2008

Repositioning IUCD in The Family Welfare Programme

Strategy, Operational Plan and Achievements

सत्यमेव जयते

Family Planning Division
Ministry of Health and Family Welfare
Government of India

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FOREWORD

The Government of India, as part of its commitment towards provision of quality spacing services in Family Planning, introduced IUCD 380A in 2002 replacing the earlier CuT 200. But the acceptance of Intra Uterine Contraceptive Device (IUCD) continues to remain below 2%, out of the total Couple Protection Rate of 48.5% for the use of any modern contraceptive method (NHFS-3).

Some of the major reasons identified for the low acceptance of IUCDs are lack of correct and complete information, both among the providers and acceptors; the advantages are understated, the disadvantages tend to be exaggerated; many myths and misconceptions prevalent in the community and among the providers leading to non acceptance; low insertion skills of the service providers and above all, limited access to skilled service providers. One of the reasons for low knowledge and skills on IUCD provision among health providers have also been due to the low priority given to contraceptive skill development of health providers in their basic training.

Achieving population stabilization, gender and demographic balance through universal access to equitable, affordable and quality health care, which is responsive to the needs of the people is the objective of the National Rural Health Mission and RCH II launched by the Government of India in 2005.

Recognizing the need of the hour for providing quality services in family planning, the Ministry of Health & Family Welfare developed a Strategy and an Operational Plan for Repositioning IUCD in the Family Welfare Programme addressing all the key areas such as, seeking policy support, creating demand, increasing provider base, improving service delivery, enhancing public-private partnership and strengthening monitoring and evaluation.

This document elaborates the strategies adopted by the Ministry for repositioning IUCD and I hope this would act as an asset in programme planning on IUCD for all the policy makers, programme managers and implementers.

(G. C. Chaturvedi)

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We wish to acknowledge the contribution of Dr. S.K. Sikdar, AC(FP), Dr. Keerti Malviya, AC(FP), Dr. Jaya Lalmohan, Consultant, FP Division, Dr. Loveleen Johri, USAID, Dr. Dinesh Agarwal, UNFPA and Dr. Nisha Gupta, FHI, who have rendered continuous technical inputs for the process as well as in the documentation of the process.

The deepest appreciation is for Ms. Nandini Johri for her efforts in developing the document in a very short period.

(Dr. M.S. Jayalakshmi)

Contents

Abbreviations

ANM	–	Auxiliary Nurse Midwife
ANMTC	–	Auxiliary Nurse Midwife Training Centre
ASHA	–	Accredited Social Health Activist
AWW	–	Anganwadi Worker
BCC	–	Behaviour Change Communication
CHC	–	Community Health Centre
DTC	–	District Training Centre
FHI	–	Family Health International
FOGSI	–	Federation of Obstetric and Gynaecological Societies of India
FPAI	–	Family Planning Association of India
FRU	–	First Referral Unit
HFWTC	–	Health and Family Welfare Training Centre
HLFPPT	–	Hindustan Latex Family Planning Promotion Trust
ICDS	–	Integrated Child Development Scheme
IEC	–	Information Education and Communication
IMA	–	Indian Medical Association
IMR	–	Infant Mortality Rate
IUCD	–	Intrauterine Contraceptive Device
JSK	–	Jansankhya Sthirata Kosh
LHV	–	Lady Health Visitor
MIS	–	Management Information System
MMR	–	Maternal Mortality Ratio
MO	–	Medical Officer
MOHFW	–	Ministry of Health and Family Welfare
NARCHI	–	National Association for Reproductive & Child Health of India
NGO	–	Non-Governmental Organisation
NIHFW	–	National Institute of Health and Family Welfare
NRHM	–	National Rural Health Mission
PHC	–	Primary Health Centre
PPP	–	Public-Private Partnership
RCH	–	Reproductive and Child Health
RTI	–	Reproductive Tract Infection
SIHFW	–	State Institute of Health and Family Welfare
STI	–	Sexually Transmitted Infection
TFR	–	Total Fertility Rate
TOT	–	Training of Trainers
UNFPA	–	United Nations Population Fund
USAID	–	United States Agency for International Development
WHO	–	World Health Organization

Introduction

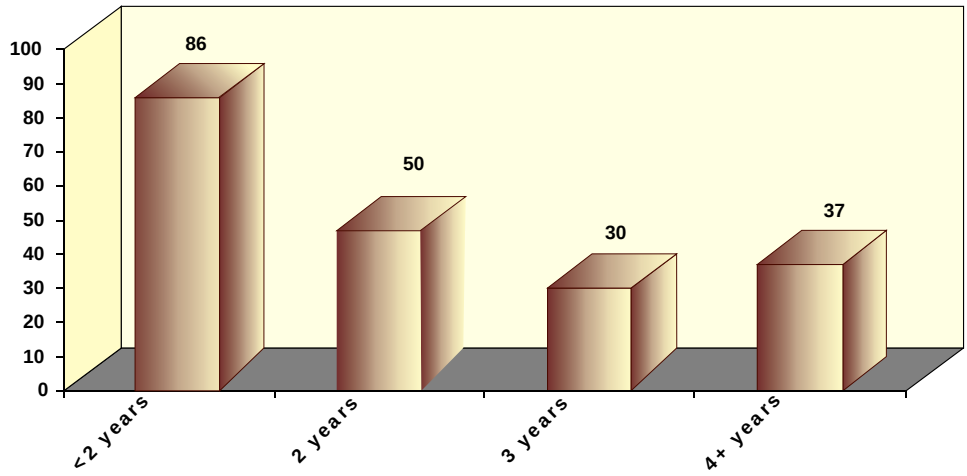
1. Introduction

India was the first country in the world to start a National Family Planning Programme in 1956. The programme remained centred around adopting permanent methods, with very little adoption of spacing methods. In 1997, the Government of India adopted the Reproductive and Child Health (RCH) Programme which advocates a client-centred, demand-driven and target-free approach with emphasis on spacing methods for quality reproductive life and promotes responsible and planned parenthood. In 2005, the Government of India launched the National Rural Health Mission (NRHM), which subsumes the second phase of RCH Programme, advocating the same approach for achieving quality reproductive life.

