information, counseling, and contraceptives as appropriate, rather than developing new categories of community based workers.

5.4 As TCI expands to new countries it will be important to build upon other existing community level health staff and/or volunteer workers to become involved in promoting FP and providing non-clinical contraceptive methods. Innovative approaches to maintaining their interest and engagement in family planning activities will be needed.

5.5 Appropriate mechanisms will need to be developed in new geographies to ensure that community volunteer workers (CHWs or social mobilizers) contact all of the poor women or households in their catchment areas.

**Mass media:** TV, radio spots and dramas are potential means of communication to the urban poor. In India and Nigeria TV has relatively high penetration in urban slums, but airing advertisements, spot messages or info-media shows is typically very expensive on national channels. In India local cable TV stations were much cheaper. In Nigeria and Senegal there was high penetration of relatively inexpensive community radio stations and thus FP radio messages were easier to sustain. In Senegal, radio shows were broadcast jointly by religious leaders, journalists, and family planning service providers and the synchronization of these events with community-based activities yielded positive results in terms of increased referral cases for family planning services. In Kenya community radio stations in each of the core cities were an important feature in demand creation. Of particular note was the radio program Jongo Love, which was targeted to youth. Exposure to Jongo Love was significantly related to contraceptive acceptance, but the proportion of the total urban population exposed was small (less than 10%). Jongo Love was also supported by a social media campaign, which probably resulted in young people seeking it out and increased its exposure among youth. Overall exposure to mass media messages was significantly related to contraceptive uptake in Nigeria (radio), Senegal (radio for women and TV for men), India (TV) and Kenya (radio). More detailed results concerning impact of mass media interventions are presented in Chapter 14 on the impact of different interventions.

- In India, the UHI made considerable efforts to employ mass media to generate demand. Initially the project developed three short TV spots, which focussed on 1) using the IUD and DMPA, 2) male sterilization, and 3) postpartum sterilization postpartum. In addition eight “behavioural films” related to the use of specific contraceptive methods, and 32 role model films were developed. However the behavioural films when finished were too long so they were edited down to produce nine short films on how to access and use specific methods. In addition they developed 12 short films addressing a range on MNCH issues, including among others, antenatal care, institutional delivery, breastfeeding and LAM, and
newborn care and immunization. The 21 short films were intended to be broadcast on local TV channels, on TVs in facilities and later were tested on tablets for counselors and smart telephones for CHWs.

- In Nigeria, NURHI had a comprehensive and coordinated demand creation strategy - the Get it Together campaign. The mass media components included broadcast of FP messages on both TV and radio and radio shows featuring dramas, presentations by providers and call-in question and answer sessions. There were also newspaper and magazine inserts, as well as social media (Facebook) and the use of text messages to telephones. A major element was the Get it Together Entertainment Education Radio program, a three season 26 weekly episode radio program developed in partnership with ARDA in different versions for Ibadan/Ilorin and Kaduna adapted and broadcast in three different languages in the five cities. The broadcasts included serial dramas, together with a host of comedy, testimonials, quizzes and other elements. In addition to NURHI’s original campaign, they also more recently partnered with several other organizations in the production and support for a national TV drama entitled Newman Street which includes FP messages.

Written channels (print media) such as newspapers and magazines do not reach many slum residents in Nigeria, Kenya or India, but there was high exposure among youth in Nairobi slums to the weekly Shujaaz comic insert in the Nairobi newspaper. Each copy was reportedly read by multiple individuals. Shujazz was linked to the radio program Jongo Love and the two were supported by an intensive social media/Facebook campaign, which may have led young people to seek out these materials, and increased their influence. “Wall paintings” which are informal messages written on the walls of houses in the slums of UP were widely viewed by residents and exposure was significantly related to contraceptive use.

Cellphones are becoming ubiquitous in urban slums in Nigeria, India, and Kenya, and with the passage of time cheap phones that can access social media are becoming more common. In the future use of social media for spreading information about FP in general and more specific information about contraceptive use, side effects and their management has much potential, particularly among the “social media generation” of young people.

At the same time digital messaging and short films promoting FP/MNCH will have the potential to reach wider audiences by being displayed on cellphones and tablets of CHWs, FP providers, TVs at facilities etc. Cheap cellphones also create the potential for their use in sending informational messages related to FP and other MNCH topics or for reminders for resupply or follow-up visits to women. Cellphones also create the possibility for women and men to call in to FP information hotlines and to “question and answer sessions” that are part of radio or TV programs supporting FP/MNCH.
• NURHI and ISSU sponsored radio call-in shows featuring community and religious leaders and providers, both independently and coupled with radio dramas promoting FP. Community members would call in with their questions and comments.

• In Uttar Pradesh, the UHI called postpartum women to follow-up on their status and encourage them to come for postpartum visits and contraception. In addition they tested calling DMPA users to follow-up on side effects and to remind women of their time for re-injection. As described above the short “how to films” for women focusing on various FP/MNCH messages were tested on tablets and CHW’s cellphones and show promise for future use across UP and neighboring states. At least one city implemented a FP hotline that was highly utilized by the local population.

**Print IEC materials:** Each of the URHIs developed a range of IEC materials including posters, brochures, leaflets, provider job aids and other materials for use in informing and counseling women and men. In each case these materials were based on extensive formative research and testing. They were highly appreciated by both providers and women in all of the countries. In India, together with the UHI mass media films, they have been adopted and rebranded by the UP and Madhya Pradesh governments with their own logos and have also been requested by other states. They are available on the UP state website and the National Population Stabilization Fund (JSK) website for access by other states and audiences. In addition, they have been translated from Hindi and are available in a number of other Indian languages including Urdu, Bangla, and Oriya.

In Nigeria, the NURHI materials are being requested for replication by other donors such as UNFPA and are being promoted as part of a potential national demand generation campaign. As mentioned earlier, myths and misconceptions about the full range of modern contraceptives were highly prevalent in all of the URHI countries. IEC materials that were developed to specifically address these prevailing myths in Nigeria, Senegal and Kenya were particularly popular with the communities. In Kenya, the Myths and Misconception Booklet has been adapted and reprinted by UNFPA, Family Health Options (the Kenya IPPF affiliate), and Jhpiego’s Adolescent Program – Brighter Futures, and is in the MOH FP resource repository.

**Recommendations:**

5.6 In new TCI countries specific messages for mid and mass media and other materials for providing information and counseling and particularly those that address prevailing myths, misconceptions, and perceived side effects will need to be adapted from existing materials or developed based on the social contexts.

5.7 Smart telephones and social media have the potential for reaching ever-wider audiences in urban slums, particularly among youth. Although some initial experience has been gained in
the URHIs in using these new channels for both demand generation and in improving services, they should be increasingly exploited in the future by the TCI.

5.8 As TCI expands to new countries or different social contexts within countries demand generation approaches and materials will require adaptation based on in-depth understanding of the social fabric and variations in the health systems. There is no single best solution for reaching people of different ethnic, religious or age groups. This has important implications for the future implementation toolkits.

Chapter 6: Human resources and provider training

Sufficient human resources with appropriate knowledge and skills are the backbone of any health system or family planning program but this represented a major service delivery shortcoming in each of the four URHIs. A key focus of interventions in each of the projects was therefore to increase the number of family planning providers to serve the urban poor and strengthen their knowledge and their technical and interpersonal competencies.

Increasing availability of providers: Efforts to expand the pool of providers serving the poor focused on both the public and private sectors in the four countries. Activities to engage the private sector in each country are discussed in Chapter 9, while those increasing availability of providers in the public sector are discussed here. For example:

- In India, the UHI expanded the human resources for family planning services through several strategies. As described earlier at the community level they hired and trained urban ASHAs whose tasks included the provision of information and counseling on family planning and basic MNCH more generally, as well as providing condoms and oral contraceptives. At the facility level the UHI used a strategy of “contracting-in” additional providers. For example, it hired, trained and equipped one additional FP counselor for each District Women’s Hospital in the cities where it worked. By the end of the UHI a number of these counselors had been hired on contract by the ministry, using funds available under the National Health Mission.

The UHI also worked closely with government counterparts to contract-in additional doctors and nurses to work at lower level urban primary care facilities through use of the PIP mechanism which provides an opportunity for additional term support (see Chapter X). Another strategy was assisting government colleagues to increase the number of trained and empanelled surgeons in the district available to provide male and female sterilizations on fixed service days.
In Senegal, the recruitment and deployment of an additional 20 midwives to high-volume facilities in two of the core districts helped increase the capacity to deliver integrated facility-based and outreach services, including improved counseling. This approach had major impact on the outcomes of the project. Its success confirmed that addition of personnel and improved human resource management (motivation, performance improvement, supportive supervision) can make a difference in improving effectiveness, even in a weak system. However, sustainability of this approach can be a challenge. Nevertheless, in Senegal ISSU’s recruitment of midwives has led to the national recruitment of 500 additional midwives, financed by BMGF. Moreover, the subsequent “proof of implementation” project in Diamniadio and Rufisque districts demonstrated that existing personnel are, although to a more limited extent, also able to implement new interventions. ISSU also worked closely with Ministry of Health (MSAS) supporting logistics, the development of training manuals and the supervision of trained workers.

Task shifting: Recent task shifting policies and ongoing implementation research on task shifting in India, Kenya and Nigeria will provide new potential opportunities to expand the number of providers serving the urban poor, increasing the time available for provision of counseling and clinical methods, and generally reducing the burden on facilities. For example in Kenya, trained nurses have been providing long acting reversible methods (LARC) including implants and IUDs, and immediate postpartum IUD insertions (PPIUD). With the recent Kenya LAPM strategy (2011), there have been increasing numbers of nurses who have been recently trained and are now providing long acting contraceptives. In addition Community Health Extension Workers (CHEWs), the supervisors of the CHWs, are now authorized to provide injectable contraceptives. Also, the CHWs affiliated with communities near facilities helped provide FP information at facilities.

In Nigeria, CHEWs have recently been authorized to provide injectables, and research is ongoing to test their provision of implants and IUDs. The next phase of NURHI will include a focus on training Community Health Extension Workers (CHEWs) to provide information and counseling for all methods, together with DMPA injections, including Sayana Press under Nigeria’s new task shifting policy. In India, an example of task shifting has been the process of training and having hospital midwives to do immediate postpartum IUCD.

Recommendations:

6.1 Hiring supplementary staff can address issues of staff shortages, but without longer-term opportunities and plans for retention of these staff it should be approached with caution.

6.2 Support for operationalizing new or existing task shifting policies to increase access and availability to contraceptives, particularly where there are currently insufficient numbers of clinical providers should be emphasized in future interventions.
6.3 Task shifting represents a key intervention for increasing access to FP services in contexts where there are chronic shortages of providers as well as for decreasing the burden on existing providers. However as initial experience is being gained with new categories of method providers it will be important to monitor the quality of care to ensure that it meets standards.

**Training and mentoring:** A key approach to improving access and quality of care is provider training. Initial assessments in the four countries revealed that FP providers needed training in technical issues concerning contraception, training in interpersonal skills and counseling, as well as refresher training, supportive supervision and mentoring to upgrade their skills. Prevalent provider biases in each country created barriers for many women to access contraception. The URHI projects worked to build MOH or other local training capacity, including the development of cadres of master trainers. Training of local trainers and building their capacity to conduct on-site training was a key intervention for sustainability and success in all of the countries.

The approaches to developing master trainers and implementing clinical and interpersonal provider training varied across the countries.

- In India, the UHI utilized “master trainers” available in each district. These were often FOGSI (Federation of Obstetrician and Gynecologist of India) members, consultants and academics who were capable of conducting modern, competency based, and at least partially interactive training. Hiring these individuals was more costly than hiring government trainers, but this was felt to be worthwhile, as the government trainers who would typically work for less, were not able to provide the quality training desired by the project. However, clinical training used government trainers and facilities to enable trainees to obtain necessary government certification. Project technical staff helped to oversee the trainings and provided onsite mentoring of trainees following trainings and later refresher mentoring during their supervisory visits.

The UHI implemented a variety of different types of provider trainings. These included contraceptive technical updates (CTUs) for both doctors and nurses. Initial CTUs provided an overview of contraception and other shorter “consultations” focused on one or more specific topics such as post partum and post abortion contraception or on specific methods including NSV or female sterilization. These were organized together with local FOGSI members and targeted to both public and private sector providers. In addition to local trainings, doctors and nurses from the District Women’s Hospitals were sent for state or national level training in post partum IUD insertion. Family planning counselors were oriented and trained, initially for the district women’s hospitals (DWH) in the eleven districts and later counselors for DWH in 41 districts were oriented and trained. The UHI also
provided infection prevention training at facilities, which were combined with whole site training described below.

- In Nigeria, training was conducted by a mixed group of experts consisting of NURHI technical experts, staff of a FP/RH NGO specializing in training and the State and LGA RH/FP coordinators, as well as some academic or teaching hospital staff. Government cadres of FP trainers were not available, but bringing these individuals together created a group who could be called upon for other future FP training. As NURHI moves to new States they intend to bring some of these experts to do training, depending on the local availability of technically competent individuals.

Initial assessments found that the majority of providers had been initially trained in FP many years before and most had not had any recent refresher training. As a result the providers from facilities (nurses and doctors) received a four-week intensive training on FP including both technical and interpersonal aspects. This was followed by on site supervision and mentoring. Later in the project period on the job training (OJT) were carried for new providers and those in smaller facilities. Shorter training and or mentoring during outreaches and supervision visits were also carried out. NURHI also implemented a five-day refresher training course for those who had earlier completed the four week course and a five-day post-partum IUD training for midwives and doctors at high volume sites. They also implemented a two-day training in contraceptive logistics management. In addition, both CHEWs (Community Health Extension Workers) and non-clinical providers received training in interpersonal communication and counseling skills. These training curricula are available on the NURHI toolkit website.

Responding to a need to reinforce provider training and to supplement supportive supervision, NURHI developed a cellphone distance learning training app for both clinical and interpersonal communication refresher training. This app had multiple modules with video clips showing examples of good and bad counseling, proper techniques for insertion of IUDs and implants etc. Initially they provided new cellphones to providers to support use of the App, but this was stopped during the last year of the project as almost all providers now have smart cellphones which are capable of displaying the modules. This App is easily available for download on the web and it is free to access. It has proved very popular and effective, so now NURHI is planning on using it more as part of its primary training and intends to encourage all trainees to have it installed on their phones. NURHI staff conducting supervisory visits to facilities will also encourage local providers to have it installed on their phones.

- In Kenya, the MOH had pre-existing regional multi-district training centers, the so-called Decentralized Training Centres, which would conduct residential long-term SRH training for
providers. This was usually project supported, but only trained one or two providers per district at a time. Tupange technical experts and trainers worked with these trainers to train more staff from the Tupange project areas, utilizing hotel based trainings so they could train greater numbers of health center staff over a shorter period. The providers who were trained then trained lower level staff in a classic cascade. Now with devolution, the government trainers and training centers do not necessarily correspond administratively with the new counties. Therefore creating training capacity in the counties, particularly where there was no a regional training center, will be critical during the TCI.

Tupange conducted several types of provider training. Contraceptive technical updates (CTU) provided in-depth training on a broad range of issues related to the provision of contraception including both technical topics and the provision of information and counseling for clients. These training sessions were followed by mentoring of trainees in their facilities to ensure that trainees had acquired the necessary competencies (especially for long acting reversible contraception). Another approach to provider training was through “in-reaches” whereby mobile teams- either MSI-Kenya or members of the District health Management Team- would visit a facility to provide LAPM contraceptives and use the opportunity train and mentor providers from the facility. This was an important means of increasing the number of providers with capability to provide IUDs and implants. Some health centers had only one trained provider prior to Tupange in-reaches, but by the end of the project had three or four who could provide them.

In addition, Tupange provided training to facility pharmacists and providers on contraceptive logistic management, use of the electronic Department of Health MIS system and the use of the project’s SMS logistics MIS system. Training curricula are available in the Tupange toolkit website.

• ISSU provided contraceptive technology updates to nurses, midwives, physicians and pharmacists. In addition personnel from 80 pilot pharmacies were trained to provide counseling on all family planning methods, as well as referral and to undertake some demand creation and follow-up activities. Members of the 16 Quality Assurance Committees created by ISSU were trained, as well as the providers and counselors involved in the integration strategy. Moreover, all community health agents (Relais) were trained on how to address rumors about family planning, how to conduct household visits and how to inform men about FP messages.

Sessions with journalists and other communicators were organized to orient them to deal appropriately with the most commonly raised family planning topics. The consortium partner Reseau Islam et Population provided training to religious leaders on appropriate interpretation of Islam’s position on family planning.
In Senegal, rather than using a specific cadre of master trainers, for all health care providers’ training needs (e.g. contraceptive technology update for nurses and midwives), the project relied on the pre-existing pools of master trainers from the MSAS, most of whom are also members of the regional and district management teams. This is in line with the existing policy and institutional mandate of the Ministry for all types of in-service training. The main role of the ISSU project was to provide the necessary technical and logistical support at all the steps, through active participation of the city managers and/or other project technical staff in the training sessions. The project also facilitated the production of training manuals adapted to the targeted cadres and supported all subsequent post-training activities, such as providing mentoring and regular supportive supervision for former trainees.

**Whole-site orientations** at facilities to create supportive environments and to reduce barriers to contraceptive use created by both clinical and untrained non-clinical staff were another important type of training implemented in Kenya, India and Nigeria. Training all staff at a facility on FP was needed as lower-level non-clinical staff typically reflect societal norms and biases against contraceptive use and they are the staff who are often the first and the most frequently in contact with potential users, especially during the post-partum period. Whole-site orientation was also used to facilitate appropriate referrals of clients for FP services through the Provider Initiated FP approach (described under integration of FP with other services). Trained providers at the facilities implemented whole-site orientations at low or no cost. In Kenya and Nigeria they typically employed a model of one hour session a week, at lunch time or after services were finished for the day, conducted over a period of several months, although Kenya had a curriculum with 12 modules that could be flexibly implemented at the facility. In contrast a one-time training of several days was used in India. In UHI this activity was combined with training on infection prevention. Non-clinical staff play key roles in infection prevention processes and this is a topic generally in need of increased attention in facilities in UP.

Whole-site orientation and quality improvement sessions in Kenya, India and Nigeria addressed client flow issues. This resulted in fewer women being turned away by receptionists and through better organization of client flow, waiting times could be reduced and more clients could be served in busy clinics.

**Frequent transfer of providers** following training was a major problem in Kenya, and in Nigeria. There was need to conduct continuous high level advocacy in Nigeria so as to keep providers in their facility for at least two years post training as well as to provide mentoring and refresher training and supervision at facility levels. As it was expensive to continually train new providers there was a need to develop effective onsite or self-learning options. Following the long and intensive initial trainings, NURHI focused on shorter refresher trainings and on the job training and supportive supervision for new staff and for additional capacity building. The in-
reaches and outreaches conducted by the NURHI supported health facilities also provided opportunities for peer to peer support and learnings. Tupange conducted mentoring activities through in-reaches consistent with national program policies.

**Provider bias** was identified as an important barrier to accessing FP services in all the four URHI countries. In India this was particularly directed to unmarried women, those recently married who wanted to delay childbearing, women with one or fewer children or to women wanting to adopt sterilization at low parity, while in Kenya and Senegal it was more for young and unmarried women. ISSU discussed the problem of provider bias with the national association of midwives (ANSFES) and they subsequently organized group discussions among midwives at the project’s service delivery points. This produced noticeable improvements as indicated by the results of the midterm evaluation. In Nigeria providers had biases against providing contraceptives to all of the groups mentioned above however, with supportive supervision this is gradually being minimized. It was specifically observed by UHI staff in India that providers’ bias was present despite their having received CTUs or training and having appropriate knowledge of national service delivery guidelines.

**Recommendations:**

6.4 Providing increased access and good quality services is dependent upon changing a wide range of prevailing provider knowledge, attitudes and practices in a complex system. It is a challenging process and one project is not likely to accomplish all that is required. It is important to recognize this and to assess where the critical gaps and obstacles are and what are the key capacity building priorities based on the project goals.

6.5 Often dedicated training resource experts or “Master Trainers” for FP are not readily available in government systems. It is therefore important to create pools of FP master trainers who are skilled in modern training methods, up to date on contraceptive technologies, and who are willing to work for government-level incentives or payments. Where government trainers are already available, they should be strengthened where necessary and utilized to the extent possible. At a minimum they should be involved in any training taking place during future expansion so as to build their competencies.

6.6 It is difficult and costly to remove providers from their service delivery points for long periods of training. One-time training is not likely to result in sufficient improvements and refresher training is usually needed. Efforts to build providers knowledge and skills through mentoring, routine supportive supervision and interactive technologies should therefore be pursued. On-site provider training- both initial training resulting from staff turnover and for updating provider’s knowledge and skills should be an important component of future training strategies.
6.7 TCI should explore adopting NURHI’s smartphone based distance learning modules for training in both interpersonal counseling and the technical provision of contraceptives, at least for other African countries. These could be relatively easily adapted to change the national dress and language of the films.

6.8 Training and mentoring needs to address persistent provider biases that are obstacles to contraceptive use - especially for young or unmarried women, for use before a first birth or use of long acting methods by women with only one or two children.

6.9 Whole-site orientation of all health facility staff in family planning can reduce barriers to contraceptive use and should be part of future efforts to strengthen service delivery.

Chapter 7: Ensuring contraceptive supplies and facility readiness

Ensuring availability of contraceptive supplies

Frequent and sometimes persistent contraceptive stock-outs were a barrier to FP use at the beginning of the URHIs. This was the case both at higher levels and at smaller, lower level facilities. All the URHIs made major efforts to address commodity management, through training providers and increasing the use of data to improve the logistics system.

• In Senegal, all the baseline studies showed that the issue of stock-outs constituted a major threat to the success of the initiative. At least 80% of all women who were using, or had ever used any modern contraceptive method had experienced unavailability of their method of choice, which often led to discontinuation. Similarly, many service delivery points had experienced prolonged stock-outs of DMPA (up to 210 days) or Jadelle (up to 300 days), which were used as tracer-commodities to assess the functioning of the contraceptive logistics and supply system. This led to the decision to test a new system, the “Informed Push Model” (IPM), which was found to help not only in eliminating contraceptive stock-outs, but also in improving the logistics management capacity of the facilities. This included improved reporting on monthly consumption, forecasting of future needs, etc.

It was noted, however, that routine availability of commodities was a necessary but not sufficient condition for increasing contraceptive uptake. Significant increases in contraceptive prevalence rates were only noted in the IPM city/sites of Pikine where other ISSU demand-creation and service delivery interventions were also being implemented. However, in Kaolack, similar increases were not observed in sites where only the IPM was implemented. This led to the recommendation to implement all the ISSU interventions in a
synchronized manner, even though the component on the Informed Push Model had already evolved into a separate project that has now expanded nationally.

- Kenya trained MOH pharmacists and providers in the principles of logistics management and developed a telephone based SMS MIS system to track commodities and promote appropriate distribution of contraceptive stocks and facilitate re-distribution among facilities. The SMS MIS system assisted the County Pharmacists/Reproductive Health Coordinators and project team in making appropriate distribution and redistribution decisions to minimize stock outs, making appropriate forecasting and quantification of commodity orders and facilitate improved FP commodity reporting rates to DHIS II. There has been interest in the MOH and UNFPA to promote a similar system nationally and UNFPA is currently supporting scaling up the system in a number of counties.

Now under devolution the purchase of contraceptive commodities is supposed to be by the counties and not the national/central government, but it is not yet clear how the logistics system and flow of procurement funds will need to be adapted in the context of devolution. Stock outs remain a problem in some counties as they have outstanding debts to KEMSA (from purchase of medical supplies and drugs), and hence KEMSA was not providing contraceptives or other drugs to them.

- NURHI’s project MIS management system used an adaptation of the Tupange’s SMS to track commodities and the project then redistributed or used the USAID “opportunity stock” of contraceptives to prevent stock-outs. The contraceptive commodity system in Nigeria is not very reliable and often contraceptives from the government are not available at the facility level. In fact, at the start of NURHI it had been promised that there would be no stock-out of contraceptives for all facilities covered by the project, but when the time came to start implementation, they were often not available due to weak contraceptive logistics management for distribution of FP commodities from the state to the LGAs. NURHI had to support these facilities while waiting for the delivery of their orders from the State or National level with the “opportunity stock” from USAID, particularly for in-reach/outreaches and as a buffer to maintain the no stock-out principle.

- In Uttar Pradesh, there were fewer problems with contraceptive logistics than in the other three countries, but at the beginning there were issues needing to be addressed including procurement by the State, and appropriate storage and distribution to facilities and providers at the district level. Under the UHI contraceptive supplies, the supply chain, and problems with distribution were formally reviewed twice during the project cycle. UHI also set up systems to regularly check on contraceptive availability, to ensure timely indenting and supply, and support the physical re-distribution of supplies from storerooms, depots, and
facilities where they were stockpiled to smaller facilities where they were in need. They also supported existing systems to account for their use.

However during the project there were lengthy stock-outs of free condoms and OCPs at public facilities. The condom is the primary spacing contraceptive method and second only to sterilization overall, but people knew where to buy low cost brands if supplies were not available. A lack of OCPs was more problematic because brands in the private sector were perceived as different and women did not realize they were equivalent or did not want to change brand. The prolonged stock-outs in UP were a result of problems with central level procurement, while more intermittent issues were due to local issues with distribution.

There were also stock-outs of the free CuT IUDs in some facilities, primarily due to distribution issues, as others had adequate supplies. UHI addressed this by facilitating the flow of these IUDs from sites with overstock to locations where they were needed.

**Recommendations:**

7.1 Logistics management to eliminate stock-outs and ensure that a range of contraceptive methods are available to meet clients’ needs is critical and will need to be addressed as URHI interventions are expanded to new geographies.

7.2 With potentially fewer resources under TCI, other solutions may need to be found to solve the commodity supply problem. This need is reinforced by the fact that because TCI will be working at the municipal district or sub-county level, leverage with national drug and commodity supply systems may be limited.

7.3 As the TCI moves to neighboring countries, variations in national contraceptive logistics and supply systems are likely to require significant adaptations in the interventions to ensure contraceptive availability.

7.4 Contraceptive security is a necessary but not a sufficient condition to achieve increased modern contraceptive use. As was clearly demonstrated in Senegal, it must be integrated with the implementation of both demand generation and efforts to improve access to and the quality of services.

**Facility readiness**

In all four countries smaller facilities are likely to need cleaning, minor refurbishment for counseling, privacy, running water and strengthening of infection prevention measures to be able to provide safe, quality services, especially for LARC. Higher-level facilities were often better equipped and likely to have running water and better sterilization technologies and practices.
However, they were observed to also need efforts to improve overall cleanliness and privacy for counseling. Private sector facilities were typically cleaner but in Kenya, Nigeria and Senegal they needed to be equipped to provide FP.

- NURHI instituted the “72-hour clinic makeover” to address the overwhelming need for improving FP facilities. Such improvements were critical for technical quality and infection prevention, privacy for women, cleanliness and to make the clinic a place that both providers and clients would be willing to spend time in. FP clinics in high volume sites were typically in the worst locales- next to the morgue, next to the garbage incinerator etc. Advocacy played a critical step in ensuring that the FP clinic was better situated within the facility. The 72-hour clinic makeover depended on involving local communities- both local donations of materials or other resources and the use of local artisans to renovate, clean, and paint clinics, with NURHI providing necessary medical equipment and supplies. This helped to provide community members with a sense of ownership of the facility. Nonetheless this intervention was relatively expensive and involved a great deal of organization by NURHI staff. As more attention was later placed on smaller facilities, these weekend makeovers evolved to become a modified 72-hour clinic makeover, sometimes referred to as “CRUFFY”, which was more limited and included cleaning, repair, update, and making functional existing equipment- as it was observed that many facilities needed some basic improvements, but not an entire physical makeover. Going forward, this modified 72-hour clinic makeover is more likely to be the predominant model due to more limited available resources. A few high volume private health facilities also benefitted from this activity. It also represents a more sustainable and scalable approach that could be adopted for TCI in Nigeria and potentially in other countries as well.

- In India, as noted earlier, the UHI trained facility staff in infection prevention procedures as shortcomings with disinfection and sterilization practices were major barriers to providing safe services. There was also a challenge in ensuring privacy for clients receiving FP counseling and in some cases for those receiving services. The UHI addressed this by developing a portable cloth screen in a folding frame to provide such privacy. The screen served a dual purpose as it was covered with information about the various available contraceptive methods.

**Recommendations:**

7.5 In future scale up attention to facility readiness will be essential. At lower level facilities some supply of equipment (e.g. for implant or IUCD insertion or for male and female sterilization) is likely to be required, as well as commodities including those for appropriate infection prevention.
7.6 Efforts to ensure basic hygiene and cleanliness are also widely needed, even at higher-level facilities in many places. This can be accomplished with available resources in most facilities or with those mobilized from communities.

7.7 Appropriate infection prevention procedures and provider practices are critical for provision of clinical methods and will require attention during scale up.

7.8 Actions to ensure privacy for clients during counseling and service delivery are often needed, but this does not always require a dedicated or separate room. If this is not possible, providing privacy screens can be an alternative where resources are limited.

**Chapter 8: Additional approaches to strengthening quality FP service delivery**

Increasing availability of and access to quality services at facilities and strengthening their organization and management were important interventions in each URHI. Prevailing problems included a need to reduce long lines and waiting times which were barriers to access in all countries. Long lines were often related to provider shortages resulting from human resource constraints.

Chapters 6 and 7 have already addressed major URHI interventions intended to strengthening service delivery related to provider shortages, training, facility readiness and contraceptive logistics. This chapter summarizes a number of additional efforts undertaken by the URHIs to improve facility management and make other necessary changes to increase availability and access to services.

**Organizing special service delivery days:** In India a major strategy was conducting so-called fixed service days (FSDs). These involved planning days at a facility on a regular schedule when a client could come to the facility and be ensured of receiving the desired family planning services—especially IUDs, vasectomy or sterilization. FSDs ensured the presence of sufficient numbers of counselors, surgeons, necessary equipment, contraceptives and commodities. This strategy was implemented at both government and private high volume sites and was very successful. In some sites it evolved so that every day became a FSD to ensure that a broad range of contraceptive could be obtained every day rather than only on certain days. The FSD strategy was consistent with the established “Static Day” strategy of the Indian FP program, but this needed to be “revitalized” as it was often not implemented in Uttar Pradesh.

The experience with FSD in India points to a more general lesson about the importance of efficiently organizing the delivery of family planning services as a key dimension of increasing access, availability and the quality of services. Strengthening quality is more than just the sum of specific technical interventions. Improving the organization and management of services can
make a significant contribution to meeting client needs, but of course these efforts must be adapted to the specific institutional context.

**Recommendations:**

8.1 The fixed service day strategy used in the UHI has potential for adaptation under TCI in other locations where providers are scarce.

8.2 The efficient organization of FP services is extremely important and needs to be specifically addressed in the future TCI. Required interventions are likely to vary significantly with the specific service delivery contexts.

**Outreach activities** were very productive in terms of reaching new acceptors in the four countries and addressing facility constraints. Outreach included efforts to provide integrated services in or near communities in all of the URHIs and “in-reaches” to small facilities (both public and private in Kenya) where there were few staff or where they were not yet trained in LARC as was the case in Nigeria, Senegal and Kenya. This made possible training and mentoring opportunities and assured availability of services to more distant slums or peri-urban communities.

Outreaches typically provided a broad range of MNCH and HIV diagnostic services. They were implemented in smaller facilities, in schools, churches or in various types of open areas. They brought in many women, especially with young children who might not have come if they only focused on FP. Through this means they were exposed to information about FP, and saw others accepting contraception. Integration of FP with other services also allowed women who did not want to be seen seeking FP services to obtain them under the “cover” of other curative services.

- In Nigeria, in-reachs and outreaches were important as a cover for women who were constrained by social norms against FP use to access services and also to bring services closer to them.
- In Uttar Pradesh, outreach services were organized at community health days, either in or nearby slums, and these provided many women with DMPA and IUDs. These were coupled with active referral and transport for women to obtain sterilization services at designated clinics.
- In Kenya, initial outreaches focused on only providing FP but they learned that the results in terms of contraceptive adoption through integrated outreaches were much better. Over the

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1 “In-reach” is the term used in Kenya when a mobile outreach team provides services at a smaller facility.
period of the project nearly 378,000 people were provided services through outreaches and of these over 76,000 received a contraceptive.

- In Senegal, the provision of FP through outreach services was a major organizational change in service delivery modalities. Initially, it was organized exclusively by the consortium partner-organizations, such as the Midwives’ Association, but during the extension of ISSU project activities to the districts of Diamniadio and Rufisque it was demonstrated that the District Health Management Teams could efficiently adapt this intervention, partly with their own resources. During the integrated outreaches, women’s first priority was often the health of their children and immunization, but if FP was also available, and given that it was free, they would also seek these services.

However, the URHI’s learned that prior community mobilization through CHWs/Social mobilizers/community volunteers/youth groups or other means was critical to the success of in-reach/outreach services. Experience showed that without a community mobilization component utilizing community workers or volunteers, turnout was limited and they were less successful.

**Recommendations:**

8.3 Conducting integrated outreaches to bring FP and other maternal and child health services closer to communities in need should continue to be a major strategy and receive support.

8.4 Community outreach services should be combined with community mobilization activities to maximize the number of participating women.

**Integration of FP with antenatal, delivery and postpartum care:** All of the URHI’S included efforts to strengthen the provision of family planning information and services during antenatal care (ANC) and the postpartum period. In all of the countries levels of utilization of ANC were high and many women who had been pregnant in the year prior to the endline survey reported having received FP information during ANC. The percentage of institutional deliveries is rising in the four countries, but they do not yet represent the majority of all deliveries and most women who do deliver at a facility do not stay long afterwards. FP information and counseling during labor and delivery is not generally appropriate or likely to be useful (unless requested by the woman). Therefore family planning counselors need to reach women on the postpartum ward before they depart. Counseling on the ward can be important in facilitating immediate postpartum IUD insertion, but hormonal methods including OCPs, DMPA and implants should not be started until 6 weeks after birth.

- The UHI tried to do address the need for postpartum counseling systematically by having counselors from the FP clinic specifically assigned to visit the postpartum ward every day. Another effort to promote immediate postpartum FP was the training of doctors and midwives from District Women’s Hospitals and other large facilities to insert IUDs in the
immediate postpartum period. This was a major focus in the UHI and the numbers of women accepting IUDs following delivery increased over time. It was particularly successful with Muslim women, as sterilization was not considered to be an option by them. However, it was reported that women interested in using an IUD were often reluctant to have an immediate postpartum IUD insertion, preferring to have it later in the postpartum period. At the same time some providers were reluctant to provide postpartum IUDs, believing that there were higher rates of expulsion, infection, and perforation with the procedure in comparison with interval IUD later in the year following delivery.

- NURHI also trained providers and promoted immediate PPIUD insertion but this option was not widely adopted by women.

Postnatal visits by women were less frequent than ANC or institutional delivery, but were a good opportunity for providing FP information, and linking women to counseling and services. These visits are particularly important as most contraceptives cannot be provided immediately following birth and in many traditional cultures women are reluctant to adopt a method in the first days after delivery. Unfortunately, relatively few women sampled in the surveys returned for early postpartum checkups, being more likely to return later for well child care and immunization.

**Recommendations:**

8.5 An emphasis on promoting and providing postpartum contraception is important for birth spacing and avoiding unintended pregnancy. However, under TCI increased efforts will be needed to promote postpartum contraception throughout the postpartum period of one year after delivery, as opposed to a primary focus on IUD insertion immediately after birth.

**Integration of FP and post-abortion services:** Although MLE survey data do not show high levels of reported recourse to abortion, other sources of data in all countries suggest that many poor women experience unplanned and unwanted pregnancies that result in illicit and unsafe abortions.

- In India, where pregnancy termination is legal under a broad range of circumstances, the UHI was highly successful in increasing post-abortion use of contraception and particularly the use of more effective methods, with a shift from condoms and OCPs to increased use of IUDs, DMPA and sterilization. Important activities included training CHWs to follow-up women in their slums who had obtained an abortion and to inform them of where they could obtain post abortion contraception. The UHI also updated providers’ knowledge so that they understood that IUDS could be inserted or DMPA injected immediately after an abortion.
• In Nigeria, NURHI trained clinical staff providing post-abortion care to also provide women with FP counseling and contraception.

• In Kenya, Tupange attempted to promote the provision of information, counseling and methods to women coming to facilities following an abortion. However, most urban facilities did not have the necessary equipment to provide post-abortion care or a dedicated service area and thus integration was not feasible.