The National Population Policy 2000 has recognized as its immediate objective the task of addressing the unmet need for contraception to achieve the medium term objective of bringing the Total Fertility Rate (TFR) to replacement level of 2.1 by 2010 so as to achieve the long-term goal of population stabilization by 2045. As per National Family Health Survey (NFHS-3), the contraceptive prevalence rate in India is 56.3%, which varies widely between different States. The unmet need for family planning is high at 13%, with unmet need in spacing methods at 6%. The current approach in family planning emphasizes on offering high quality contraceptive services among eligible clients on a voluntary basis with spacing methods as an important component. However, the acceptance of spacing methods still remains low in the country.

It is an established fact that use of spacing methods can effectively reduce Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR). Studies indicate that children born less than two years after a previous birth are nearly three times at greater risk of death than children whose mothers waited three years between births (NFHS-3). Hence, promotion of spacing methods would not only contribute towards reduction in TFR but also in reduction of MMR and IMR.

Infant Mortality Rates by Birth Interval



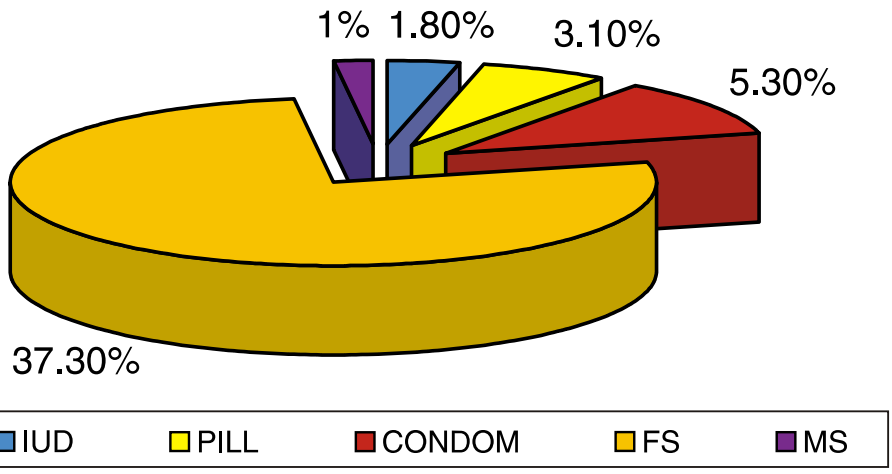
Data Source: NFHS – 3

4 Repositioning IUCD in The Family Welfare Programme, *Strategy, Operational Plan and Achievements*

Intrauterine Contraceptive Device (IUCD) is one of the most commonly used reversible methods of contraception among women of reproductive age worldwide which is needed for spacing between children. Results of recent studies have confirmed that IUCDs provide very effective, safe, short-term as well as long-term protection against pregnancy and the health risks associated with the method are negligible.

Lippes Loop was the first IUCD to be introduced in the National Family Planning Programme of the country in 1965. Based on the results of clinical trials conducted by the Indian Council of Medical Research in 1972, Copper T 200B was introduced in the programme in 1975. In 1997, ICMR conducted a comparative study between Copper T 200B and 380A, based on which Copper T 380A was introduced in 2002 replacing Copper T 200B in the programme. In India, only 1.8% of married women of reproductive age use IUCDs despite the fact that the Government offers IUCD services free of cost.

IUCD usage in India vs other methods



FS-Female Sterilization, MS-Male Sterilization
Reference NFHS-3 (2005-06)

One of the main reasons that IUCD is under utilized in India is that many health service providers and potential clients lack accurate and up-to-date information about the IUCD. It is often found that the advantages are understated, the disadvantages tend to be exaggerated and many myths and misconceptions are prevalent in the community and among the providers, leading to poor product image. The high discontinuation rate is due to problems related to providers' knowledge and skills leading to improper selection of clients, poor counselling and lack of follow-up, all resulting in poor quality of services.

With the objective of improving the method mix in the contraceptive acceptance through IUCD, the Government of India developed a strategy to reposition IUCD in the Family Welfare programme. A meeting of experts comprising senior obstetricians and gynaecologists from various States, State Programme Managers, trainers from the National Institute of Health and Family Welfare, international agencies like USAID, UNFPA and WHO was held in October 2006 to identify the gaps and areas which need further strengthening in the IUCD programme in the country. The three major areas were identified as:

A. Training

The training provided in IUCD had the following lacunae:

- Adequate caseload not available for skill training due to low availability of acceptors.
- Limited training in IUCD for Medical Officers and nursing personnel during their basic medical and nursing training resulting in low skills in service provision. In-service training on IUCD is also not provided to these two categories of health service providers.
- Skills on Reproductive Track Infection (RTI) screening and counselling, which are the major factors contributing to client satisfaction and continuation rate, not adequately addressed.
- Competency certification as well as performance assessment of trainees following training not given due importance.

B. Provider Base

- The IUCD in the public facility is mostly provided by Auxiliary Nurse Midwives (ANMs) at the peripheral level where 70% of the population resides. Trainings for Medical Officers, Staff Nurses and Lady Health Visitors (LHVs) in addition to the ANMs needs to be conducted in order to increase the provider base as well as to ensure the availability of trained supervisory cadre.