• In Senegal, ISSU did not attempt to integrate FP with post-abortion care due to the political sensitivity of doing so. Other projects working on post abortion care emphasized contraception as part of comprehensive care.

**Recommendations:**

8.6 Future efforts will need to develop strategies to better address the issue of unsafe abortions and post-abortion care and to promote adoption of contraception after abortion or post abortion care. This should include promoting long acting contraceptive use (or sterilization if desired) immediately following abortions.

**Integration of FP with other health services** (e.g. child health, immunization and HIV/AIDS voluntary counseling and testing (VCT) and treatment) was a major focus of all of the URHI projects. Mechanisms for integration varied among the projects. When these specific other clinic sites were not too busy, FP information, counseling and the direct provision of contraceptive methods could take place. However in other circumstance it was necessary to establish referral mechanisms from these clinics to the family planning clinic within the facility and this was a common and successful approach to integration. These referrals sometimes raised client flow issues, but Tupange learned that if a referral slip was used, then the women referred could get priority and did not have to wait for long periods at the FP clinic. Integration of FP with well child and immunization clinics through a “no missed opportunities policy” was also successful. With this model all providers in facilities were trained in FP and used a short, systematic proactive assessment (see below) of women’s potential need for contraception. Identified women were then either provided services or linked by referral to the FP clinic in the facility. These within-facility referrals were important sources of new acceptors in NURHI, Tupange and the UHI.

A simple tool for providers to screen women for unmet need for contraception was initially used in both Tupange and the UHI and then later adopted by NURHI and ISSU. With this proactive approach, providers where trained to use a four question tool with every woman coming for child health services- asking her if she was pregnant or trying to get pregnant; if not whether she was using FP, and if not, why not and whether she was interested in learning more or considering adoption of a method. This helped staff to identify many women with unmet need and provided
an opportunity to inform and refer them for further FP information, counseling and services. In Senegal, a major step toward the institutionalization of this intervention has been to include this set of questions in several clinical tools, such as antenatal and postnatal care registers, child care/immunization registers, etc.

High levels of immunization and infant care visits provide excellent opportunities to reach women before the return of their fertility. Sometimes it is not easy to provide in-depth information or FP services in immunization clinics due to the noise, if many mothers and children attend. However it can be a good time to emphasize that if you are beginning immunization for your child’s health you should also start FP for your child’s health. If client loads were not too large, Tupange found that counseling and provision of some methods was possible, but if the immunization clinic was busy, referral to the FP clinic nearby in the facility worked well. Similarly NURHI staff reported that such integration of FP with immunization was a successful strategy.

ISSU trained community health workers as counselors to integrate family planning with immunization of pregnant women and children. However after one year this approach was abandoned given the lack of motivation of these counselors who expected additional compensation.

**Recommendations:**

8.7 Training providers and emphasizing the integration of FP with other services at health facilities can contribute significantly to increasing numbers of new acceptors. It is sometimes not feasible to actually provide counseling and contraceptives to new acceptors directly in these other clinics or services, but establishing an in-facility referral mechanism can make this feasible and effective.

8.8 Providers should be trained to use a simple screening tool to identify and refer all women with unmet need for FP who are coming for other postnatal, and infant and child health services, including immunization.

**Costs of services as a barrier to access:** The costs of contraceptives and FP services were a major barrier to FP utilization across the countries- including in both the public and the private sector. Although contraception is supposed to be free in the public sector in Nigeria, the costs of consumables used in the provision of methods was an important barrier to adoption and NURHI struggled to obtain local government funding for these. In Senegal, instituting one day each month when contraception, including consumables, was provided free of charge resulted in substantial increases in acceptance. In Kenya public sector FP is free but the efforts to strengthen the private sector provision of low cost FP services through social franchising still resulted in
substantial increases in new acceptors in the private sector in the larger cities of Nairobi, Kisumu, and Mombasa. In Uttar Pradesh not only are contraceptives free in the government system, but new users of male and female sterilization receive financial incentives. However efforts to provide low cost FP in the private sector did lead to increases in new acceptors from private sources. Providing clients information about where to obtain contraception from a choice of low cost providers, when services were available and the cost of these private services was critical in facilitating uptake (see more in-depth discussion of the private sector in the next chapter).

**Recommendations:**

8.9 Costs of services including both contraceptive and associated commodities (even when contraceptives are free) can be significant barriers to use of FP by the poor. During future expansion under TCI, efforts to reduce or eliminate the costs of contraceptive use by the poor will need to be implemented.

8.10 Clear information about options for where to obtain contraception, the time of availability and the prices of services need to be made easily available to prospective clients among the urban poor.

**Chapter 9: Working with the private sector**

One of the key objectives of the URHIs was to increase the private sector share of the contraceptive market in the four countries. However, involving the private sector in providing quality family planning services for the urban poor proved to be difficult in each country. The nature of the private sector varied greatly from country to country, as well as within countries—from state to state and district to district. This required not only differing interventions but also considerable prior effort to assess the private sector context in each country. In comparison the public sector was more homogeneous within each country.

- In India, the UHI implemented a variety of approaches to strengthen the availability and utilization of private sector FP services for the urban poor. One approach was working with independent private providers and nursing home facilities to increase their motivation and capability to provide contraception. This involved making contraceptives available to them at below market prices (or transferring free government IUDs for fixed service days) and to collaborate with FOGSI (Federation of OB-GYN Societies of India) who conducted contraceptive technical updates for private providers and played a leadership role in promoting the provision of FP at low cost. These leaders were prominent, often academically connected and more willing to provide low cost services on specific days as a social good. The UHI learned that younger general doctors with fewer clients could also become
motivated as the provision of FP helped to publicize their general practice and the other services they provided.

The UHI also worked with a prominent trust hospital in one district to provide services to slum residents and entered into collaboration with two not-for-profit private reproductive health service networks, Janani and PSS. UHI urban ASHAs referred clients from their slums to these services. However, a number of problems were encountered with these networks, both in terms of their reaching agreed targets and with regard to administrative issues. Both provided far fewer female sterilizations than expected, although they greatly surpassed targets for IUD insertion and provision of DMPA. Both of these financial agreements were eventually discontinued but the collaboration continued with active referrals of women from the slums and these clinics continuing to serve slum residents.

A major obstacle to engaging the private sector in providing contraception was the issue of government accreditation. This was critical for private providers to be able to receive government payments or incentives for the provision of different types of contraception. These payments were necessary for the providers to consider making their services available free or at low cost to the poor. In the later years of the project, at least in part due to the UHI’s efforts, accreditation became more streamlined and the number of private providers significantly increased, as did the number of women served by these providers.

The UHI learned it was important for clients to be provided with information about where private clinical FP services can be accessed, the clinic hours, and the prices for services. The poor were often unaware that private providers provide contraception (FP is often seen as a public sector service), or that they provide it at a low cost to the poor and they may not be aware of the more flexible hours. Thus providing poor slum residents information about where specifically they can access low cost private clinical FP services is important in increasing utilization. In UHI slums the CHWs distributed handbills listing addresses of nearby providers and clinics that provided FP and MCH services to the poor, the costs of specific services and the hours of the clinic.

Another approach to promote the private sector were efforts to promote the sale of socially marketed condoms (the most frequently used reversible method of contraception in India) and oral contraceptives (OCPs) at both traditional and non-traditional outlets (NTOs) such as small kiosks in the slums. Sales of condoms increased markedly over the project but there were low volumes of sales of condoms and particularly of OCPs in NTOs, as everyone already knew where they could be obtained near the slums.

- In Nigeria, very few private medical doctors, apart from Obstetrician-Gynecologists, are interested in providing contraception and very few do so even if they have interest in FP.
When they do, it is typically as a means of generating new clients for their general practice. NURHI created a Family Planning Providers Network (FPPN) of prominent FP providers as a platform for interaction between private and public providers and across professional cadres of clinical & non clinical providers. This network stimulated a great deal of interest among the private sector providers and was able to play a leadership role in promoting FP in the States and LGAs where the project was working.

At the same time a large vibrant non-clinical private sector of pharmacies, drug shops and patent medicine vendors (PMVs), who are a mix of individuals selling drugs and traditional medicine, exists in urban areas. They provide over half of the contraception in Nigeria, primarily condoms, emergency contraception, as well as DMPA, as some of the patent medicine vendors are actually retired or unemployed nurses or CHEWs who can provide injections. NURHI initially attempted to have these private sources refer clients for initial provision of contraception. However, this did not work so in the next phase, NURHI 2, they will be training PMVs and focusing on having them provide appropriate information on FP, including on LARC to potential new FP acceptors. NURHI was able to involve and collaborate with existing PMV networks in Ibadan, Ilorin and Kaduna and in NURHI 2 plans on expanding the network by working with the TBA association in Lagos to promote family planning.

- In Kenyan urban slums there are a variety of private clinics and providers, including nurses, midwives and physicians, as well as unregistered and untrained private providers. Tupange trained the formal private sector in FP, provided free or subsidized equipment as needed, and linked private providers with government so they could access free contraceptives. They also created a branded socially marketed private network of facilities and private practices known as “AMUA-Tupange” clinics. The project conducted outreaches at these clinics to create a “buzz” in their communities and an opportunity to train and mentor providers in LARC. Tupange leadership viewed the experience as a mixed success. It was not clear if support for the AMUA facilities was cost effective, as opposed to implementing outreaches held directly in communities and in-reaches at public facilities. When they scaled up to new counties the formation of AMUA networks was dropped as there were not enough private providers in the new more rural districts to make it worthwhile. However, they continued to collaborate with MSI-Kenya to ensure implementation of MSI-Kenya funded outreaches to smaller public facilities in these districts.

- In Senegal, the baseline population-based studies had shown that the private sector was the source of supply for up to 25% of clients who were using -or ever used- modern contraceptive methods. ISSU’s efforts to involve private sector in the provision of FP services through clinics and pharmacies located in poor urban areas have also had mixed success, and the methods of work of the consortium partner responsible for this area, may
have been part of the problem. For example, only 30 private clinics located in three suburban districts in Dakar were accredited in the Blue Star network, indicative of the low coverage of this intervention. The MLE midline survey revealed that only 11% of women were then obtaining their contraceptives from the private sector.

The introduction of a social franchising network as well as the provision of services through the outreaches or through pharmacies was one of ISSU’s promising innovations. It improved quality of and access to FP services and broadening choices of contraceptive methods through the provision of LARC methods. ISSU’s efforts to involve the private sector in the provision of services for the urban poor have contributed to repositioning family planning even though the relevant interventions could not be retained in the “paquet porteur” because they scored very low in terms of effectiveness, efficiency and sustainability. It is also important to note that all the DHMTs interviewed expressed concerns about the persisting reluctance of the private sector to share the data from their SDPs for inclusion in the statistics of the district. This reluctance makes it difficult for the DHMT to provide a complete picture of progress made towards reaching the targets set for each district and their respective contribution to achieving the goals of the national FP strategic plan.

Despite the variation in the private sectors and in the types of interventions that were pursued by the four URHIs, a number of common themes and lessons learned emerged.

The need to map and understand the private sector: It is critical to understand the factors that influence the motivation of private sector providers. A central lesson is that these factors are often quite varied and therefore learning how the private sector works is a major task. All the URHIs needed to start by mapping private sector services; understanding who were the providers providing FP, who were potentially willing to provide low cost to the poor, and the fees they charged. It was also necessary to assess their level of knowledge and skills in order to determine the need for updating or training. In this context NURHI supported the National MOH in collaboration with Society for Family Health to develop a modular training programme for private clinical providers.

Mechanisms of support: In general, the experience in the four countries showed that private providers need at least some training, whether contraceptive technical updates or more basic training. They also required mechanisms to support contraceptive logistics so as to ensure that they have contraceptives available at their place of practice. Perhaps most important were mechanisms to increase their motivation, including incentives for private providers of clinical methods to provide them at low cost to the poor. One means of increasing margins for private providers was by giving them free contraceptives, as well as other commodities and equipment required to provide services. Providing contraception takes time if done appropriately with the provision of information and counseling, and thus has low profit margins. It is a social good but
not a major profit maker for providers so they need to have incentives to provide contraceptives at low cost.

**Promoting the private sector:** The promotion of private sector services was also important, whether through branding and social marketing of private provider networks in Kenya, the danglers promoting a clinic site in NURHI or by having CHWs distribute information sheets publicizing clinic addresses, hours and fees charged in UHI supported slums. Clients need information about where private clinical FP services can be accessed, the clinic hours, and the prices for services. The poor are often unaware that private clinics practices provide contraception (FP is often seen as a public sector service), or that they provide it at a low cost to the poor and they also may not be aware of the more flexible hours. Thus providing slum residents information about where specifically they can access low cost private clinical FP services is important to increase utilization.

**Professional associations** can play an important role in supporting quality FP programs as was learned working with FOGSI in India and with the Family Planning Providers Network in Nigeria. Leaders of such associations are typically prominent, often academically connected and perhaps more willing to provide low cost services as a social good, as they also provide contraception at high prices to their wealthy clients. Not only are they potentially influential in changing norms in their professional communities but can be effectively mobilized to provide contraceptive updates and “training” acceptable to their peers.

All these actions helped expand utilization of private services, as well as making it more attractive for private doctors, midwives and nurses to provide FP services.

**Recommendations:**

9.1 During expansion to new geographies a critical first step in engaging the private sector will be the mapping of private sector providers, learning who is likely to serve the poor, assessing their knowledge and skills and the factors related to their motivation. It will also be important to learn who from the communities are already accessing private services and where they are doing so. This will facilitate strategic selection of providers to engage with and support.

9.2 It is important to actively promote providers, facilities or networks that provide contraception to the urban poor at low cost and to find means of supporting them.

9.3 Providing information to the client population on the location, hours of operation and prices of low-cost private services is essential. Effective mechanisms for this need to be developed as expansion takes place.

9.4 Professional associations can play an important role in supporting quality private sector FP services for the urban poor and should be engaged in future expansion to new geographies.
Chapter 10: Issues not given enough attention

In spite of the very comprehensive approach of the URHIs and the wide range of project interventions that were implemented, the project leadership identified several areas, which in retrospect, they felt should have been addressed and which in future expansion require more attention.

Adolescents and Youth: Addressing the family planning and reproductive health needs of young people was not a primary focus of original URHI design and was not included as a formal project objective. Although some of the URHI interventions served youth, particularly in Tupange, the teams in all of the countries felt that greater emphasis should have been placed on this group. A large proportion of urban slums consisted of adolescents and youth who were unmarried and the URHI teams felt that future efforts should address these populations in a more comprehensive manner. In India young people were addressed to a certain extent in that many youth in the slums were married, but UHI specifically decided to not focus on unmarried youth because it was thought that this would not yield large numbers of new acceptors. In Senegal, a strategic choice was made not to focus on providing services to unmarried youth at the beginning of ISSU in order to safeguard the newly forged alliance with the religious leaders and their support for child spacing. In Nigeria the Youth Urban Mobilisation strategy under the demand component provided a platform for engaging young people who were also within the age bracket of women aged 15-49 years where NURHI intervened. They were actively involved in community visibility parades and were an important part of the social mobilization activities. A few community events such as football matches across city groups were notable but did not produce significant effects.

In Kenya, more of the Tupange interventions where targeted toward adolescents and youth. These included the Shujaaz comics and the Jonga Love radio series and the related Facebook social media campaign supporting these mass media activities. In addition Tupange organized youth groups for community mobilization and dissemination of information through radio, theater, dialogue and action days, Mutani (street) walks, and other edutainment approaches. Tupange also organized activities for youth such a sports events, beauty pageants, and bicycle races. Despite this wide range of activities the Tupange team members nevertheless felt that in the future it would be important to have even more focus on serving youth in slums.

Central role of men in FP: The MLE baseline and endline studies also included surveys of men and the questionnaires for women also included questions about whether women needed to obtain approval or permission from their husbands to adopt contraception. However, the initial URHI interventions did not include interventions that explicitly focused on the role of men as gatekeepers to contraceptive use beyond a more general inclusion of men as secondary targets of some of the demand creation activities. The UHI added activities which focused on mobilizing men to accept vasectomy through reaching them at places where they gathered for work.
Promotion of vasectomy emerged as an important facet of the UHI. This was not so much due to the actual number of new acceptors, but rather that they demonstrated the feasibility of reaching men. By the end of the project a significant proportion of all new acceptors of vasectomies in UP were a result of the UHI. However, the UHI Project Director stated that they wished they had paid greater attention to the role of men, beyond their initiative on vasectomy. They came to greatly appreciate the importance of the role of men as gatekeepers for use of family planning by women, the role of men in terms of sexual violence in the communities. A qualitative study at the beginning of the project showed that spousal communication was high which was the reason for dropping plans for a major effort to address spousal communication.

- In Nigeria, the role of men also emerged as a critical issue. The data from the MLE endline survey and other special studies, as well as the voices of community members strongly highlighted the critical roles of men in family planning- including the influence of spousal communication on contraceptive acceptance, the role of men as gatekeepers and the importance of spousal consent for contraceptive use by women. Men were engaged as part of the key audiences during multi-media campaigns and advocacy interventions.

**Sexual violence and rape:** The initial URHI design did not address sexual violence including rape and the MLE surveys did not address these issues. The UHI Project Director felt in retrospect, that the project should have included greater focus on sexual violence in the community, as this was pervasive and a critical issue when promoting family planning. Women’s lack of autonomy in deciding when to have sex and whether to use family planning, were intimately tied to domestic violence in India. However she felt that the project had not been prepared to address these issues, as they did not have good data of the actual levels, the critical determinants of domestic violence, or sufficient knowledge about what effective interventions could be implemented in the urban slum settings. Subsequently the authors have learned of data from slums in Bangalore revealing the very high prevalence of domestic violence, often related to FP use and of successful interventions that have been tested to address this. Furthermore in Uttar Pradesh, Population Services International (PSI) also has a new project that is addressing violence against women. The Project Director also felt that more effort should have been given to promoting emergency contraception, particularly given the reported high levels of rape in the urban slums.

Although the issues of domestic violence against women and rape were not raised by the other URHI staff during our visits or the interviews, it is likely that high levels of domestic violence are experienced in the urban slums in the other three countries as well. This deserves further study and attention in the future, as it is likely to be strongly related to successful contraceptive use and the sexual and reproductive health of women.
Furthermore, if the levels of sexual violence and rape in urban slums across countries are indeed high, an important unaddressed SRH issue is the need for health workers to be trained in providing emergency contraception and post exposure prophylaxis for prevention of sexually transmitted diseases and of HIV infection.

**Recommendations:**

10.1 TCI should learn from URHI experiences and other projects addressing youth in the countries, as well as from the growing international experience with youth interventions, what interventions can be feasibly added the toolkits to ensure access for to contraception for young and unmarried people.

10.2 Further analysis of the MLE data related to men’s role in family planning should be conducted and used in TCI to adapt or develop necessary FP demand generation messages that promote spousal communication and approval of contraceptive use by men.

10.3 There is need to learn more about the epidemiology of sexual violence in urban slums in the four countries and what interventions have been tested and been successful. It may be possible to learn from these experiences and to strategically add feasible components to TCI intervention packages.

10.4 Given the likely relatively high prevalence of sexual violence, rape and STIs in urban slums, it will be important to ensure that providers have some training in the appropriate care and initial management of these issues and that emergency contraception and antibiotics and anti-retrovirals for prophylaxis and treatment of STIs, including HIV are available.

**PART IV. USE OF DATA FOR DECISION MAKING**

**Chapter 11: Using data for designing the interventions**

As noted in Chapter 3, the use of data for the initial design of the interventions, as well as the management of activities and the adaptation of interventions over the course of the projects was a foundation of the overall URHI concept. In this chapter we discuss in greater detail their use in designing the URHI interventions.

The URHI projects each had an extended initial period of up to one year when they reviewed available data and past program experience to better understand what were the most appropriate
and potentially effective interventions, arriving at a subset of those under initial consideration. National and locally available data and relevant literatures were reviewed, special studies were conducted, key stakeholders consulted, and support and input from external experts was obtained. This included some socio-cultural research (in addition to the MLE baseline), mapping of public and private facilities and their resources, and their needs for strengthening, as well as other efforts to understand the social and institutional context.

Staff considered this process to have been very important in developing and fine-tuning interventions to meet the local contexts and needs. At the same time at least one key staff person (city manager) in Nigeria thought this period was too long as it delayed the onset of implementation. In India, the period was seen as valuable, but also generally perceived as too long.

The MLE baseline survey results were intended to play an important role in providing data for developing the interventions and demand generation materials. MLE baseline data analysis was available and was felt to have been extremely important for these tasks in Nigeria. However in India, Senegal and Kenya implementation of the survey was delayed until well after design of the interventions and the beginning of program implementation. For example in Senegal the interventions were conceptualized based on the existing results from the 2005 Demographic and Health Survey, monitoring results from the government’s health MIS and other national studies. Data from the MLE baseline were available approximately one year after implementation began and were used at the end of the second year to refine the interventions and to prepare the third year work plan. A UHI manager highlighted the value of using existing and already widely accepted Indian data as the basis for planning, given the extensive availability of reliable sources of information.

Although acknowledging the importance of data for the design and adaptation of interventions to new geographies, an Uttar Pradesh UHI leader also argued that there are some interventions that TCI can start with that do not need a great deal of new data in order to expand to new districts in UP. For example, interventions for strengthening service delivery are basically common to a particular health system and will not need a great deal of adaptation. New cities and districts in the same state/country can start with training and establishing counselors in facilities, start to implement fixed service days, provide infection prevention and whole site training, use IEC materials previously developed by the UHI, and then bring in community mobilization as this is a critical component. Activities can also start with medical colleges, as they tend to be more innovative than the ministry and are opinion leaders. Furthermore, a great deal of health and FP data is already available in India, including the recent DHS with data for all states, and the Annual Health Surveys. In these annual reports urban and rural data is subdivided. Other available resources include mapping of facilities, providers, and slums and the former UHI staff know where and how to access these data. The basic lesson is that in some settings, working in
the same health system and social context results in many common needs and interventions that do not need a great deal adaptation.

At the same time, in future expansion, there will also be a need to assess what are the needs, priorities and appropriate interventions in new geographies, whether in different contexts in the original URHI countries or in neighboring countries.

In the future under TCI there will also be a need to understand the local context, so as to adapt the toolkit interventions as necessary and to map facilities and their resources when expanding to new districts, counties or countries. To facilitate rapid expansion this will have to be based on a minimal process of review of what data are available in country. New cities, districts, or states will not have the luxury of six months or one year landscaping and preparation. Thus a critical task will be to ascertain the minimum package of new information, data, landscaping or mapping required to give enough information to design the program, as well as the time required to undertake such an assessment.

The Gates Foundation and NURHI, in preparing for scaling up a very similar package of proven interventions for the peri-urban and rural areas of Kaduna state where they had implemented urban activities and the new scale up state of Lagos, spent $2 million over a period of about nine months on data collections and special studies for “landscaping” covering public and private sectors, marketing and regulations, and new channels for expanding access. Even though this is not a feasible model for future expansion, it is indicative of how important and valuable it is to understand the local context.

An example of a rapid assessment was the “diagnostic de base” used by ISSU and the district teams to prepare for the extension of ISSU interventions to the additional districts of Diamniadio and Rufisque. It used simple tools to collect information on how to select appropriate interventions from ISSU’s package, to assess the District Health Management Team’s interest in leading the initiative as well as the existing condition of service delivery, community needs and available partners. However, the team felt that this exercise should involve additional key stakeholders, such as local municipalities, to get their buy-in in order to enhance the sustainability of the selected community-based interventions.

**Recommendations:**

11.1 As part of initial review and collection of data to either design or to adapt interventions from a toolkit, it is extremely useful to gather relevant data from already available sources, such as Demographic and Health Surveys, other national or local health surveys, research reports and MIS data.
11.2 An early activity of the TCI should be the development of a common framework for a rapid assessment of FP needs and priorities, together with guidance for the mapping public and private facilities and their available resources. The assessment and mapping tools and related guidance should be based on prior experience in the four URHI countries. Following development of a common generic tool and guidance for the common toolkit, the TCI Hubs should be supported to develop more specific rapid assessment and mapping tools for their geographies.

11.3 Implementation of the rapid assessments and mapping should be undertaken in collaboration with local government partners and other stakeholders.

Chapter 12: Monitoring and evaluating the interventions: using data for program management

The use of monitoring and evaluation (M and E) data played a critical role at multiple stages in the URHIs, including for managing the activities and making mid-course corrections. All four countries placed great emphasis on the use of data for decision-making and helped to strengthen local capacity to do so. Flexibility and adaptation of interventions and how they were implemented, based on learning were necessary for early success and even more so during the process of scale up. Such a data-driven approach was strongly endorsed by the BMGF.

Each project utilized a variety of robust sources of data to monitor implementation and the results being achieved. These included the MLE midline and endline surveys including surveys of women and facility based surveys of providers and client exit interviews. The MLE grant was designed as an impact evaluation intended to measure increases in contraceptive use and to contribute to the evidence on what works and does not work (and why) for serving the urban poor with FP. It was originally intended to keep this partner separate from the implementing partner. About one and one half years after the grant had been launched the BMGF also began to give greater importance providing data that could inform programming.

A key lesson learned from the MLE evaluations was therefore the importance of not separating the external evaluators from the implementers, especially early on when the baseline was initially designed. In India and Kenya URHI staff felt that the three survey rounds did not adequately reflect operational issues that could be changed or adapted during the life of the project, perhaps in part because communication with MLE had not been sufficient early on and MLE colleagues did not know enough of the fine details of program implementation. Overall, MLE midterm data were most useful for making mid-course corrections related to demand-side activities. Given the more limited data collection on supply-side activities, the data were less useful for making mid-course corrections related to the nature and quality of services.
Other sources of data included locally commissioned surveys and research studies, special in-house M and E systems and other data collection, as well as the use of service statistics collected as part of routine health MIS data. Another critical source was routine field visits and observations by staff.

All four projects regularly reviewed monitoring and services statistics and adjusted work plans accordingly. In addition, each had a specific mid-project review, coordinated with the presentation by MLE of midline survey results. These workshops provided important opportunities to review the initial population based results. However, in order to make appropriate mid-course corrections it was important to combine analysis of MLE data with other information, especially observational and service statistics from routine and special sources.

Having locally owned data was very important to the four URHIs. Helping the local health authorities to use their own service statistics to show success was often even more important for advocacy, program management and scale up to new areas in Kenya, Nigeria and India than external surveys and research. In Nigeria the team reported that national level decisions by the Federal Ministry of Health (FMOH) are only made when there is Nigerian data to show effectiveness of the intervention. The NURHI team presented the MLE endline evaluation results to the FMOH body that determines changes in national policy and norms in order to promote national level institutionalization and adoption. In India, MLE data were always shared in tandem with data and information already accepted and owned by the government, to validate similar trends in progress and achievement.

In Senegal, however the results of the DHS 2014 were very important in highlighting the significant contribution of the project to the sharp increase of mCPR in urban areas, particularly from the western part of the country (Dakar and Thies regions).

A problem faced in the four countries was that national health MIS systems face many difficulties and are typically not considered to be accurate reflections of reality- due to under reporting, biases toward reporting from stronger areas with higher capacity, infrequent feedback, and the falsification of data. All four URHIs undertook efforts to improve the capacity of health staff to present and use available MIS data for program management both in the facilities and at higher levels. This generated attention and increased interest in FP achievements, brought attention to those performing well and was received positively, especially in India and Nigeria where MIS data had not been functioning well or were little used at lower levels.

In India, having data to show achievements led to recognition from higher levels and increased decision makers’ interest in FP. For example, the UHI’s success in promoting and providing vasectomy in UP was a major topic of interest and gained attention from senior officials, as project cities in the last two years accounted for the majority of new vasectomy acceptors in the
state. ISSU’s painful experience during the Senegalese Health Workers’ Union action/strike in 2013 showed the vulnerability of relying on the government MIS system, as the Project together with other government programs “navigated in the dark” for many months because the Union had used the withholding of MIS data as leverage for their negotiations.

Because of the problems with the reliability of routine MIS data, all four URHIs made intensive efforts to gather complementary data from other sources. For example, UHI commissioned six-monthly surveys of women in slums where they were working, gathering a few key variables to monitor outcomes and achievements. As scaling up proceeds under TCI it will be important to reflect on the experience gained with these intensive M and E efforts that were not a part of routine program implementation and to learn what are the minimal data that will need to be collected (if any) outside of existing MIS systems for TCI.

MLE survey data was collected in each of the core cities as well as in two additional scale up cities in each country. In the future there will be a need to have basic data for assessing implementation and outcomes in all cities under TCI. There is a plan to use PMA2020 survey data in cities where it is already collected, and perhaps to commission additional data collection in some of the expansion cities. However because PMA2020 is not likely to cover all TCI cities, some additional data collection may be needed.

**Recommendations:**

12.1 As population based data from MLE will not be available and PMA 2020 is only implemented in some states and districts in some countries, data from routine MIS systems will have to play an important role for mid-course corrections. Thus simple approaches to strengthening the reliability of local MIS systems and efforts to increase the capacity of local health staff to present and use them for program management will be critical. This will be particularly important as government data can be highly influential, if not necessary, to gain the attention and support of policy makers and program managers.

12.2 Collaboration with other stakeholders working in the same contexts to collect and share data will be required to avoid duplication of efforts in TCI.

12.3 TCI will need to assess what minimal data should be collected in moving to different areas within a country or to new countries to understand how variations in socio-cultural and health system contexts should influence selection and adaptation of interventions.

12.4 Simple qualitative studies of the process of scale up to complement the MIS and PMA2020 quantitative data up will be useful to learn and make any necessary adaptations or corrections in implementation.
Chapter 13: Adaptation of the interventions to lessons learned: the role of mid-course corrections

Consistent with the URHIs’ use of data and their functioning as learning organizations, they all made significant changes over time in the packages of interventions, in addition to making adaptations in specific interventions. These changes contributed substantially to their success. Examples of the types of changes or adaptations made during the course of implementation are as follows:

• In India, UHI “spot checks” and six-monthly monitoring surveys indicated that there were pockets of slum households that were not being reached. As a result they undertook additional mapping of slums and poverty clusters to identify those not being served. The UHI then reallocated or trained new CHW to serve these households. Furthermore, they realized that informal commodity outlets were not providing significant numbers of condoms and OCPs, as everyone knew where to find them and were purchasing them at traditional outlets such as drug shops and pharmacies. In addition, because UHI’s social marketing partner HLFPPPT’s condom distribution work was funded by NACO statewide, HLFPPPT was dropped as a financial partner but collaboration continued.

The Happy Dampati mass mobilization activities were also dropped because they were found to be taking large amounts of staff time, providing few new acceptors as they focused on mobilizing current users to be filmed for “satisfied users” TV spots. When analysis of the midterm survey showed high numbers of both new acceptors and discontinuing contraceptive users, the UHI adjusted their strategies to place greater emphasis on supporting contraceptive continuation.

• In Kenya, there were a number of interventions that Tupange dropped or adapted early in the project when it was clear that they were not working. For example they discontinued working with pharmacists and mothers’ clubs, as these were not producing many new acceptors but were costly.

• In Senegal, in the work with religious leaders ISSU decided to drop TV debates among scholars to avoid exacerbating the divide with extremists. Instead, they concentrated on organizing talks in the communities and on radio, as well as supporting Imams to deliver messages on FP and child-spacing when preaching in mosques. Similarly, some demand-creation activities that were initially organized by health care providers (conversations with community groups, theatre forums) were also dropped and emphasis shifted to the community health workers helping mobilize the communities in preparation for the special FP services days.
• In Nigeria, there was an ongoing focus on using various sources of data as a source of learning, including operations research studies to refine or adapt implementation. One intervention that was dropped was working with PMVs and pharmacists to have them counsel and refer women to clinical services. However, in the future NURHI will test whether PMVs who have a clinical background (retired nurses and midwives) can provide counseling on contraception including for long acting methods.

Adaptation of interventions as part of the process of the scaling up strategy or in the management of scaling up is discussed later in the Chapter 15.

**Recommendations:**

13.1 A focus on learning, using available data to determine how interventions need to be adapted to be most effective, should be an important emphasis in TCI.

**PART V. IMPACT OF INTERVENTIONS**

**Chapter 14: Analyses of impact**

**Increases in contraceptive use:** MLE results\(^2\) show that the URHIs achieved substantial increases in both modern contraceptive use and long acting and permanent method use in their core cities and in the scale-up cities where data were collected (Figure 14.1). In general, increases in mCPR and LAPM in all countries were greatest among the poorest segments of the urban populations, which were the primary focus of the URHIs (Figure 14.2). The largest relative increases in mCPR were often in countries and cities with the lowest levels of mCPR prevalence at baseline (see Annex I, Figures A.1 –A.16 for graphs showing data by city for each country).

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\(^2\) See the MLE final reports of URHI endline surveys from Nigeria, Kenya, Senegal and Uttar Pradesh, as well as other related unpublished reports and publications available at the MLE website [https://www.urbanreproductivehealth.org](https://www.urbanreproductivehealth.org).
It should be kept in mind that the MLE baseline and endline estimates of increases in contraceptive use were based on longitudinal surveys and did not correct for aging of the study population. Women in the baseline cohort all aged five years and thus the endline survey no longer has a cohort of young women ages 15-19. Therefore, the total sample “aged” and moved into age groups more likely to use contraception. Thus, the positive changes observed in mCPR are likely to be overestimates of the true impact of URHI interventions. This phenomenon was observable in India where both longitudinal and cross-sectional endline surveys were conducted. The increases observed in modern contraceptive prevalence in the cross sectional endline survey were lower than those in the longitudinal survey. As future impact of TCI on mCPR will have to be estimated on the basis of available cross-sectional surveys (e.g. the PMA 2020 or DHS)

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3 see unpublished MLE graphic analysis of age specific modern contraceptive use in the four URHIs and unpublished discussion paper “Understanding changes in modern contraceptive use in Kenya with the varying data sources” MLE 2015, unpublished, provided by Lisa Calhoun in an email dated 4/12/16.
surveys) or other means including service statistics, this overestimation of mCPR due to aging of the longitudinal cohorts should be kept in mind. In other words, even with similar inputs, observed impact of TCI can be expected to be lower if the results are from cross sectional surveys.

The relatively low rates of survey respondent follow-up at endline in three of the countries should also be taken into account in interpreting increases in contraceptive use. Despite extensive MLE efforts to ensure that all women were re-interviewed, between 59% of initial respondents in Kenya, 66% in Nigeria, 74% in Senegal and 84% of these women in Uttar Pradesh could be located. While the re-interview rates for India were relatively high, those for the others and especially Kenya were lower. This is not unexpected due to high rates of mobility among the urban poor, but there may be differences between migrants and more stable households that could introduce bias to the results. For example, women who are long-term residents may be more likely to be exposed to the program and to use contraception.

**Multivariate analysis of the impact of URHI:** The Challenge Initiative would benefit from a clear picture of which of the URHI interventions were most impactful. The table below presents the available results of the MLE multivariate analysis of the marginal effects (ME) of exposure to various program components. They indicate the change in the magnitude of the probability of using modern contraception if the average woman were switched from non-exposure to exposure to program interventions.