C. BCC

- A focused strategy is required for creating awareness and generating demand for IUCD by addressing the existing myths and misconceptions among the community members and the providers.

Based on the identified need, a **National Strategy for Repositioning IUCD** was developed. This document enumerates:

- The Goals, Approach, Strategies, Objectives and Operational Plan for Phase I, II and III for repositioning IUCD in the Family Welfare programme.
- Activities undertaken and milestones achieved in Phase I (2006-2008).
- Challenges faced, lessons learnt and the success stories in Phase I.
- Areas that require strengthening during Phase II and III based on the lessons learnt in Phase I.

Purpose of this document

The purpose of this document is to provide information on the genesis of repositioning IUCD strategy, the experiences gained and lessons learnt in its implementation and way forward for scaling up and operationalizing the strategy to all the 613 districts in the country. The document is proposed to serve as a reference guide for all the States to scale up IUCD repositioning from initial pilot districts to all the districts and monitor its implementation.

Target Audience

This document will be helpful for the policy makers, State Programme Managers and State training institutions in implementing this strategy for improving IUCD acceptance in the country. It would also be of help to NGOs and international agencies interested in providing support to the Government of India in this endeavour.

National Strategy for Repositioning IUCD

2. National Strategy for Repositioning IUCD

2.1 Goals

- To reduce the unmet need for spacing methods.
- To improve quality of life through reduction in IMR and MMR in addition to TFR.

2.2 Approach

- Client-centred, demand driven, holistic, decentralised and quality approach.
- Introduction of the strategy in a phased manner i.e. in three phases -
  - Phase I Pilot introduction in 12 districts in 12 States (one district per State).
  - Phase II Scaling up to all the remaining districts of 12 States and pilot introduction in one district of the rest of the 17 States and 6 Union Territories (UTs) in the country.
  - Phase III Scaling up to all the remaining districts of 17 States and 6 UTs.
- Involving the private sector including NGOs in ensuring quality services.

2.3 Guiding Principles

- Supportive policy environment
- Human Resource Development
- Maintaining demand-supply balance
- Quality Assurance
- Monitoring and Evaluation

2.4 Strategies Addressing the Key Areas/Issues

2.4.1 Policy Support

- Sensitising policy makers in the Central and State Government on the strategy.
- Giving more emphasis on IUCD skill training in the basic trainings of Medical Officers, nursing personnel and ANMs.
- Increasing advocacy on IUCD by sensitising health professionals from the public and private sector, using forums like Federation of Obstetric and Gynaecological Societies of India (FOGSI) and Indian Medical Association (IMA).
- Enlisting the support of national and international agencies for assistance in expanding trainings in NGO and private sector and monitoring and evaluation of the repositioning strategy.

2.4.2 Human Resources

- Increasing the provider base by training the Medical Officers, Staff Nurses and LHVs in addition to the ANMs, thereby improving the capacity of the supervisory cadre.
- Enhancing the skills of service providers by adopting a humanistic approach in training, using the anatomical pelvic models to address the non-availability of sufficient caseload for competency building in IUCD.
- Empowering the providers' knowledge through revised IUCD Guidelines with latest technical updates on WHO Medical Eligibility Criteria for selection of cases and also emphasizing on areas like infection prevention and counselling.
- Involving grassroot level functionaries like Anganwadi Workers, (AWWs), Accredited Social Health Activists (ASHAs) and Male Health Workers who mobilise the clients through awareness generation on IUCD.

2.4.3 Service Delivery

- Improving the infrastructural facilities where IUCD services are provided.
- Strengthening logistics through supply of IUCD kits, IUCDs and BCC tools.

2.4.4 Demand Generation

- Addressing myths and misconceptions amongst the community members and service providers with the help of BCC tools.
- Creating awareness among the target audience through multi-media approach and decision-making tools.

2.4.5 Public-Private Partnerships

- Enhancing Public-Private Partnerships in collaboration with national technical organizations and NGOs.
- Involving health professionals from the private sector in the training programmes for IUCD.
- Developing viable social franchising models for IUCD promotion.

2.4.6 Monitoring and Evaluation

- Conducting regular monitoring through the routine Management Information System (MIS) reports.
- Conducting periodic reviews with implementing States before scaling up to all the districts of the country.
- Establishing a supportive supervisory and monitoring mechanism in all the States and UTs.
- Conducting periodic evaluations with the support of external agencies.

2.4.7 Newer Areas in IUCD Services

- Introducing Multiload 250 for enhancing IUCD choice.
- Introducing 'Immediate Post partum IUCD Insertion'.

Operational Plan

Phase I (2006-2008)
Phase II (2008-2009)
Phase III (2009-2010)

3. Operational Plan
Phase I (2006-2008)
Phase II (2008-2009)
Phase III (2009-2010)

3.1 Objectives and Activities for Repositioning IUCD

The objectives and activities specified below are common for all three phases of operationalising the strategy for repositioning IUCD in the Family Welfare programme.

Objective 1 — To enlist policy support through advocacy and sensitisation for repositioning IUCD in the context of Family Welfare programme

Activities Planned

- Developing a strategy on repositioning IUCD in the Family Welfare programme.[1]
- Involving policy makers from Central and State Governments in adopting the strategy.
- Holding State level workshops for sensitising policy makers, State officials, gynaecologists and other health professionals from the public, private sector and NGOs.
- Using forums like FOGSI and IMA for sensitisation of medical professional bodies and its members.
- Awareness generation and orientation on IUCD for grassroot level functionaries like AWWs, ASHAs and Male Health Workers.

Objective 2 — To ensure the availability of skilled service providers at various levels of health care delivery system

Activities Planned

- Revising the existing Guidelines on IUCD and developing Reference Manuals for Medical Officers and Nursing Personnel.[1]
- Making anatomical pelvic models available for trainings.
- Introduce the Alternative Training Methodology in IUCD training in a phased manner
  - o Phase 1 Pilot introduction in 12 districts in 12 States (one district per State).
  - o Phase II Scale up the methodology to all the districts in the 12 States.
    - — Introducing one district per State in the remaining 17 States and 6 UTs.
  - o Phase III Scale up the methodology to the remaining districts in the 17 States and 6 UTs.
- Conducting the IUCD trainings using the Alternative Training Methodology technique at three levels.
  - o Level 1 National level TOT for State Training Teams

[1] One time activity

- Level 2 State level TOT for District Training Teams
- Level 3 Training of the Service Providers - Medical Officers, Staff Nurses, LHVs and ANMs from CHCs, 24x7 PHCs and their satellite Sub-centres

  A total of nearly 400 service providers to be trained from one district in one-year period.

- Issuing competency certificate to the trained service providers.
- Training the State and the District Training Teams for assessing the quality of trainings and performance standards.

Objective 3 — To strengthen the infrastructure and logistics for providing quality care in IUCD

Activities Planned

- States to ensure that:
  - Infrastructural up-gradation of CHCs/PHCs and Sub-centres and facilities for providing quality IUCD services takes place in a time bound manner.
  - Effective utilization of the untied fund for making the supplies available for infection control, waste management and supportive care for IUCD acceptors.
- Strengthening logistics for continuous supply of IUCDs.
- Supporting States in procurement of IUCD kits.

Objective 4 — To create awareness and generate demand among the community regarding IUCD

Activities Planned

- Developing BCC prototype materials like audio, video CDs, print posters, flipcharts and leaflets on IUCD and distributing them to the States for creating awareness.[1]
- States to translate these materials into local language.[1]
- Holding regional review meetings for sharing BCC tools, strategies and the guidelines.[1]
- Centre and States to broadcast (through various channels) messages on various spacing methods, including IUCD.
- Mobilize communities on IUCD issues through the group meetings organized by ASHAs, AWWs, and ANMs.
- Sensitising policy makers in the Central and State Government on the strategy.
- Distribution of the BCC materials and mobilisation of the eligible couples on Village Health & Nutrition Days by ASHAs, AWWs, ANMs.
- Counselling eligible couples on spacing methods during ante-natal, post-natal and immunization clinics by the MOs, Staff Nurses, ANMs and LHVs.

[1] One time activity

Objective 5 — To promote public-private partnership

Activities Planned

- Organising sensitisation workshops on IUCD for public and private gynaecologists through national and state FOGSI workshops.
- Promoting the Alternative Training Methodology in IUCD through short training workshops for the service providers from the private sector.
- Training of private doctors and NGOs on Alternative Training Methodology in IUCD for social franchising.
- Implementing innovative PPP models to promote IUCD service delivery, such as social franchising, vouchers scheme and social marketing.
- Documenting innovative PPP models and disseminating best practices to the stakeholders.
- Developing guidelines for accreditation of the private sector facilities providing IUCD services.

Objective 6 — To develop a strong Monitoring and Evaluation system

Activities Planned

- Development of core teams at the national, state and district levels for providing supportive supervision and monitoring.[1]
- Development of monitoring tools and checklists for[1] —
  - o Assessing the quality of the State and district trainings.
  - o Performance standards assessment of the service providers.
  - o Display and utilisation of BCC materials.
  - o Maintenance of registers and records.
  - o IUCD acceptance level and clients' satisfaction following the trainings.
- Regular reporting on the progress of the trainings by the District Training Teams.
- Collation and analysis of regular MIS reports received for quality improvement in IUCD services.
- Holding review meetings for monitoring the progress and identifying correctional course.
- Assessing providers performance and clients' satisfaction - A concurrent study to be conducted for evaluating the effectiveness of the strategy which would also look into clients' perceptions, continuation rates and side effects of IUCD.[1]

Objective 7 — To explore newer opportunities for enhancing IUCD usage

Activities Planned

- Enhancing the basket of choice in IUCDs. Pilot introduction of Multiload 250 in the Family Welfare programme.
- Introducing 'Immediate Post partum IUCD Insertion' in a phased manner for capitalizing on the successful scaling up of institutional deliveries under the present NRHM and RCH II Programme.

[1] One time activity

3.2 Activities Undertaken during Phase I (2006 -2008)

Objective 1 — To enlist policy support through advocacy and sensitisation for repositioning IUCD in the context of Family Welfare Programme

Activities Conducted

- A meeting of experts from the field of obstetrics & gynaecology, State Programme Managers, National Trainers from NIHFW (the national apex institute in training), international agencies like USAID, UNFPA, WHO was held in October 2006 to identify the gaps and areas needing strengthening in India's IUCD programme.
- Based on the discussions, a Strategy to Reposition IUCD in the Family Welfare programme was developed with the approval of the Secretary, Health and Family Welfare, Government of India.
- Two specific areas needing focused attention were identified
  1. Training Strategy.
  2. Developing a BCC strategy and materials for creating awareness and generating demand
- An Alternative Training Methodology addressing the specific training needs in IUCD services was developed (Annexure A).
- 12 States representing different regions of the country were selected for piloting this strategy in Phase 1 (2006-08).
- The Secretary (Family Welfare), Director (Family Welfare) and Director, SIHFW of the 12 States selected for the pilot introduction were appraised on the strategy being adopted and the States were requested to identify one district for piloting this initiative in the first phase. However, Uttar Pradesh and Delhi identified more than one district.
- Various gynaecologists' forums like National and State Obstetrics & Gynaecologists Associations were utilised for creating advocacy on IUCD.
- Awareness generation and orientation on IUCD for AWWs, ASHAs and Male Health Workers was initiated in the States along with the trainings.