<table>
<thead>
<tr>
<th>Program component (exposure)</th>
<th>Marginal effect</th>
<th>% Exposed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tupange</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heard Jongo Love radio program</td>
<td>8.5**</td>
<td>7</td>
</tr>
<tr>
<td>Discussed FP with a CHW</td>
<td>5.5*</td>
<td>13</td>
</tr>
<tr>
<td>Seen or know about Amua health facility</td>
<td>3.1w</td>
<td>46</td>
</tr>
<tr>
<td>Tupange health facility within 1.5 Km.</td>
<td>2.9*</td>
<td>68</td>
</tr>
<tr>
<td>Exposure to FP information at a community event</td>
<td>-</td>
<td>48</td>
</tr>
<tr>
<td>Saw Tupange Poster</td>
<td>-</td>
<td>32</td>
</tr>
<tr>
<td>Attended meeting about FP</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>Read or seen Shujaaz</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Saw brochure with Tupange logo</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td><strong>NURHI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heard NURHI Radio program</td>
<td>4.3***</td>
<td>75</td>
</tr>
<tr>
<td>Attended Community outreach/events</td>
<td>3.5***</td>
<td>33</td>
</tr>
<tr>
<td>Saw NURHI provider badge</td>
<td>3.2*</td>
<td>26</td>
</tr>
<tr>
<td>FP outreach program at facility within 1 Km.</td>
<td>2.7**</td>
<td>53</td>
</tr>
<tr>
<td>Saw NURHI FP message on TV</td>
<td>2.0*</td>
<td>60</td>
</tr>
<tr>
<td>NURHI health facility within 1 Km.</td>
<td>1.3*</td>
<td>45</td>
</tr>
<tr>
<td>IEC program at health facility within 1 Km.</td>
<td>0.8</td>
<td>71</td>
</tr>
<tr>
<td><strong>Saw NURHI print media</strong></td>
<td></td>
<td>38</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---</td>
<td>----</td>
</tr>
</tbody>
</table>

**UHI**

<table>
<thead>
<tr>
<th><strong>Saw UHI FP brochure</strong></th>
<th>7.0***</th>
<th>24</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UHI public facility within 1 Km. (full implementation)</strong></td>
<td>2.5*</td>
<td>29</td>
</tr>
<tr>
<td><strong>Saw FP poster/wall painting / billboard</strong></td>
<td>2.1*</td>
<td>79</td>
</tr>
<tr>
<td><strong>Discussed FP with a CHW (survey could not distinguish between UHI and other CHWs)</strong></td>
<td>1.7w</td>
<td>16.5</td>
</tr>
<tr>
<td><strong>Heard UHI radio spot</strong></td>
<td>0.7</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Saw UHI TV message</strong></td>
<td>0.6</td>
<td>62</td>
</tr>
<tr>
<td><strong>Saw UHI mid-media</strong></td>
<td>-1.0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Attended women’s group</strong></td>
<td>-</td>
<td>54.5</td>
</tr>
<tr>
<td><strong>Living within 1.75 Km of a UHI supported private facility</strong></td>
<td>-</td>
<td>57</td>
</tr>
</tbody>
</table>

**ISSU All Women**

<table>
<thead>
<tr>
<th><strong>Heard about FP at community based events or from CHW</strong></th>
<th>5.9***</th>
<th>25</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heard ISSU FP Radio messages</strong></td>
<td>1.7</td>
<td>20</td>
</tr>
<tr>
<td><strong>Heard religious leader speak favorably about FP</strong></td>
<td>0.5</td>
<td>58</td>
</tr>
<tr>
<td><strong>Facility with commodities (Push model) within 1 Km</strong></td>
<td>-0.4</td>
<td>96</td>
</tr>
<tr>
<td><strong>ISSU TV program</strong></td>
<td>-</td>
<td>74</td>
</tr>
<tr>
<td><strong>Saw FP message in newspaper/magazine in last 3 months</strong></td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td><strong>Live within 1 Km of facility with ISSU supplied supplementary midwife</strong></td>
<td>-</td>
<td>23</td>
</tr>
<tr>
<td><strong>Live within 1.5 Km of a pilot pharmacy</strong></td>
<td>-</td>
<td>84</td>
</tr>
</tbody>
</table>

**ISSU Women in lowest two wealth quintiles §**

<table>
<thead>
<tr>
<th><strong>Heard about FP at community based activities or from CHW</strong></th>
<th>9.3***</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heard ISSU radio messages</strong></td>
<td>5.1*</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Heard a religious leader speak favorably about FP</strong></td>
<td>1.5</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Live within 1 Km of facility with commodities (Push model)</strong></td>
<td>3.6w</td>
<td>NA</td>
</tr>
</tbody>
</table>

wp<0.1, *p<0.05, **p<0.01, ***p<0.001

§ Analysis for women in lowest two quintiles is only available for ISSU.

*(Data from slide deck of I. Speizer dated January12, 2016 presented at USAID, Washington D.C.)*

- In Kenya, statistically significant impact (marginal effects) observed for different interventions were in descending order of impact as follows: exposure to Jongo Love radio program, having discussed FP with a CHW, seeing or knowing about an Amua Tupange health facility and having a Tupange public facility within 1.5 KM of the respondent’s residence. Although having been exposed to a community event with FP information was high (48%), this was not significantly related to contraceptive acceptance. In contrast, exposure to Jongo Love was strongly related to contraceptive use but relatively few women were exposed to these interventions (7%).
• In NURHI cities, statistically significant impact was observed for exposure to NURHI radio programs, exposure to community outreach or events, having seen a provider with a NURHI badge, living within 1 Km of a public facility with outreach, exposure to NURHI messages on TV, and living within 1 Km of a NURHI supported facility. The NURHI provider badge is clearly a marker for a provider trained by NURHI and working in a facility supported by NURHI.

• In the UHI, project impact was associated with having seen a UHI brochure, living within 1 KM of a UHI supported public facility, being exposed to a community FP poster or wall painting, and having discussed FP with a community health worker. Being exposed to a brochure is likely to be a proxy variable for having received quality information and counseling from a CHW or a health provider.

• In Senegal, among all women statistically significant impact was observed for having heard about FP at community-based events or from a CHW. Among women in the two lowest wealth quintiles, having heard about FP at community events or from a CHW, having heard FP messages on the radio, and living within 1KM of a facility with the ISSU commodity push model was associated with contraceptive use. Analysis of data from baseline and end line interviews of men in Senegal was available and showed that the variables associated with impact were somewhat different, with significant results observed for exposure to FP messages on both radio and TV as well as at community events, and for hearing a religious leader speak favorably about FP. The results for the men were presented as associations instead of impacts given that the data were from multiple cross-sectional samples.

**Additional factors to consider when assessing the impact of interventions:** When using the MLE data for assessing the relationship between interventions and contraceptive use the following factors need to be kept in mind:

• The surveys of women utilized a sample representing the entire city (although there was oversampling of the poor), while the program focused intensively on slum residents. This was the case for both demand creation, as well as supply-side interventions.

• The factors that had significant impact depend to a great degree on what variables were measured and selected (and how they were grouped) for the analysis. Exposure to the key service delivery interventions discussed in previous chapters were not directly measured in the women’s survey and therefore exposure to supply side interventions was represented by the variable of household distance to a facility with the interventions, a proxy variable for all of the various provider and facility level interventions. Another proxy for NURHI supply side interventions was whether a woman reported having seen a NURHI provider badge- a marker for a provider trained by NURHI and working in a NURHI supported facility. Thus when in the Indian context, exposure to billboards/posters and wall hangings had a greater impact on contraceptive use than living within one kilometer to a UHI supported facility should not be interpreted to mean that billboards etc. are necessarily more important than improving the supply environment. It may only reflect that the variable “living 1 km from an
improved supply environment” is not a particularly good measure of supply side interventions.

• The evaluation’s primary objective was to assess changes in contraceptive prevalence and increased use of LAPM. Thus the evaluation’s quantitative survey data and currently available analyses concerning many interventions do not provide in depth information about why some of them showed significant impact and others did not. For example exposure to CHWs was found to be related to contraceptive use, but more detailed data concerning the frequency of contact with CHWs or the content of the interactions required to lead to contraceptive use is not available. To more completely understand why some interventions had impact and others did not in specific contexts qualitative studies supplementing the quantitative surveys would have been essential.

• The social and service delivery contexts in which interventions are implemented affect their impact on contraceptive outcomes. The impact of a mass media intervention depends on what media messages are already presented by the national program or other local projects. Likewise the impact of provider training is dependent on what prior training providers have received. If a particular intervention or group of interventions was not significantly related to contraceptive uptake in one context, it does not mean that they would not have been significant in a different setting, even in the same country.

• The MLE facility based surveys conducted at baseline and endline provided data on some aspects of providers’ knowledge and their past training, the availability of FP and related services and some aspects of the quality of care of service delivery, based on client exit interviews. However, the facilities included in the survey include a wide variety of levels or sizes, as well as both public and private sector facilities. In the endline reports the SDP data analysis presented for many of the key variables does not distinguish between URHI and non-URHI supported facilities (particularly in the UHI and Tupange reports). Instead they tend to focus on overall baseline-post project or public-private sector comparisons. Thus, it is difficult to confidently interpret the impacts of the URHI projects on the range of services or the quality of care provided.

Furthermore, the SDPs surveyed in each country included a different mix of public and private facilities and the baseline data that is segregated for URHI and non-URHI facilities in each country shows that non-URHI facilities tend to have lower levels of positive attributes (eg. number of types of contraceptives, absence of stockouts, types of services provided, integration of services and conduct of outreach services etc). When data is available one often sees that URHI facilities at endline improved their quality in comparison to baseline, but non-URHI facilities started at lower levels and also improved- often to levels lower than URHI facilities- but their improvement was proportionally greater.

A few general conclusions from the SDP data stand out. Based on client exit interviews (women who received a range of different reproductive health services) having received information about FP or a specific contraceptive method in all facilities was lower than expected, pointing to inadequate integration of FP with other services and inadequate quality of FP services. However, there appeared to be general tendency for facilities to offer more
methods and to experience fewer stock-outs of contraceptives. Further analysis of the data from the facility surveys is ongoing and will provide additional insights, but this is beyond the scope of this report.

The importance of both demand and supply-side interventions: Overall the data show that the total package of both supply and demand side interventions was successful. However, it is impossible to separate out “magic bullet” interventions for replication. Significant factors varied considerably between countries, and the data have obvious limitations in the extent to which they can measure the nature and quality of the interventions, especially those on the supply side. Nonetheless, the data show clearly that while there are differences in the types of interventions that were significantly associated with contraceptive use, in each country these included both supply and demand-side interventions. This was reinforced by conversations with URHI staff, providers and community members which confirm that it was important to include and to ensure synergy among both demand generation and supply-side interventions. This is a conclusion that has been reached in the FP literature for many years.

Taken together, multivariate analyses suggest that with regard to demand creation activities, exposure to CHWs talking about FP, together with exposure to mass and mid-media and community-level activities (including information provided at service outreaches) played an important role in contraceptive acceptance. Although not included as independent variables in the multivariate analysis data from bivariate analysis presented in the four MLE endline country reports suggest that information and counseling from providers, whether counselors, nurses, midwives and doctors, are also likely to all be an important component of demand generation.

In the multivariate analyses, some factors that showed high marginal effects were often those with relatively low levels of exposure (e.g. exposure to Jongo Love or discussed FP with a CHW in Kenya, or exposure to a brochure in India) which suggests that greater impact could be gained by increasing coverage of these interventions.

Beyond demand generation, efforts to increase access to services, to overcome barriers to services and to improve quality of services are also needed. At least minimal quality of services—e.g. the presence of providers, contraceptives and supplies is a necessary but not sufficient condition for increasing demand and utilization. Good quality in service delivery has been shown repeatedly in the FP literature to enhance both demand and utilization. Increasing coverage of effective services is critical but so is improving their quality. The impact analyses shown above were not able to include direct measures of the quality of services being provided, but this does not mean that the interventions to strengthen quality were not important.

Other recent multivariate analyses conducted by MLE using data from health facilities in the three African countries showed that various supply-side interventions, including those related to training providers, the contraceptive supply chain and method availability, the presence of IEC materials, and outreach activities, were associated with increase the number of new family

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Bringing services closer to where people live was important everywhere- whether through service delivery outreaches, community mobilizers and CHWs, or midwives in Senegal. This was clear from both the MLE analysis and reported by URHI staff. However outreaches were found to require community mobilization and were not successful without this component.

Staff in Kenya and Uttar Pradesh commented that URHI worked better in cities where there were not many other competing projects. In these settings it was easier to obtain government buy-in and involvement and there was existing, or easily mobilized demand because services had previously not been available or were of poor quality.

**Importance of implementation:** The MLE survey data are not only valuable in showing the impact of different interventions, but also in demonstrating the importance of the implementation process as it relates to both coverage and quality.

Some of the interventions reached relatively low percentages of the populations while others reached higher levels of coverage. Coverage was at times low because the interventions were addressed to a specific subpopulation. For example, Jonglo Love was aimed at urban young people. More generally, as indicated above, one must keep in mind that this survey sample represents women in the entire city, while the focus of many or most of the interventions was the urban poor. However, many of the interventions were intended to reach larger numbers of women, and the exposure levels were lower than expected, indicating that the level of implementation of project interventions was inadequate. Low coverage of interventions, even though they are effective, will not achieve the desired results.

Another issue relates to the quality of the implementation process. Data from observations and the facility surveys suggest that there were substantial quality gaps in the services. For example the percentage of women who reported interactions with CHW or providers in facilities during which FP was discussed, whether during pregnancy or during the postpartum period was lower than expected in each country, particularly as each URHI made an effort to ensure that these interactions took place. Poor implementation of effective interventions cannot be expected to achieve the desired results. However, it must be remembered that a project often cannot control the quality of implementation especially when working within the context of routine programs. Even when implementing potentially effective interventions, working within some contexts or programs may limit what can be achieved.

**Comparing cities and countries:** Given the many competing explanations for success, assessing which were the most successful cities and why would require much more data and analysis than is available or feasible for this report. The impact at a city level represents an interaction among local cultural norms and traditions regarding fertility and use of contraception, and the level or intensity of implementation. It also depends on local health officials and other stakeholders’
involvement and leadership, the available human and financial resources and the capacity, skills, leadership and dedication of the city level project teams.

Furthermore, when comparing achievements across cities or countries, one needs to consider the population and scale of the URHI cities. The number of cities covered and the size of their populations were quite different. The four country family planning programs also had very different levels of resources available and constraints in their health systems. These and potentially other factors interacted to determine the outcomes.

**Recommendations:**

14.1 The lesson that achieving results requires multi-component interventions, including advocacy, supply side and demand generation should strongly influence the interventions implemented by TCI.

14.2 TCI scale up in a particular region should be influenced by the results from the specific URHI in the region, but consideration of the results from the other URHI countries should also inform the choice of interventions to be implemented. However, in each case, their relevance to the specific programmatic and socio-cultural contexts, as well as the need for adaptation or for new interventions should be carefully considered.

14.3 Future TCI efforts need to focus not only on selecting effective URHI interventions, but also on how to ensure high levels of coverage and good quality of the implementation process.

**PART VI. SCALE UP, IMPLEMENTATION TOOLKITS AND SUSTAINABILITY**

**Chapter 15: Scaling up: accomplishments and lessons learned**

All of the URHI projects included a focus on scaling up to additional cities as part of their original design. In the UHI scale up proceeded from four initial core cities to an additional seven cities one year after implementation began. In Kenya, Tupange began in three large cities in different regions of the country and expanded to two additional cities, near two of the core cities, but they were considerably smaller and more peri-urban in nature. NURHI began in four large cities and then expanded to two additional cities, all strategically selected to represent very different social, cultural economic linguistic and religious contexts. In Senegal ISSU began in eight districts in the medical region of Dakar and initially scaled up to two new districts in two other regions. An additional two districts from the medical region of Dakar were later added.
The expansion to multiple additional cities with large populations in both India and Nigeria was important in gaining government’s attention and interest. This was particularly true in India where the initial implementation cities, although large in size, were a small subset of those in the state of Uttar Pradesh (population over 200 million) and the government was highly suspicious of boutique projects that do not fit the national model and as a result leave little behind when they end. Following scale up to 11 cities, which accounted for 40% of the urban residents of UP, the government realized the potential for rapid scale up and the importance of learning from and replicating interventions based on the UHI experience.

**Scaling-up strategies:** All of the projects employed systematic approaches to develop scaling-up strategies to guide implementation, although some did this more explicitly than others.

- In Tupange, after learning about the ExpandNet framework and tools, the team conducted a formal 9-step strategy development workshop with ExpandNet support. This guided a process of initial advocacy and information visits with local government health officials in the new cities, joint initial needs assessments and joint work planning, which was then followed by the start of implementation.

The Tupange staff felt that the process of using the ExpandNet/WHO 9 step strategy development process and the lessons that they had learned from working with ExpandNet advisors had a major influence on their thinking about project implementation. Their “mindset” had been transformed from a project to a program approach. Project approaches are characterized by

“interventions that are focused on short-term results and not necessarily on what is needed to ensure sustainable scale up, even though large-scale impact is often stated as the ultimate goal. In this approach levels of financial, technical and human resources that are unlikely to be available for subsequent implementation in routine programs and parallel structures to existing government or private sector programs tend to be created. Moreover, only limited attention is given to addressing the legal, policy, bureaucratic, institutional and programmatic frameworks essential for institutionalizing interventions” (Keyonzo, N. et al 2015).

In contrast, working in a program approach means:

“organizing projects from the outset in ways that enhance the potential for subsequent sustainable scale up. The focus of such an approach is on the broader health system and

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on how the intervention implemented initially in the project will contribute to the national program. Efforts are made to limit external resources to what can be maintained or mobilized on a larger scale. Government ownership and a participatory process involving key stakeholders are central” (Keyonzo et al 2015).

As described in the article the Tupange team began a participatory process that emphasized government leadership, ownership and coordination of the interventions in both the public and the private sector, and produced solutions that would otherwise not have emerged. New emphasis was placed on adapting interventions to the different local contexts and integrating them with ongoing activities. Because available resources were more limited than in the core cities, the package of interventions was substantially reduced, simplified and adapted to be more scalable. New field offices were not established; instead activities were managed from the existing core city sites. Fewer CHWs were trained, shorter training was given to providers (but with the local MOH playing a greater coordination role), and fewer outreaches were implemented. No private sector AMUA-Tupange branding activities were conducted, reflecting the scarcity of private providers in the new areas, the smaller population size and the more rural character of the area. Funding for MSI outreaches were also dropped in new areas as they were considered too expensive, and outreach/in-reach activities could be conducted by district health teams. However MSI outreaches continued to a lesser degree with funds leveraged form MSI’s donors.

Interventions were aligned with existing institutions rather than creating parallel processes. For example the team learned that training could be provided through the local government-training center and Tupange’s role shifted from that of being trainers to mentoring trainers. Also, emphasis was placed on integrating activities into the district’s annual work plan, which meant they could be covered by available MOH funds and supervised by local health management teams. Moreover, Tupange FP data were incorporated into the government’s health information system DHISII, which meant that government began to own the data. The local health management team was now driving the process and the project was in a supportive role (Keyonzo et al. 2015).