Objective 2 — To ensure the availability of skilled service providers at various levels of health care delivery system

Activities Conducted

- Existing Guidelines on IUCD for Medical Officers and ANMs by Government of India were updated by an expert group, incorporating the recent information about IUCD on Medical Eligibility Criteria and no-touch technique of insertion. These revised Guidelines titled 'IUCD Reference Manuals for Medical Officers' and 'IUCD Reference Manuals for Nursing Personnel' (translated into Hindi) were printed and distributed to the States. The training package developed also included: 'Alternative Methodology of Training in IUCD -Facilitator's Guide' and 'Operational Manual for Alternative Methodology of Training in Intrauterine Contraceptive Device'.
- 76 anatomical pelvic models were made available for the national and state level trainings by USAID for adopting the Alternative Training Methodology in the 12 districts in 12 States.

- Three National TOTs for 12 States - Delhi, Madhya Pradesh, Rajasthan, Uttar Pradesh, Assam, Chattisgarh, West Bengal, Karnataka, Kerala, Gujarat, Jharkhand and Maharashtra were organized for pilot introduction of 'Alternative Training Methodology in IUCD' during June and July 2007 with experts from JHPIEGO as the Master Trainers.
- Following the National TOTs, all the 12 States conducted the State TOTs for the District Trainers from the selected pilot districts between September 2007 to January 2008.
- The District Trainers conducted trainings for the service providers Medical Officers, Staff Nurses, LHVs and ANMs from CHCs, 24x7 PHCs and the satellite Sub-centres from the selected districts.

Objective 3 — To strengthen the infrastructure and logistics for providing quality care in IUCD

Activities Conducted

- CHCs, PHCs and Sub-centres are being upgraded under NRHM, which would ensure adequate infrastructure support for provision of quality IUCD services.
- Regular and sufficient supply of IUCDs ensured from the Centre to the States.
- Medical Officers In-charge of CHCs and PHCs empowered to purchase materials for infection prevention and related items through untied funds provided under NRHM.
- Procurement of IUCD kits decentralized to district level by empowering district CMOs to purchase these from RCH flexipool funds.

Objective 4 — To create awareness and generate demand among the community regarding IUCD

Activities Conducted

- BCC tools and materials on IUCD 380A were developed by the MOHFW and disseminated to the States.
- Pamphlets and flipcharts on IUCD 380A were developed as job-aids for aiding in the decision-making of the clients (Annexure B).
- Audio and video spots on IUCD 380A have been developed as prototypes.
- IUCD 380A and spacing methods messages are being broadcast through various television and radio channels at the Central level.
- States requested to broadcast the promotional messages on spacing and IUCD 380A through the State IEC budget released through NRHM, using the prototypes developed.
- Acceptors being mobilized by ASHAs/AWWs/ANMs from their field areas.
- ASHAs, AWWs and ANMs acting as BCC agents during their regular contacts with the women and during the Village Health & Nutrition Days.
- Counselling process has been strengthened at the ante-natal, post-natal and immunization clinics.
- Audio, video and print material on IUCD 380A developed by the Ministry have been uploaded on its website for wider dissemination and use.

Objective 5 — To promote public-private partnership

Activities Conducted

- Sensitisation workshops for private practitioners on spacing methods and IUCD 380A were held through professional bodies like IMA and FOGSI. Five sensitisation workshops on IUCD 380A for FOGSI members from public and private sector were organized at the national and state level.
- Short training workshops on the Alternative Training Methodology in IUCD for private gynaecologists were organized by JSK (National Population Stabilization Fund, a registered society of the MOHFW, Government of India) for the State of Delhi and two districts of Haryana State.
- JSK has initiated the social marketing of IUCD 380A through private practitioners in Delhi and 2 districts of Haryana for which free IUCDs are provided by MOHFW.
- A Training of Trainers workshop was held for staff from HLFPPT, a public sector organization of the Government of India, for their social franchising project in IUCD. The six trainers trained from HLFPPT would now provide training to all accredited private providers under the social franchising project in Uttar Pradesh.
- IUCD being promoted through voucher scheme in Agra, Kanpur and Haridwar through private providers for BPL (Below Poverty Line) clients as part of the IFPS II bilateral project.

Objective 6 — To develop a strong Monitoring and Evaluation system

Activities Conducted

- Monitoring tools and checklists for performance standards assessment have been developed. State Trainers have been trained on the monitoring technology by JHPIEGO and States have started using it.
- All 12 States TOTs and few district trainings of MOs and nursing personnel (one from each district chosen) have been monitored and documented, using the training quality checklist.
- Assessment of the competency of service providers using the performance assessment tools was conducted.
- Monthly reports are being received regularly from States on the status of the trainings conducted.
- In February 2008, a Review Meeting with the Programme Managers and State Trainers from the 12 States was held to review the progress made in the trainings. The State Trainers were also provided training in Performance Standards Assessment by JHPIEGO during this meeting.
- At the end of one year of training strategy implementation, a second Review Meeting was held in June 2008 with the SIHFW Directors, Programme Managers and State Trainers. After reviewing the progress, MOHFW decided to scale up the training strategy to the rest of the districts in the 12 States chosen in Phase I and also introduce it in one district each of the remaining 17 States and 6 UTs of the country.

Objective 7 — To explore newer opportunities for enhancing IUCD usage

Activities Conducted

- An Expert Group Meeting was held by the Ministry on 17th May 2008 for exploring the possibility of including other types of IUCDs in the Family Welfare programme. Based on the recommendations of the Expert Group, a decision was taken to introduce Multiload 250 in the Family Welfare programme in a phased manner.

- Action has been initiated for procuring Multiload 250 for pilot introduction in 12 States.
- ICMR is developing a feasibility study on the introduction of Multiload 250 in the 12 pilot districts.
- An Expert Group Meeting was held by the MOHFW on 22nd July 2008 to study the feasibility of introducing 'Immediate Post partum IUCD Insertion' in India, following the successful scaling up of institutional deliveries under the present NRHM and RCH II Programme. It was decided to introduce this technique in select Medical Colleges after a national level training.

3.3 Support provided by International Agencies

- 'IUCD Reference Manuals for Medical Officers', 'IUCD Reference Manuals for Nursing Personnel', 'Alternative Methodology of Training in IUCD - Facilitator's Guide' and 'Operational Manual for Alternative Methodology of Training in Intrauterine Contraceptive Device' were developed with the assistance of experts from various States, USAID, JHPIEGO, WHO, Constella Futures and FHI.
- National TOTs for 12 States were organized for pilot introduction of 'Alternative Training Methodology in IUCD' with assistance from USAID and JHPIEGO in June and July 2007.
- 76 anatomical pelvic models were provided by USAID for the pilot introduction in 12 States.
- UNFPA is procuring anatomical pelvic models for all the 29 States and 6 UTs.
- Population Council, UNFPA, USAID and Constella Futures supported the Ministry in reviewing, adaptation and development of BCC tools and materials.
- Population Council helped in printing the prototypes on all contraceptives including IUCD 380A.
- USAID and UNFPA have provided consultants for facilitative supervision and monitoring.
- FHI has provided the support for documenting the repositioning strategy.
- PSI to provide support in monitoring, training, involving the private sector and BCC on IUCD in 6 States.

3.4 Milestones Achieved and Success Stories in Phase I

Advocacy

- The policy makers at the national and state level and State Programme Managers have been sensitised on the repositioning strategy and support for the programme has been ensured.
- Support of senior gynaecologists from the public and private sector has been enlisted in many States.

  Success Stories

  - Kerala has organized three regional orientation workshops on IUCD for gynaecologists in the public and private sector under the leadership of the FOGSI President of the State. This has helped to remove many myths and misconceptions among the providers.
  - During the Annual Conference organized by NARCHI, Delhi Branch in 2007, a training stall was put up for senior gynaecologists, demonstrating the 'No-Touch' technique in loading IUCD. A CD developed on the technique of loading the IUCD during this conference is now being utilised for further trainings.

- AIIMS, Delhi organised a half-day training workshop for gynaecologists from Delhi.
- Karnataka has organized sensitization workshops for Integrated Child Development Scheme (ICDS) sector staff and ASHA workers and has trained Family Planning Association of India, an NGO, who provide outreach services for IUCD.
- Gujarat has adopted camp approach for popularising and promoting IUCD through trained providers. The State Legislators of Gujarat are now acting as strong advocates during these camps, after their sensitisation by the State officials, and are actively promoting IUCD.

Trainings

- A team of State Trainers and District Trainers for one district in each State has been developed in all the 12 States. They are now in the process of training the Medical Officers, Staff Nurses, LHVs and ANMs in the selected districts (Annexure C).
- The States have begun the process of scaling up the training to the remaining districts.
- The skill training on the anatomical pelvic model for IUCD insertion and removal has been found to be useful in developing the competency of the service providers before they practice on clients. As a result, the clinical training sites and hospitals with minimum caseload could organize the training on IUCD for service providers, taking into consideration client's rights and safety.

  Success Stories

  - Gujarat has scaled up the Alternative Training Methodology in IUCD to the entire State and has already provided the anatomical pelvic models to all the districts. The District Health Administration is actively involved in organizing and monitoring the trainings.
  - Maharashtra has conducted TOTs in Alternative Training Methodology on IUCD for the faculty of SIHFW and six regional HFWTCs in July 2008. These teams would now conduct the trainings for all the districts under them. Three gynaecologists from Bombay Municipal Corporation (BMC) have been trained as trainers who would now scale up the training to all the service providers in BMC in a cascading manner.
  - The ANMTC, Jorhat district, Assam has incorporated the training on IUCD in the basic curriculum of ANMs and General Nursing Midwives.
  - Karnataka has been a model State in team work. Due to the good team work involving SIHFW, DTC and the District Health Administration, Belgaum district could conduct the trainings of Medical Officers and Staff Nurses from CHCs and PHCs in a time bound manner.
  - Kerala has now incorporated the training techniques of the Alternative Training Methodology in all the other trainings conducted by the State.
  - HLFPPT has adopted this methodology for training private and NGO providers under their social franchising model.

Performance

The performance in IUCD can be measured in terms of improvement in quality care provided in IUCD services and the increase in IUCD acceptance by the community.

- With reference to quality of care, the performance standards assessment undertaken from the Centre during Phase I in all the pilot districts shows a marked improvement in quality of services (Annexure D).
- With reference to the increase in IUCD acceptance, it is too early to expect a marked change as the demand generation component is yet to be scaled up. However, a positive trend has been seen in some States.