- In the UHI, activities were scaled up very early, expanding from the initial four core cities to seven additional cities one year after initial implementation. They did not originally employ a 9-step strategy development process, but they developed a very systematic strategy for scale up. Essentially this consisted of the full package of activities, except for some of the mass and mid-media components which were not supported. The other interventions were not significantly simplified or adapted as part of the scale-up strategy, but they were still in an ongoing process of ongoing learning, adaptation and revision. However, implementation of the outreach component did not cover all of the slums in each of the new cities because available resources were reduced. The UHI team initially implemented activities in a subset
of slums in the scale-up cities, but then realized that they could expand coverage to all slums by involving the Anganwadi Workers of the Integrated Child Development Services (ICDS) in the community Anganwadi Centres, wherever they were present in the slums. In the following years there was a continuing process of learning and sharing of experiences between the cities resulting in new adaptations being adopted in both the core and the scale up cities.

The early successes in the UHI supported cities resulted in considerable government interest in support for replicating the interventions, especially where government staff had been transferred after working closely with UHI and wanted to replicate the experience in their new district or hospital. There was also interest among Chief Medical Officers in expanding interventions to the rural blocks of the districts where UHI supported cities were located. The UHI staff then used the ExpandNet framework and 9-step process to develop strategies for scaling up a more minimal package of activities to these areas.

In the last year of UHI the long planned National Urban Health Mission officially became a component of the National Health Mission, and the significant successes of the UHI in supporting both the family planning program and the strengthening of the urban health program resulting in strong interest and requests for support from the Uttar Pradesh Mission Director. The UHI responded to this request by supporting scale up of a minimal package of interventions to support FP. This included training FP counselors for 41 (out of a total of 75) district women's hospitals (DWHs), and the provision of IEC materials (both print and films for use on clinic and hospital televisions), counseling privacy screens and technical support in initiating fixed service days in 71 DWHs.

In addition the UHI supported the expansion of interventions to strengthen the government’s urban health activities in 72 major cities of Uttar Pradesh. This included working with officials to map slum communities, to mobilize funding through the existing NHM Project Implementation Plan (PIP) mechanism for establishing or revitalizing urban health posts, the recruiting of urban ASHAs, supporting training of AWWs, development of city specific PIPS and more generally through close collaboration with the State Program Management Unit of the National Health Mission. This included efforts to strengthen their capacity to utilize data for program management. For further details concerning the final status of scale up see Chapter 17 on Sustainability. (Detailed discussion and analysis of the UHI scaling up experience is available in the document “Review of the Urban Health Initiative: Process and Achievements, 2010-2015”, by Simmons, R. and Fajans, P., Sept. 2015 unpublished).

At the end of the UHI, high level government officials expressed strong request for continued technical support for the urban health and family planning programs, as these were new areas for them and they felt that the UHI team had critical expertise in providing needed support.
In retrospect, the UHI team members also felt that the UHI ended too abruptly at a peak of heightened interest, but amidst a period of transition and some uncertainty with regard to implementation of urban health and FP activities. The last phase of the UHI had been a period of hectic activity, trying to respond to government requests for joint actions within the limited timeline, and scaling up a few interventions without sufficient time for the gradual handover to government officials.

- In Nigeria, when scaling up of NURHI interventions was to start, they had heard about ExpandNet through the BMGF Senior Family Planning Program Officer, who had also provided the link to download the tools. Thereafter a JHU-CCP staff working with the project team then “translated” the “9 Steps for developing a scaling-up strategy” document into the Nigerian context with NURHI examples, which the team then used in a strategy-development process. As in the UHI, NURHI had been implementing systematic data review and work planning exercises each year and thus they were already thinking about implementation challenges and the need for adapting materials and interventions for different cultural, environmental and programmatic contexts. However, implementation in the new cities was essentially the same package of activities and benefited from the same substantial resource levels as had been implemented in the original cities. It remained a proof of concept model demonstrating that effective demand generation coupled with quality FP services could increase mCPR in different Nigerian urban contexts. Staff admitted that concern for future sustainability was not a major focus at the time of the design of the original NURHI project although some elements of sustainability were embedded in the strategies.

At the request of BMGF, NURHI 2 will scale up to additional new areas- Lagos State(urban/rural), plus rural areas in Kaduna and Oyo State (with funding from a private donor TJ Mather) and drop Abuja Federal Capital Territory (FCT) and Ilorin, originally core cities, and Benin City (an initial scale-up city).

- The ISSU team did not use the 9-step guide for developing a strategy for scaling up because, when they were first introduced to this systematic approach, they were already advanced in their work with the DHMTs in the scale-up cities. Using monitoring results and the experience of the ISSU team, the scaling up conducted in Dakar, then Mbour and Kaolack, attempted to replicate core interventions implemented in the initial core cities of Pikine, Guediawaye, Keur Massar and Mbao, but with fewer resources. Replication of several interventions in the areas of demand creation was constrained because some consortium partners responsible for these components were not available to work in the new districts.

Three years into the project the districts of Diamniadio and Rufisque were added, based on the request of the director of the Dakar medical region. This was used as an opportunity to assess the extent to which the DHMT could implement impactful ISSU interventions as an
integral part of their work plan, partly with their own human and logistics resources and with limited support from ISSU. In other words this provided a “proof of implementation” for the potential to implement the interventions under conditions similar those of the routine national program.

During the expansion to Diamniadio and Rufisque the role of the ISSU city managers (coordinatrices de ville) changed significantly. In the initial districts they were deeply involved in the entire implementation process. They ensured that ISSU interventions were included in the district work plan, carried out the activity programming with the DHMT and all the counterparts within the team and were involved in the implementation of ISSU activities and even other related programs as the need arose. By contrast, during the Diamniadio and Rufisque experiment they had to step back and limit themselves to an advisory or coaching role to the DHMT.

The process and lessons learned from the scaling up a more limited package of ISSU interventions in Diamniadio and Rufisque, but with greater ownership and reliance on the district health management team is described in detail in the paper “From proof of concept to proof of implementation: the experience of strengthening family planning in Diamniadio and Rufisque in Senegal”, Seck, C. et al., (submitted for publication 2016).

**Resource teams:** Resource teams to support scaling up are critical, as it requires systematic guidance to be successful. In scaling up, the URHIs transferred experienced staff to lead scale up in new cities which allowed them to move faster. They knew what to do and how to do it - “what doors to knock on”, who were the key stakeholders to meet and advocate with, what arguments would be of interest to program managers. They also had gained the respect from government partners for their work and accomplishments.

**Phased implementation:** A central lesson from the literature on scale up is the importance of avoiding overly rapid or explosive scale up. The pace of expansion needs to be in proportion to the human and financial resources available, the complexity of the interventions, the capacity of the implementing institutions and the context or environment in which it is taking place. Even when a package of successfully tested interventions is available, it is important to proceed gradually and in a phased manner as learning and adaptations will be required in expanding to new geographies with new contexts. Such a phased approach to implementation was important in all of the URHIs.

**Simplification and adaptation of interventions:** In the planning for and implementation of scale up in all four countries, interventions were either simplified or adapted to be more effective, to be less resource intensive and thus more scalable. For example, in Senegal the capitalization exercise was a major undertaking to simplify the innovations based on which
interventions were most relevant, effective, efficient and sustainable in anticipation for adoption and adaptation during future scaling-up.

The importance of simplification and adaption of the interventions is a primary lesson from global experience and the literature on successful scale up. As one moves from the former URHI cities to scale up in new cities, counties, states or districts, it will be critical to continue to simplify and adapt interventions, particularly as human and financial resources to support scaling up will be reduced. Moving to new regions implies changes in the environment that are also likely to require adaptation of the interventions to be implemented. As TCI expands to neighboring countries this adaptation is likely to be even more important, if scale up is to be rapid and successful.

**Monitoring expansion and adaptation of interventions:** As scaling up proceeds the monitoring of outcomes is essential so as to be sure that they continue to have the original impact. Adaptation is required to maintain the initial outcomes and impact as activities are expanded to new geographies with differing levels of resources, both human and financial, and differing sociocultural contexts and institutional contexts. Environments change over time, which also contributes to the need for adaptation. At the same time there is a need for an underlying fidelity to the tested interventions so that they continue to produce the expected outcomes and impact. Good monitoring will be required to assess whether outcomes and impact of the interventions are sustained. In the URHIs the results varied considerably by city within a country, but levels of increases in mCPR were not clearly different between core and scale up cities.

- In Kenya, although interventions were reduced, simplified and implemented with fewer financial resources and technical support from Tupange, the increases in mCPR were roughly similar to those in the original cities.

- In India, scale-up cities implemented activities with fewer resources, and did not cover the entire cities, but in general increases in city-wide mCPR were similar to the core cities (although there was variation among both core and scale-up cities). It is not easy to assess to what degree this resulted from different cultural and socioeconomic contexts and to what degree it reflects variation in the intensity or success of implementation by local government or of the city UHI team.

- Scale up to Zaria in Kaduna State utilized the same model and the same state team and was also very successful, despite starting from a lower mCPR than in other cities and working in a more conservative context. At endline, mCPR had increased to a lower absolute level but the percentage point increase was greater than in the other cities. In contrast, scale up to Benin City implemented the same model with similar inputs in a new city/state with new
staff and in a city with higher economic and educational levels. Contraceptive prevalence started from a higher baseline level and reached a higher mCPR, but the percentage point increase was much smaller.

**Managing the process of scale up:** Systematic monitoring and active management of the process of scale up is essential. A good scale-up strategy is only a first step. Increasing the capacity of the public sector/government health system to manage the process is a major requirement. All of the project teams concluded that good management of the process was critical and increasing the managerial capacity of the public sector to scale up the interventions was necessary for future success. Implementation toolkits were seen as a key means of supporting or developing both technical and managerial capacity the government partners.

**Coordination with other partners and leveraging resources:** A key lesson learned during scale up was that coordination with other partners made it possible to implement core intervention packages with more limited project resources. Poor health systems tend to be supported by multiple donor-funded projects related to FP, RH, MNCH as well as HIV/AIDS, health systems strengthening and primary health care. If government can exert more coordination, it is possible to leverage funding and coordinate support for CHW and provider training, integrated outreaches and integrated health messaging to include FP.

- In Kenya, such coordination was an important strategy. For example, during scale up to Kakamega and Machakos there were a variety of other projects active in the same sub-county (e.g. USAID AphiaPlus) that were doing some training of providers, conducting service outreaches and working with CHWs. Tupange learned the benefits of collaboration among projects, which was not the prevailing pattern. Through working with the sub-county health management teams to implement coordinated joint work planning they were able to mobilize additional resources to support provider and CHW training and for conducting integrated outreaches. There also was an opportunity to benefit from MSI-Kenya’s (a Tupange consortium partner) ongoing in-reaches to facilities, which were being funded by other donors. Tupange also collaborated with the Jhpiego project that mobilized funding for training doctors and midwives in post partum IUD insertion, with the IPPPF Kenya affiliate Family Health Options of Kenya for advocacy for civil society organizations, while PSI provided DMPA to facilities when there were shortages in Tupange cities or counties.

- In a similar fashion UHI collaborated with a number of other donor-funded projects. For example their collaboration with Janani and PSS who were jointly funded by UHI and other donor funding. They also collaborated with the USAID funded Abt DIMPA network of providers for DMPA provision in the private sector. As previously discussed, the UHI also assisted government health staff in mobilizing funding from the annual Project Implementation Plan (PIP) mechanism of the National Health Mission, mobilizing available
funding for urban health and FP that previously was not accessed and therefore returned to the central government each year. Another example was how the UHI realized during scale up to additional cities that they could coordinate with existing government Anganwadi workers to reach pregnant and lactating women with FP messages and contraceptives.

• In Senegal, efforts to leverage additional resources from other projects were made during the testing of the “proof of implementation” of ISSU interventions in the districts of Diamniadio and Rufisque. As the leadership of the District Health Management Teams became stronger, they were in a better position to coordinate the inputs from other projects working in the area in support of MCH and health systems strengthening more generally. In particular, other projects supported by Intrahealth used this opportunity to work in synergy with ISSU and pool the resources allocated to these two districts. Subsequently, as the support from another international NGOs (ChildFund) working in the communities became also stronger, the district management team was empowered to stop partner organizations working in these districts from implementing interventions not consistent with the government program. However this was not always easy, and the DHMT concluded that much more efforts needed to be done to ensure implementation partners in the district coordinate appropriately with the district authorities.

• In Nigeria, the NURHI team worked together with DFID (UKAid) and USAID to co-fund the TV drama series Newman Street, which includes FP and malaria messages. Now with the demonstrated success of NURHI, UNFPA and USAID want to leverage NURHI’s capacity to implement integrated demand generation, advocacy and service delivery activities for FP in additional states in their own FP-MNCH projects and more general in primary health care and health system strengthening projects. This will enable NURHI’s successful demand generation models to be greatly expanded across Nigeria and to lay the foundation for a future national FP campaign. NURHI also collaborated with the MSION to kick-start the inreach/outreach element of the service delivery for one year. The NURHI team continues to be a valuable resource to FP technical working groups of governments at all levels and especially to other implementing partners (e.g PPFN, Pathfinder and MSH) for guidance in designing effective FP programmes in Nigeria.

Resource required for scale up: Even though scale up employed fewer project resources in three of the four URHIs and leveraging funds from other sources contributed significantly to support scale up, the activities in the scale up cities benefited from a considerable level of inputs from each URHI. These extra resources were important determinants of the success that the projects were able to achieve in the scale up cities.

Local government coordination of partners: When government is in the driver’s seat it is easier for them to exert coordination among different donors and projects. For example, the UHI
city managers thought that it is important to encourage the district level government functionaries and the CMO to take the initiative of coordinating and synchronizing the efforts of diverse agencies at the district level. If government authorities coordinate planning, the system becomes more efficient and efforts become more sustainable.

**Success facilitates scale up:** The projects also learned that efforts to leverage resources were facilitated by demonstrating success. This made it easier to get other projects to collaborate and co-fund because everyone wanted to be associated with success. The accomplishments of the URHI projects in each country has created interest among a variety of country level donors to support implementation of URHI tested interventions. For example other donors are seeing Tupange’s success and now wanting Tupange to collaborate with them in “their” counties. However, one still must deal with the perspective that each project team wants to be able to attribute accomplishments to “their” activities and to satisfy their donors.

**Diffusion and spontaneous scale up:** In addition to expansion and institutionalization, another type of scale up is that of diffusion or spontaneous scale up. Although complex packages of interventions rarely spread on their own, efforts to promote appropriate diffusion can contribute to faster expansion. For example, scale up to other cities and to peri-urban and rural areas can be easier as it can benefit from advocacy already done at higher levels, in addition to benefiting from diffusion of information to communities from mass media coverage in earlier cities, through migration or through use of project-supported urban facilities by rural people. Also frequent staff transfers, rotation of health managers and staff who have previous experience with the interventions can facilitate demand for the interventions in new areas and result in more rapid scale up. Such a pattern was observed in Nigeria, India and Kenya. As the positive results of the projects were shared more widely this also generated interest among government and other donors.

**Recommendations:**

15.1 Starting implementation in new areas in a limited number of sites to learn if interventions are working and creating early credibility with government and other partners is essential, as is initiating scale up in a phased manner. Avoid overly rapid scale up, with the pace in proportion to the complexity of the interventions, the capacity of the implementing institutions, the human and financial resources available, and the social and programmatic context in which it is taking place.

15.2 Conducting a rapid assessment of the socio-cultural, institutional and programmatic context in new geographies which differ in terms of their social and institutional contexts from current URHI sites is a critical first step in scale up.
15.3 Using a systematic process to develop a scaling up strategy is essential for successful scale up. One such option is to use the WHO/ExpandNet nine step process for scaling up strategy development.

15.4 Simplifying the package of interventions should be an essential part of developing the scale-up strategy.

15.5 Continuous monitoring and active management of the scale up process is essential. Simple approaches to monitor the process of scale up should be developed to identify and understand bottlenecks and the means of overcoming them.

15.6 Learning what adaptation is needed to maintain outcomes as scaling up proceeds will be important, as environments are likely to be changing.

15.7 Ideally the TCI Hub or resource team should include members who are experienced in implementing URHI interventions. The members should include individuals from government, relevant NGOs and others working in the field of family planning.

15.8 Increased coordination of donors and partner organizations implementing projects is an essential goal to strive for, as it is likely to produce more efficient and effective programs.

15.9 Under TCI there are likely to be a variety of opportunities for leveraged funding. TCI Hub members and other former URHI staff are likely to have close contacts with those responsible for a variety of other FP/RH projects. These will present opportunities for collaboration to support local health officials to implement FP activities.

15.10 Local program officials should be given a strong role in the coordination of activities among multiple projects being implemented in their areas. This can be an important means of leveraging and encouraging the efficient use of available resources.

15.11 Learning from the diffusion of the URHI interventions will be important to indentify mechanisms to promote it.

15.12 Sudden discontinuation of technical support to local governments should be avoided. It is more effective to slowly and incrementally transfer responsibility for new interventions to local health management teams.
Chapter 16: URHI implementation toolkits

The original four URHI proposals included as deliverables the development of implementation toolkits that could be used to guide and support future expansion of successful URHI interventions to new geographies. Coming from a common project model and based on FP good practices the toolkits have similar interventions, but they are quite different in a number of ways, reflecting substantial socio-cultural and programmatic differences among the four countries.

- NURHI’s toolkit is web-based and comprehensive in nature, documenting in great detail essentially all of the interventions the project undertook, rather than serving as a concise practical guide for implementation. For example, the toolkit includes very detailed strategy documents for each component of the project, in addition to ‘how to’ guidance on implementing the interventions, and necessary support materials developed by NURHI for each of the project interventions. In discussing the toolkit, NURHI staff felt that for the future it would be useful to develop a companion guide for others on how to use the toolkit when scaling up to new states. This would include how to use assessment tools to decide what components or specific interventions are needed, more practical guidance on costs and guidance on how to actually adapt and implement key interventions in different contexts. While the toolkit has been widely publicized and is available at http://www.nurhitoollkit.org, NURHI has yet to collect information on direct experience with having local government health staff use the toolkit as the basis for expansion to new areas.

- The Tupange toolkit, which is also web-based and available at http://fptoolkit.or.ke (and also linked to NCPD and MOH websites), addresses only a subset of interventions considered by the team to be most relevant and effective, as well as replicable with minimal external inputs. It is practically oriented, including a short overview of the interventions considered to have been most impactful, the rationale for their use, what is needed to implement the interventions, key indicators to monitor their implementation and basic cost elements (but not an estimate of total cost per unit of implementation). The toolkit was developed collaboratively with input from the MOH at national and county/district levels. This was important for ownership and institutionalization. There is some early experience with its use by health staff in one or more sub-counties. This experience was presented at a Tupange 2015 scale-up workshop for ten counties, as well as in a more recent workshop introducing 26 counties (5 former Tupange and 21 additional ones) to the TCI concept. In both for a the toolkit received a very favorable response and met with interest among the participants.

- UHI initially produced tools for postpartum and post-abortion family planning, and for each FP method. Each tool was a package that included: 1) tested and widely used IEC print materials and films that standardized communication and counseling; 2) job aids and quick references for community workers, counselors, and clinicians that were consistent across providers and with government guidelines; 3) PowerPoints to supplement government
training modules for ASHAs and counselors and clinicians; together with 4) relevant
government tools and strategy guidelines. Some of the communication tools were available
in more than one Indian language to meet the needs of migrants to UP speaking Bengali,
Urdu, Oria, etc. and some have been adapted and reproduced in the states of Madhya Pradesh
and Rajasthan. Their alignment with government strategy guidelines and their development,
and testing with government counterparts facilitated the widespread interest in these tools
beyond the initial project cities.

These UHI tools were initially available on the UHI website, (which is online but no longer
functioning), and later in 2014 on the website of the Social Behaviour Change Commission
of the India National Health Mission, Uttar Pradesh at the following web address:
http://www.iecrmncha.in/node/114. They are also available through a link on the MLE
website at https://www.urbanreproductivehealth.org/resource/urban-health-initiative-uhi-
toolkits. On both they are packaged with two other documents produced by UHI
summarizing the key FP statistics by state in India and by district in Uttar Pradesh. Many of
the method specific communication materials, including the versions in the other languages
are also available on the virtual resource center of the National Population Stabilization Fund
(JSK) website http://www.jskvrc.gov.in/uhi-fp.asp.

Subsequently, the UHI started work on a toolkit that was similar in concept to the Tupange
toolkit, providing detailed practical guidance and relevant materials on how to implement a
subset of nine UHI interventions considered by the team to have been 1) most successful, 2)
essential for achieving impact and 3) feasible to be implemented by districts within the
context of the routine FP program and available resources. The team reached the stage of
initial field-testing of the tools with positive feedback. However, the toolkits was never fully
compiled and completed, but individual draft tools are available.

Following the end of the project, the former Project Director working with two former staff
members developed a new urban health website http://www.urbanhealthindia.net/ intended to
serve as a platform for sharing information, resources and tools with individuals and
organizations interested in improving urban health and family planning. The UHI
communication materials are included on this new website. As part of this effort they also
compiled tools for the key government strategies which had been supported by UHI. The
tools consist of national technical guidelines, policies published by UP and national
government, training modules, communication materials developed by UHI and other
relevant materials. This included tools to support strategies including fixed service or static
days; ASHA recruitment and training; collaboration between ASHAs and the AWWs;
training of counselors and counseling tools; the formation of women’s group (MAS);
guidance on developing Public-Private Partnerships; and the development of urban health
and FP Program Implementation Plans.
The ISSU team chose to develop a toolkit to support scale up of interventions through an exercise referred to as “capitalization”. This effort assessed the various interventions implemented by the project according to their relevance, their effectiveness, whether they were efficient and whether they were potentially sustainable within the context of implementation in the national FP program. The resulting document described components that were retained as part of the “paquet porteur” - the set of interventions to be considered when scaling up. This document includes discussion about how to implement the interventions, together with reference to potential obstacles. There also is a section with additional reference materials developed in the course of the project, such as the booklet clarifying the position of Islamic teachings on family planning (http://ISSU.sn/ressources/Rapport de la Capitalization des Approches du Pacquet Porteur des Interventions du Project ISSU).

The URHI toolkits - a major resource for TCI: Although the URHI toolkits represent somewhat different approaches in their presentation and are at different stages of development, they are a major resource for further scaling up urban FP/RH interventions in the four countries and beyond. Their tools have proven their value in the local social-cultural and policy-programmatic context and have received positive responses from key government and other stakeholders.

It is important to recognize, however, that in each case, the success of these tools was strongly influenced by the general philosophy and approach pursued by each of the URHIs which are not identified as a "tool" in the current version of the each toolkit. Being deeply embedded in the fabric of how each team worked, the philosophy and approaches were not perceived as something that required highlighting. Central to this was the importance of the principle of “government or country ownership”, which although present from the outset also grew over time as the URHIs evolved. As Goosby et al. argued in the case of HIV prevention and treatment: “the overall leadership role belongs to the country, not to the external partner” (Goosby E, Von Zinkernagel D, Holmes C, Haroz D, and Walsh, T. “Raising the bar: PEPFAR and New Paradigms for Global Health”. J Acquired Immune Deficiency Syndrome 2012;60:SI58-S162). The principle of government/country ownership came to be well understood by all project teams and was a strong factor in the success of URHI interventions.

The principle of government or country ownership also implies that the URHI toolkits are deeply grounded in local culture and institutions. While tools from one URHI have lessons for other countries and, during the URHI project period, had considerable cross-project influence, their “contextuality ” will remain an important factor in their future utility. It is very likely that their broader use as scaling up proceeds will require adaptation and further learning.

Importance of local evidence for relevance of tools: A key factor in the utilization of a toolkit and tools in TCI will be to maintain the principle of evidence-based application. If URHI tools are being applied in contexts similar to where they were previously tested and implemented,
broader utilization can proceed. However, as contexts change review of their relevance and assessment of the need for further testing or adaptation will be an important first step.

By the same principle, application of emerging or best practices tested in other regions of the world should be explored, but if considered relevant, should be carefully evaluated by testing them on a more limited scale prior to large-scale application.

**Recommendations for TCI toolkit development:**

**Purpose and users of the TCI toolkit:**

16.1 The purpose of the TCI toolkit should be to provide concrete guidance for each specific country/regional context as well as more generic general guidance.

16.2 The TCI toolkit will be intended for members of the existing and any new hubs, as well as the city, county, and district level program managers and others seeking to improve demand for and access to quality family planning services.

**Basic distinctions among components of the TCI toolkit and types of information presented:**

16.3 It will be helpful to distinguish between: 1) the global component and 2) the regional component of the TCI toolkit. The regional component will provide country specific guidance based on evidence and experience from NURHI, Tupange, ISSU and UP (India) as presented (and further revised) in each country toolkit.

16.4 The global component of the TCI toolkit will provide generic guidance based on a synthesis of what has been learned across the four URHIs and the experience with TCI scale up as it progresses.

16.5 It will also be helpful to distinguish among: 1) overarching principles for introducing and scaling up URHI interventions (e.g. country ownership, participatory approaches, involving relevant stakeholders; utilization of flexible learning approaches; use of the nine-steps for developing a scale-up strategy); 2) strategies and approaches for supply and demand side interventions, as well as for advocacy (e.g. whole site orientation; household educational visits, use of champions); and 3) technical guidelines and materials supporting specific interventions (rapid assessment tools; training materials, films and IEC materials).

16.6 Both the global and the regional component should contain overarching principles, intervention strategies and guidance materials. However, in the regional component these will be specific to the country and regional context. For example in terms of:
o overarching principles, the specific approaches and experience with obtaining country ownership in ISSU will be included or alternatively how learning about the principles of scale up influenced approaches in scale up cities in Tupange;

o tested intervention approaches in the UP based toolkit will discuss among others how to implement the fixed service delivery day, while in the Senegal based toolkit the detailed guidance for the educational household FP visits by relais will be presented, which are different from the CHW household visits in India or the visits by community social mobilizers in Nigeria, and

o in terms of technical and educational materials/guidelines the UHI movies and IEC materials in the different Indian languages will be presented in the UHI country toolkit, while the Tupange toolkit will include the FP myths and misconceptions document and the NURHI based toolkit will have links to the radio drama discussion guides and training materials relevant for Nigeria.

**Process of further development of the regional component of the TCI toolkit (country toolkits)**

16.7 All of the existing country toolkits need further development with regard to the type of guidance needed about how to implement and adapt the interventions in different contexts, both in-country or in neighboring geographies. For example the PASS2020 project has revised the interventions used in Diamniadio and Rufisque, in order to enhance their programmatic focus as scaling up to additional districts proceeds. As a foundation for sustainability at the district level, they want to broaden the range of key stakeholders involved and seek inputs from the municipalities, key religious leaders, and local health committees.

16.8 It will be important to establish a process of sharing the contents and the formats of the four current country toolkits among the TCI Hubs, so that the teams can explore and learn from each other how their country/regional toolkits can be strengthened. However flexibility should be maintained to allow each country team to present their guidance in ways that they consider most appropriate for the local context.

**Development of the global component TCI Toolkit**

16.9 Simultaneously with the further evolution of the country-specific component of the TCI toolkit, the global component of the TCI toolkit will have to be developed based on a synthesis of past experience of the URHI's and learning as TCI scale up progresses.
The global component of the TCI toolkit should include comprehensive guidance on the general principles and how to ensure their implementation, interventions approaches and guidance materials available. This may include the development of general guidance documents and materials based on what has been developed at the country level. For example guidance materials with cross-regional relevance might include a tool for the rapid assessment of needs, programmatic capacity and general socio-cultural context. This could be developed based on the experience of the four URHIs on how to conduct such assessments.

An issue for further consideration will be the extent to which emerging or best practices tested in other parts of the world should be incorporated into the global component of the TCI toolkit. It will be essential to ensure that any such practices are first introduced and tested on a small scale within a TCI region, prior to the expectation for large-scale expansion.

**Type of presentation and dissemination**

The TCI toolkit components should be clearly written in simple language, practically oriented and organized in modular format to facilitate easy access and assembly of the specific approaches and associated materials needed.

The components of the TCI toolkit should be easily available on the web, on CD-ROM and in a format to facilitate printing of sub-components if required.

**Need for flexibility to allow learning as scaling up proceeds including the pretesting of additional interventions**

Mechanisms should be established to integrate into both of the TCI toolkit components learning about new interventions that are developed and tried out in the process of scale up and which prove to be relevant, feasible, effective and efficient. Mechanisms should be created for ongoing updating and revision as learning advances.

The current country toolkits should never be considered fixed or complete. Lessons related to the process of adaptation as tested interventions are implemented in new contexts will need to be added. It will also be useful to consider the benefit of testing additional intervention approaches rather than assuming that previously tested URHI approaches in each country represent the most appropriate package of interventions.
Technical support required for use of the toolkit

16.16 The use of the TCI toolkit will require technical support as cities, districts, or counties begin to use them. None are likely to be widely used on their own, particularly as in most countries sub-national health and FP program managers are busy and not likely to read lengthy documents. Such support would ideally be from a resource team that knows the interventions and how to implement them. This will enable the scale-up process to move forward more rapidly and with better chance of success than without such support.

Chapter 17: Sustainability

From the outset of the URHI projects there was a clear intention to ensure that successfully tested interventions would be sustained in the geographies where they were originally implemented and that initial scale up would be undertaken in a sustainable manner. Key efforts to promote sustainability already discussed earlier in this report included efforts to work within government policy and programmatic frameworks, to involve government and other stakeholders in the design and implementation of interventions to create ownership, and efforts to advocate with national and local governments for dedicated budget line items and budgetary allocations.

This chapter presents additional information on how the URHI sought to achieve sustainability and what is known about the extent to which interventions continue to be implemented in the four countries.

- India: Several developments suggest that the influence of the UHI has continued to be felt in Uttar Pradesh since implementation of the UHI supported interventions ended in mid 2015. First of all, it is significant that a large number of the more than 2000 UHI community health workers, the Urban ASHAs, have been or are still being recruited by government as part of the Urban Health Component of the National Health Mission. Their extensive training and experience, as well as the positive reputation in the communities they gained as part of the UHI will benefit the poor of the urban communities in the 11 cities where the project worked.

Moreover, most of the training, IEC materials, provider job aids and other UHI materials are available on government websites in Uttar Pradesh and the IEC materials in particular (see previous chapter) have also been requested by other states in India for use in their programs. In addition there is continuity because of the BMGF-funded Technical Support Unit (TSU) project, which supports the Uttar Pradesh State MOHFW for rural areas, is utilizing or adapting many of the UHI approaches and materials as many have been found to be relevant for the rural areas as wel. The fact that a large number of UHI staff have been hired by the TSU has also made it possible for many of the UHI interventions and lessons learned to be
applied to the TSU districts. The UHI films are now being pilot tested on tablets and smart phones for ASHAs to use in five TSU supported rural districts. TSU staff at the block level in these districts are also utilizing the films and they are being shown in FP clinics in government facilities.

The UHI’s deliberate effort to work entirely within the framework of government policy and interventions and its extensive capacity strengthening efforts are also likely to have continuing positive influence in the 11 cities, as well as more widely in UP. A key achievement in this regard was the UHI’s work with the state and district health officials to help prepare the annual National Health Mission’s Program Implementation Plans for urban health and for FP, so as to obtain and better utilize funding for FP and related SRH services. For example, the service improvements achieved by mobilizing resources for the establishment of additional urban health posts will have lasting benefits. Moreover, the capacity building efforts in regard to the FP and other areas will also be felt for longer periods of time.

A great deal of good will had been created while the UHI lasted. The project was highly regarded by government as a supportive, reliable and very effective partner. Their absence during the year following the end of the project was acutely felt by government. The knowledge and capacity of UHI staff to work in urban health and FP was particularly appreciated as government was and is still relatively inexperienced in urban FP work and especially with urban community mobilization. This widespread appreciation of the UHI among health officers also provides indirect evidence that UHI efforts will have lasting influence.

UHI city managers noted that once a team has established good relations with government there can be a tendency for Government to keep asking for more and more support. This can then lead to government dependency on the project, which becomes problematic for sustainability when projects end and support is often rapidly withdrawn. In India senior government officials acknowledged that given that the NUHM had not yet been implemented, it was the UHI team that had the skills and experience of working in the urban areas and their inputs and TA were critical to move forward. However the end of the UHI happened at an unfortunate time as it came when health officials felt a critical need for their assistance. As the urban component of the National Health Mission was just beginning when the UHI came to a close, it made sustainability of some of the interventions tested under UHI difficult. The UHI city managers felt that the transition was too abrupt and that they had insufficient time to ensure full transfer of some interventions to the government counterparts. They noted that experience following the end of the project suggests that recruitment of new acceptors may be decreasing in the cities formerly supported by the UHI.
This learning will be critical to the Foundation and to TCI. If intensive inputs and longer term involvement of project staff are required for sustainability then TCI needs to factor this into the implementation model.

- In Kenya, continuity of FP interventions can be observed in Tupange supported counties after the end of direct support of activities on 31st March 2015. The County and Sub-County Health Management Teams have continued to use Tupange innovations based on the Tupange FP Toolkit. Programmatic visits to these counties by Tupange staff, however, indicate that the intensity and frequency of these interventions is now reduced due to lower levels of available county funding.

The following activities are continuing at some level in a number of counties and sub-counties:

  o **Commodity security:** Due to the Tupange’s system strengthening at county and sub-county levels, a number of contraceptive depots are well stocked, especially with LARC commodities. While utilization of these commodities has been ongoing in the public and the private sector, the quantities being ordered are reduced as there are fewer FP demand creation activities taking place. The practice of monitoring facilities by sub-county health management teams to identify stock-outs is ongoing and the sub-counties and facilities are still continuing to redistribute commodities among themselves with their own resources. This practice has now expanded to include other RH commodities.

  o **FP reporting and use of data for decision making:** FP reporting rates for both commodity logistics and consumption data continue to be relatively high at the facility and county levels. Some sub-counties are facing a challenge because of the inadequate availability of reporting forms. However they are reporting on improvised forms to ensure continuity. The use of data for decision making is still on-going at all levels as providers and managers are using data for the identification of areas that are doing well, issues that require strengthening for better provision of services, improved targeting of services and for the identification of gaps in provider skills.

  o **Service Delivery:** Provision of FP services, including increased numbers of LARCs, is ongoing in almost all public and private sector facilities. Integrated FP outreaches are ongoing, but instead of monthly outreaches, some sub-counties are conducting quarterly outreaches.

  o **Capacity building of providers:** Mentorship is still ongoing but on a lesser scale. Supportive supervision incorporating FP is also continuing. Capacity building of
The efforts to simplify and integrate Tupange interventions with health teams’ work plans in Kakamega and Machakos represents a model with considerable sustainability potential, because interventions are embedded in the work plans of routine local government health management teams for purposes of supervision, outreach, and other activities. However, continued observations and monitoring will be important to follow what is happening in these sub-counties. It will be particularly valuable to compare these scale-up cities with what happens in the sub-counties of Kisumu, Nairobi and Mombasa to see whether interventions there will be more or less sustainable by comparison.
A Kenya official noted that in the end sustainability will depend on getting community members mobilized to express their needs and demand that local authorities create budget lines and invest in health and FP services.

- In Nigeria, NURHI’s advocacy efforts with state and LGA governments to create budget line items and to make and track expenditures for FP were a major effort to promote sustainability of FP commodities and services. The creation of state level Advocacy Core Groups was another key activity in Abuja, Ibadan, Ilorin and Kaduna. They have transitioned into semi-self sustaining NGOs, providing advocacy services for other FP partners such as, HERFON, PPFN, Pathfinder AFP and MSION FH plus projects and on other health related projects. Mobilization of core groups of FP master trainers in states where they have worked will also contribute to sustainability.

Despite these efforts sustainability of interventions remains a question mark. Some states/LGAs have created budget line items but actual expenditures have been minimal or non-existent where they have been created. Despite achieving considerable numbers of new acceptors, FP in general and use of modern contraception, apart from condoms and OCPs, are not community norms. NURHI has dropped supporting implementation in Abuja, Ilorin and Benin City (at the request of the Foundation). It will be interesting to see the extent to which activities, both services and demand generation/community mobilization will be sustained in these cities.

The philosophy underlying NURHI has always emphasized that creating demand for FP and making contraceptive use a social norm will create the conditions for increased political attention and investment in FP services.

- In Senegal, the “Paquet porteur” which was developed as a legacy from ISSU has been fully endorsed by the Directorate of Reproductive Health and Child Survival (DSRSE) as model for implementing the FP program within the context of the National Strategic Plan for Family Planning. The experience gained in Diamniadio and Rufisque showed that when provided with the necessary back up, the districts health management teams can take up the technical and managerial leadership for selecting and adapting some of the interventions tested by ISSU to their own context. However their constrained resources allowed for implementation of only a limited subset of the ISSU interventions. This experiment also made it clear that considerable external support remains essential for sustainability and scale up. The PASS 2020 project awarded to Intrahealth is aiming to strengthen the managerial capacity of all the 23 districts in the medical regions of Dakar (ten districts, all previously covered), Thies (one out of nine districts previously covered) and Kaolack (one out of four previously covered). However, it is not clear how much support will be provided in order to strengthen the
implementation capacity and sustain the interventions in the future, especially in the eleven new districts.