District/State	Performance (IUCD Acceptance)		
	Jan - Jun.07	Jan - Jun.08	% change
Belgaum, Karnataka	12,543	13,065	4.2%
Jorhat, Assam	512	1,591	210%

Success Stories

- In Jorhat district, 9 PHCs including the satellite Sub-centres with trained service providers have provided an average of 20-25 cases per month as against the earlier 2-3 cases per month in the past 6 months. The acceptance of IUCD in one PHC has gone up from earlier level of 15 insertions in 3 months to 114 in 3 months (7 times increase). This PHC is now identified as a clinical training site.
- Gujarat has adopted a camp approach with intense BCC campaigning. IUCD camps are organized on a fixed day in all the health facilities (District Hospital, CHCs, PHCs) with the trained MOs, Staff Nurses, LHVs and ANMs with wide information dissemination. The State has shown an increase of 9.2% in IUCD acceptance over the last year's performance.

BCC

- Demand generation for IUCD in the community is essential to ensure utilisation of the skilled human resources that are being generated through intensive efforts in training. The State IEC Officers were involved in the TOTs and given the responsibility of initiating BCC activities to improve the demand for IUCD.

Success Stories

- In Uttar Pradesh, SIFPSA has branded the Government supplied IUCD 380A as 'Suvidha' and packaging of IUCD was done which included a follow up card in each IUCD pack. A BCC campaign was developed that included 5 TV spots, 4 posters (urban, rural, addressing myths and misconceptions and job aid posters); wall paintings and hoardings. The campaign was initiated in 33 districts and the TV spots were aired for 3 months. The ANMs were trained in IPC and counselling skills for IUCD.

3.5 Lessons Learnt and Challenges Faced in Phase I

3.5.1 Lessons Learnt

- **Advocacy:** Building advocacy on IUCD usage is an essential step for rolling out the strategy for repositioning IUCD. States like Gujarat, Uttar Pradesh and Kerala where the legislators, policy makers and opinion leaders have been enrolled as strong advocates, implementation of the strategy was easier with better output.
- **Establishing State Institute of Health and Family Welfare (SIHFW) as nodal centre:** The best results were seen in States where SIHFW took an active role, like in Assam, Kerala, Karnataka, Delhi and Gujarat. Capacity building of SIHFW and making SIHFW as the nodal centre is crucial for all skill trainings.
- **Team building at the State level:** The States like Assam, Gujarat, Kerala, Karnataka, Delhi, West Bengal and Uttar Pradesh, which had a dynamic team approach between the policy makers, State Directorate of Family Welfare and SIHFW showed the best outputs. Hence, team building becomes a crucial factor for the success of this strategy.
- **Team building at the Service delivery level:** The strategy of involving various categories involved in service provision like programme managers, gynaecologists, faculty members of SIHFW, Nurses and ANM Training Centres and State IEC personnel has helped in developing a core team of committed officials at the State and district level with a common objective of scaling up IUCD acceptance.
- **Identification of a Champion:** Motivation of single person/few individuals, who may not necessarily be the decision makers in the hierarchy, to be the champions for a cause can make a large difference as seen in Assam, Jharkhand, West Bengal and Maharashtra.
- **Attitudinal change:** One of the important outcomes of this 'Alternative Training Methodology' is the change in attitude among the trainers and service providers, motivating them to work as a team for providing primary health care according to the needs of the community. Hence, for sustaining this benefit it is essential that the methodology and the quality of the training adopted under this strategy does not get diluted.
- **Conducting sensitisation and orientation workshops:** States such as Gujarat, Kerala, Delhi and Karnataka which had conducted sensitisation and orientation workshops garnered support from a wider section of opinion makers. This area needs to be given much more attention in Phase II and III.
- **Monitoring and Supervision:** This has played a crucial role in sustaining the quality of trainings. From the earlier 12 States in Phase I, all the 29 States and 6 UTs in the country would be adopting this strategy in Phase II. Hence, there is a need to have a wider monitoring and supportive supervisory mechanism with NIHFW, SIHFWs and HFWTCs taking the lead role at their respective levels. External support also needs to be tapped for operationalising this very crucial element in the programme.

3.5.2 Challenges Faced

Advocacy

- Bringing in a new 'clinical skill training methodology' in place of an already existing methodology in clinical training.

Training

- Bringing in the desired attitudinal change in some State Trainers is still a challenge.
- Availability of sufficient caseload to provide clinical training on clients at the District Hospitals that are selected as clinical training sites in all the States.
- Providing the certification for competency due to lack of caseload.

BCC

- Trainings were not always accompanied by activities to generate demand, though such activities are crucial for the success of the strategy.

Coordination and Monitoring

- Developing a national core team for facilitating and monitoring the trainings at various levels and the end point of the trainings i.e. performance standards of the trained service providers.
- Ensuring coordination and support from the concerned SIHFWs and State Directorate.
- Many States found it difficult to assess the performance of the trained personnel.

3.6 Areas to be Strengthened during Phase II and III

Based on the lessons learnt from Phase I, more thrust will be given on the following areas while scaling up the strategy for repositioning IUCD during Phase II and III.

3.6.1 Advocacy

- The States to be advised to hold sensitisation/orientation workshops for policy makers, State Programme Managers, SIHFW faculty, IEC personnel, gynaecologists and other health professionals from both public and private sectors immediately after the National TOTs held at NIHFW, Delhi. Similar sensitisation workshops also to be organized in the districts implementing the IUCD strategy.
- Active involvement of ASHAs, AWWs and Male Health Workers by orienting and motivating them for mobilizing the acceptors from their field areas.
- Identification of champions who can play a crucial role in enhancing advocacy on IUCD, provide support during training programmes and in creating demand generation on IUCD.

3.6.2 Training

- Ensuring that the quality of the cascade training is sustained and counselling and communication skills of the trainees get enhanced during the trainings besides the clinical skills.