In Senegal, while the intention was to strengthen the institutional capacity of the districts, the posting and modus operandi of the ISSU city managers (coordinatrices de villes) in the initial core districts also resulted in dependency because they worked as a direct interface between the DHMTs and the consortium partners for the implementation of ISSU interventions within the districts. However sustainability of interventions was enhanced due to ISSU’s intense advocacy to institutionalize interventions at all levels of the Ministry. A key area of success in this regard is the fact that ISSU city managers were incorporated into the ministry at the end of the project.

**A strong focus on sustainability from the outset is essential:** The need to begin projects with sustainability in mind from the outset was clearly established by the URHIs. The type of interventions that were abandoned along the way because they were not sustainable contain important lessons for what not to attempt in the future. Interventions that were clearly not sustainable in the context of local capacities or human and financial resources that are likely to be able to be mobilized in the future (post TCI) should not be implemented as part of the TCI.

**A decline in sustainability is to be expected:** International experience in the field of family planning, health and more broadly in development suggests that it is to be expected that there will be some fall off in the intensity of implementation with diminished results when the intensive support and inputs of the projects are no longer in place. Competing interests and the contextual constraints, particularly with decreased financial resources will inevitably result in less intensive implementation efforts. (Korten, 1984; People-centered development).

**Gradual withdrawal ensures greater sustainability:** UHI and NURHI team members noted that achieving sustainability is even more difficult when implementing new activities, which had not been previously been an explicit part of the government program. Where strong advocacy and collaborative activities were motivating the government, and the “push” is suddenly withdrawn, it is likely that new activities stop and do not go forward. A more gradual process of transfer of responsibility to government can help them continue these activities and better ensure sustainability. This calls for changing the intensity of support over time, gradually tapering off towards the end of the project. UHI city managers stated “The key to sustainability is to jumpstart the program with intensive support but then gradually pull back the level of support as the government develops interest and capacity to implement on its own. There needs to be exit planning with sustainability in mind”.

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Recommendations:

17.1 Future efforts should avoid rapid withdrawal of project support and instead seek to gradually taper off support and fully transfer responsibility and skills to government prior to the end of the project, as this contributes to sustainability of project interventions. There needs to be exit planning with sustainability in mind.

17.2 Major emphasis on sustainability of interventions must be a key emphasis of future projects from the outset. A focus on institutionalization, with government ownership from the beginning, is a key means of achieving sustainability.

PART VIII. PROJECT ORGANIZATION

Chapter 18: Consortium and team management

Consortium management: The URHIs were implemented by a consortium of international and national non-governmental and community based organizations. In order to function effectively as a resource team for the government family planning program, a first major step was for the URHI consortiums to transform themselves into cohesive groups. It was essential that although staffed from different partnering organizations, they each became a unified team with a common vision. However, getting individuals who represented different consortium partners to work as a seamless team was a challenge. There was sometimes competition for visibility and/or budgets among partners. Thus, it took strong leadership and also a willingness to drop partners if their style of working or their technical composition was not appropriate, their performance below expectation or they were not flexible and willing to work together with common purpose and methods, despite efforts to get them aligned. During the course of the projects both UHI and NURHI dropped one or more partner organizations.

The ISSU consortium sought to establish a new model of delivering FP services by bringing several disciplines together and making sure they work in synergy and in a complementary manner. The methods of work were new compared to other consortiums that had worked in Senegal. The capacity of the partner organizations needed to be strengthened in several ways:

1) strengthening the management and institutional capacity of several NGO members,
2) facilitating regular reviews focused on productivity and achieving results,
3) building capacity in budgeting and financial management.
The leadership of the team was a key element of success: the Director did his best to ensure that the best qualified staff from partners were brought onto the team, even if that entailed to obtain exceptions from some rules of the coordinating agency Intrahealth.

- Tupange staff felt that strong leadership had been key to the successful functioning of the consortium. Each partner brought their strengths to the process of implementation and there was a friendly competition among them to succeed. They had regular management meetings with all the partners to discuss progress and to solve problems together.

The Project Directors all reported that partners were more likely to work as a coherent team if they seconded staff to a core team, rather than each partner implementing a set of assigned tasks by themselves. This resulted in activities of the project being implemented by the project team rather than by individual partners alone.

The Directors and their staff also highlighted that in addition, the success of the team working together was also due to the exceptional nature of the staff that they had been able to recruit, as opposed to the overall capacity of the partner organization per se. They felt that it was important that all staff be answerable to one leader, i.e. the Project Director of the multi-disciplinary team with responsibility to maintain a healthy and harmonious environment within the team.

Experience from all four URHI countries clearly showed that good management of the consortium was important, but a good manager is not necessarily a highly technical person. However, when the Director is both a strong manager and is very technically competent, it can be an advantage.

It was interesting to note that the URHI staff interviewed felt that in their previous experiences with other teams and consortia, they had not always been well managed and as a result these experiences had been qualitatively different their experiences with the URHIs.

**Recommendations:**

18.1 There needs to be a clear and transparent process of forming and managing the partnerships for them to succeed. This involves establishing clear roles for the individual partners, as well as rules, procedures and expectations that help to bind the team together. At the same time it is essential to maintain flexibility to allow changes over time.

18.2 The partnerships should be led by an individual with strong management skills, as opposed to being selected solely for their technical knowledge of FP.

**Managing the team:** All of the URHI teams thought that implementing good principles of personnel management were important for creating the staff motivation required for project
success. The teams highlighted a number of managerial factors that contributed to high levels of motivation and strong performance.

An essential factor in success was the selection and recruitment of highly competent individuals with strong technical skills and motivation. Not only was a rigorous process of recruitment important in creating an excellent team, but the fact that some members of the team had known each other through previous work created trust, and they were not afraid to challenge each other. Staff felt that having the best colleagues created a culture of excellence that spurred high levels of performance.

Creating a learning organization was also an important aspect of team management in each country. Cycles of assessment, implementation, monitoring and adaptation, were considered critical to learn and adapt interventions for effectiveness, efficiency and for successful scale up.

Developing a project culture that could embrace failure and learn from it was also important in each of the countries. The fact that management supported their staff to try new approaches without personal risk if these were not successful, contributed to innovation and success. Giving autonomy to staff in producing results was also cited as important. Once the goals and objects of the URHIs had been laid out, staff had autonomy in implementing activities to achieve results. This was reported having been highly motivational because people felt they could debate issues, learn and change their approaches based on this learning. As one Project Director stated, “This type of management gets people with good process skills to step up and get the team moving. It creates enthusiasm”.

A related factor in creating strong staff motivation was ensuring supportive supervision, communication, and opportunities for sharing. This helped create a context for personal growth and facilitated internal advancement within the team for those demonstrating strong performance. Staff from both UHI and NURHI explicitly cited this factor. In the UHI this extended to having external management skills-coaching for senior staff and even for a senior government counterpart, as well as a one-time management skills training session for a larger group of staff.

Country teams also emphasized the role of the fair salary structures and their competitive salaries in encouraging them to put in the many long hours and extra work on evenings and weekends that the URHIs’ demanded of them. Differing partner organization norms with regard to salaries and per diems needed to be addressed by Project Directors in transparent ways that either eliminated major differences or addressed staff concerns about equity.

Finally, the Project Directors all emphasized that they had been able to build staff enthusiasm and motivation by clearly presenting and continually emphasizing the URHI project goals. This
was not related to the initially stated URHI goals of a 20 percentage point increase in modern contraceptive prevalence, but rather to the larger goal of meeting the needs of the poor and the vulnerable in urban areas. They translated the quantitative project goals into those of serving people’s needs and made sure that this was understood by everyone and was continually reinforced. For example, NURHI emphasized their continuing use of a “consumer lens” to guide their efforts; “focusing on people’s needs and benefits, so as to give them what they want and when they want it”.

The importance of promoting communication and sharing was also highlighted in regard to the effective implementation of activities. Communication among staff was promoted not just through vertical lines of authority but also laterally among people with different responsibilities. This was reported to encourage acceptance of divergent views and the emergence of creative solutions to challenges. One Project Director noted that staff “owned” their efforts to a greater degree if new ideas had been discussed and debated among peers to reach agreement.

Former UHI team managers noted a difference between the UHI approach and how they observe the current Technical Support Unit (TSU) team to be working in supporting the UP MOHFW to implement FP and other MNCH interventions in rural Uttar Pradesh. Many of them now work as senior managers in the TSU. In this new context they stated that they now realize how important it was that in the UHI there was clear, horizontal and vertical communications and continual sharing among team members. As a result “everybody was on the same page” and clear about the reasons for making adaptations or changes if they needed to be made. This level of communication among different members of the team was also noted to be important in ensuring complementarity of action and supporting synergy among different components of the project.

Strong communication was also important in building mutual respect and trust among team members. The ISSU team emphasized the need to establish a team that cultivates mutual trust and understanding among the members. Team members must demonstrate their commitment to achieving the same goal, be ready to work in a complementary manner and be accountable, individually and collectively, to produce results. In the case of ISSU such commitment was in part created by the fact that most of its staff came from the Ministry of Health. For example, the director’s experience both at the district and national level has facilitated collaboration and advocacy with the MOH and made it possible to establish a team built on complementary skills and expertise. As a result, solidarity within the team was created as well as the commitment of members to take on the work of colleagues when they were ill without having to replace them.

All of the teams came to realize the value of having input from external experts to review the process and achievements of the project on a periodic basis. This external review increased staff motivation to excel and also provided insights that came from being outside of the national and project context and culture.
Finally, the Tupange, NURHI and UHI teams all highlighted the importance of a decentralized management structure. Project staff responsible for implementation at the city/county/district level were given the authority to make administrative and operational decisions necessary to learn, react to and respond to the program experiences and problems in the specific context where they were working. This flexibility was considered a major factor in the rapid response to challenges faced and to the ultimate success of the projects at the local level.

**Recommendations:**

18.3 It is important to ensure that teams are led by strong, capable managers who are committed to building learning organizations and creating high levels of staff motivation through rigorous recruitment and good personnel management practices.

18.4 TCI implementation will benefit from encouraging decentralized management and devolution of authority to the Hub, country and city/district/county levels.

18.5 Making use of external experts for conducting periodic field-based review of activities and achievements will be valuable for the TCI.

**Donor relations:** The flexibility of the BMGF was seen by all the teams as critical in allowing them to try new approaches, to drop activities that were not successful and then to adapt or reprogram efforts - in short to develop a learning culture. In India, an appreciated example was the dropping of the family planning voucher scheme. In Senegal, staff noted that thanks to the flexibility of the donor, the city managers were given autonomy to run the activities, provided they did them well, quickly, and in a timely manner. The prevailing guidance was “Don’t spend time complaining about mistakes or failures, but make sure you learn from them!”

The teams felt that the engagement of the donor staff with project management was strong, more than in their previous experience with other projects. At first this caused some discomfort, but they later realized how helpful it was in making them think critically about what they were doing. The close engagement, including through field visits, provided strong motivation to the project teams, including those at lower levels.

**Recommendations:**

18.6 In the future under TCI it will be important that the JHU Gates Institute provide flexibility to the Hubs and to teams implementing activities in new cities/geographies to adopt learning approaches: to test new interventions, drop planned activities that are not successful and reprogram efforts as required.
Close engagement by GI with the Hubs and implementation teams in new geographies should be pursued as part of an effort to motivate teams and provide external input to activities. However this engagement should be guided by flexibility and support for autonomy on the ground.

PART IX. CONCLUSION

This report has provided a detailed description of the URHIs in India, Kenya, Nigeria, and Senegal, presented the accomplishments for each of the major objectives and put forth a set of recommendations for the future scale up of their interventions. In this conclusion we briefly highlight five key contributions and reasons for the success of the URHIs.

First, the URHIs have made an important contribution to the global family planning field by focusing on the needs of the urban poor. In the past, the focus of family planning programs had been on rural areas. While this was much needed, especially in the early years, it led to the neglect of the urban poor. India is perhaps the best example of this. First initiated in 1952, the Indian family planning program has gone through major evolutions and transitions. However, the emphasis was always on the rural areas where the need was most urgent in the early years of the Family Planning Program. Yet with the extraordinary growth of the urban areas, in particular of the urban poor populations, attention to cities was essential. However, the long planned Indian National Urban Health Mission, which includes family planning, was slow in coming. When it finally began to be implemented, the BMGF-funded Urban Health Initiative in Uttar Pradesh, had been working for several years in 11 major cities, successfully modelling the approaches that were being planned by government for the urban poor. This experience assisted the government of Uttar Pradesh to initiate its urban health and FP program.

Second, all the URHIs can point to very impressive achievements in increasing modern contraceptive prevalence where they worked, and more generally in terms of creating demand for and improving access to quality family planning services for the urban poor. These accomplishments were not only made in a few limited slums, neighborhoods or districts, but in each country were achieved at an impressive scale covering diverse urban settings. For example the NURHI project worked in a number of major cities, which varied considerably in regard to ethnic, socio-cultural, linguistic, religious and service delivery context diversity. This was critical in each country, not only because it is essential to go beyond the small impact of typical pilot projects which do not benefit many people, but also because of the importance of scale in gaining the attention of government, and their willingness to institutionalize the interventions modelled by the URHIs.

Third, a major determinant of the URHIs success, was the way they worked as true partners with government, understanding that ensuring government ownership must be central. There was
considerable learning in this regard, with ISSU’s experience expanding to Diamniadio and Rufisque (discussed earlier in Chapter 15 and in Seck et al, 2016) a good example. However, all four projects were clear about the importance of government involvement and ownership from the outset and thus gained the respect of government counterparts.

Fourth, the URHIs could not have achieved their significant outcomes had they not focused simultaneously on demand creation, supply-side improvements and advocacy for needed policy, regulatory, and other necessary institutional change. Although the importance of such a holistic approach is widely recognized it is often not practiced.

Fifth, the URHIs were exceptional in terms of their focus on scaling up beyond the initial core cities to additional ones from the time the projects were designed. What was unusual in this regard was not only the effort to replicate interventions in new urban areas, but their willingness to apply systematic approaches to scale up in ways that prepared the ground for future sustainability and expansion. This application of a systematic approach to scale-up and its impact on the project team is described in the article by Keyonzo and colleagues, referred to in Chapter 15, which highlights the profound change in mindset which took place in Kenya.

Finally, the extraordinary success of the URHIs would not have been possible without the commitment of the Bill and Melinda Gates Foundation to provide extensive funding to the projects and to allow each team to function with autonomy and flexibility. This enabled the teams to learn on an ongoing basis how to adapt interventions and make the changes needed to succeed.

Overall, these five factors were instrumental in creating a strong basis for The Challenge Initiative.
Annex I.

Figure A.1 Percent Modern Contraceptive Method Use at Baseline (2010/2011) and Endline (2014) in Nigeria

Figure A.2 Percent Long Acting and Permanent Method Use at Baseline (2010/2011) and Endline (2014) in Nigeria
Figure A.3 Percent Modern Contraceptive Method Use at Baseline (2010/2011) and Endline (2014) in Kenya

Figure A.4 Percent Long Acting and Permanent Method Use at Baseline (2010/2011) and Endline (2014) in Kenya
Figure A.5 Percent Modern Contraceptive Method Use at Baseline (2011) and Endline (2015) in Senegal

Figure A.6 Percent Long Acting and Permanent Method Use at Baseline (2011) and Endline (2015) in Senegal
Figure A.7 Percent Modern Contraceptive Method Use at Baseline (2010) and Endline (2014) in India

Figure A.8 Percent Long Acting and Permanent Method Use at Baseline (2010) and Endline (2014) in India
Figure A.9 Percent Modern Contraceptive Method Use for Poorest Wealth Quintile at Baseline (2010/2011) and Endline (2014) in Nigeria

<table>
<thead>
<tr>
<th>City</th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuja</td>
<td>22%</td>
<td>40%</td>
</tr>
<tr>
<td>Ibadan</td>
<td>25%</td>
<td>36%</td>
</tr>
<tr>
<td>Ilorin</td>
<td>17%</td>
<td>28%</td>
</tr>
<tr>
<td>Kaduna</td>
<td>12%</td>
<td>22%</td>
</tr>
<tr>
<td>Benin City</td>
<td>26%</td>
<td>32%</td>
</tr>
<tr>
<td>Zaria</td>
<td>1%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Figure A.10 Percent Long Acting and Permanent Method Use for Poorest Wealth Quintile at Baseline (2010/2011) and Endline (2014) in Nigeria

<table>
<thead>
<tr>
<th>City</th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuja</td>
<td>1%</td>
<td>8%</td>
</tr>
<tr>
<td>Ibadan</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Ilorin</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Kaduna</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Benin City</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Zaria</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Figure A.11 Percent Modern Contraceptive Method Use for Poorest Wealth Quintile at Baseline (2010/2011) and Endline (2014) in Kenya

Figure A.12 Percent Long Acting and Permanent Method Use for Poorest Wealth Quintile at Baseline (2010/2011) and Endline (2014) in Kenya
Figure A.13 Percent Modern Contraceptive Method Use for Poorest Wealth Quintile at Baseline (2011) and Endline (2015) in Senegal

![Graph showing the percent modern contraceptive method use for the poorest wealth quintile at baseline (2011) and endline (2015) in Senegal. The graph compares the use of contraceptive methods across different regions (Dakar, Guediawave, Pikine, Mbao, Mbour, Kaolack), with Baseline and Endline data presented for each region.](image)

Figure A.14 Percent Long Acting and Permanent Method Use for Poorest Wealth Quintile at Baseline (2011) and Endline (2015) in Senegal

![Graph showing the percent long acting and permanent method use for the poorest wealth quintile at baseline (2011) and endline (2015) in Senegal. The graph compares the use of long acting and permanent methods across different regions (Dakar, Guediawave, Pikine, Mbao, Mbour, Kaolack), with Baseline and Endline data presented for each region.](image)

Figure A.15 Percent Modern Contraceptive Method Use for Poorest Wealth Quintile at Baseline (2010) and Endline (2014) in India.

Figure A.16 Percent Long Acting and Permanent Method Use for Poorest Wealth Quintile at Baseline (2010) and Endline (2014) in India.