3.6.3 BCC

- Ensuring that the States develop a well coordinated BCC strategy for creating demand following the training of service providers.
- The States should initiate the BCC campaign to complement other efforts such as the training of service providers.

- States to air and telecast the promotional messages on spacing and IUCD 380A through the State IEC budget released through NRHM, using the prototypes developed.
- Ensuring the use of BCC tools and material by ASHAs, AWWs, ANMs and Male Health Workers for creating awareness on IUCD while mobilising the acceptors from their field areas.
- States to give greater stress on use of locally appropriate BCC tools and materials.
- Strengthening the counselling process at the ante-natal and post-natal/ post- partum clinics for promotion of spacing methods, offering IUCD in the basket of choice.

3.6.4 Monitoring and Evaluation

- Supportive supervision and monitoring mechanism for all 29 States and 6 UTs through a core team of supervisors consisting of consultants at the Central level and monitoring team from NIHFW is being established. In addition to this, international agencies like UNFPA, USAID and PSI are supporting monitoring in some States with their own resources.
- Regular review of the programme with the State Programme Managers and sharing experiences.
- Training all the supervisors (consultants and supporting agencies) in the training methodology, quality and performance assessment.
- A monitoring strategy with uniform guidelines has been laid down. Reporting and documentation of monitoring to be undertaken simultaneously.
- Population Services International (PSI), in addition to providing support in monitoring would also be involved in scaling up IUCD acceptance in the private sector in 6 States.

3.6.5 Public-Private Partnerships

- Exploring partnerships with FOGSI, NGOs, private providers through different PPP models for providing support in creating demand generation and service provision.
- Documentation of various PPP models and dissemination of the best practices.
- Formalising mechanisms for public-private partnerships based on States experiences.
- Development and dissemination of guidelines for accreditation of the private sector for IUCD services.

Annexure

Annexure A

Guidelines for Alternative Training Methodology on IUCD

ROAD MAP FOR IUCD TRAINING

IUCD training will be scaled up through a four-step process. This process will begin with Training of Trainers at the national level and cascade down through States and districts. This training process will ultimately build a sustainable self-renewing system of PHC based trainers responsible for preparing ANMs to competently provide IUCD services throughout India. The competency building will be first imparted on pelvic models prior to hands-on experience on clients (1 pelvic model for 3 trainees).

Step I: National level TOT for State Trainers	
Responsible Agency	National Institute of Health and Family Welfare
Target Participants	- 1 Programme Manager from State Directorate - 2 Gynaecologists from Medical College/District Hospital - 1 Gynaecologist/Communication Officer from SIHFW - 1 Nursing College/Staff Representative
Training Team	- 3-4 National level Trainers with expertise in IUCD service provision
Capacity, Venue & Duration	5 participants from each State. Total 20 participants per batch Duration - 6 days Venue - NIHFW, New Delhi
Training Objectives	- Standardize knowledge, skills and attitudes in accordance with GOI National IUCD Guidelines and understanding training needs of ANMs. - Standardize training competencies needed to lead state level training activities. - Introduce GOI Operational Guidelines to support implementation of the alternative model for IUCD training within State.

Step II: State level TOT for District Trainers	
Responsible Agency	State Institute of Health and Family Welfare
Target Participants per District	- 3 district Gynaecologists / 1 FOGSI Representative - District RCH Officer and District Public Health Nurse - 2 ANMTC Faculty and 2 DTC Faculty - 1 Communication Officer from District Health System
Training Team	- State Trainers trained at NIHFW - For a batch of 8-10 trainees - 2 in-house trainers and 1 guest trainer from outside (1 trainer for 3-4 trainees)
Capacity, Venue & Duration	No. of participants - 8-10 participants from one district Duration - 6 days Venue - SIHFW
Training Objectives	- Standardize knowledge, skills and attitudes in accordance with GOI National IUCD Guidelines and understanding training needs of ANMs. - Standardize training competencies needed to lead district level training activities. - Introduce GOI Operational Guidelines to support implementation of the alternative model for IUCD training within the district.

Step III : District level TOT	
Responsible Agency	District Family Welfare Officer
Target Participants	3 Medical Officers, 3 Staff Nurses and 3 LHVs from identified PHCs/CHCs and FW Centres
Training Team	- District Gynaecologists mentored during State level training - ANMTC Faculty mentored during State level training - For a batch of 8 trainees - 2 in - house trainers and 1 guest trainer from outside (1 trainer for 3-4 trainees)
Capacity, Venue & Duration	No. of participants -9 Venue - District Hospital/DTC/ANMTC Duration - Total 6 days (two to three days of training using models at training centres and an additional three to four days of clinical experience on clients in the hospitals under the supervision of district level Trainers).
Training Objectives	- Standardize knowledge, skills and attitudes of service providers in accordance with GOI National IUCD Guidelines. - Standardize training competencies needed to lead PHC level training of ANMs on clients.

Step IV District level Training of ANMs	
Responsible Agency	ANMTC/ District Hospital and CHCs/PHCs
Target Participants	ANMs from selected CHCs/PHCs (24x7)
Training Team	Medical Officers, Staff Nurses and LHVs trained at district level mentored by district level trainers as required.
Capacity, Venue & Duration	10 participants will attend a three day training using models at the District Hospital/ANMTC. Participants will gain clinical experience at PHC or Sub-centre under supervision of trained MOs. Competency Certificate to be provided by the Medical Officer within a period of 3 months. In case of failure to achieve competency within 3 months, training on models to be repeated in the DTC/ANMTC.
Training Objectives	Develop competency of community based service providers in IUCD.

Competency Certificate: The trainer should evaluate participant using the IUCD counselling and clinical checklist.

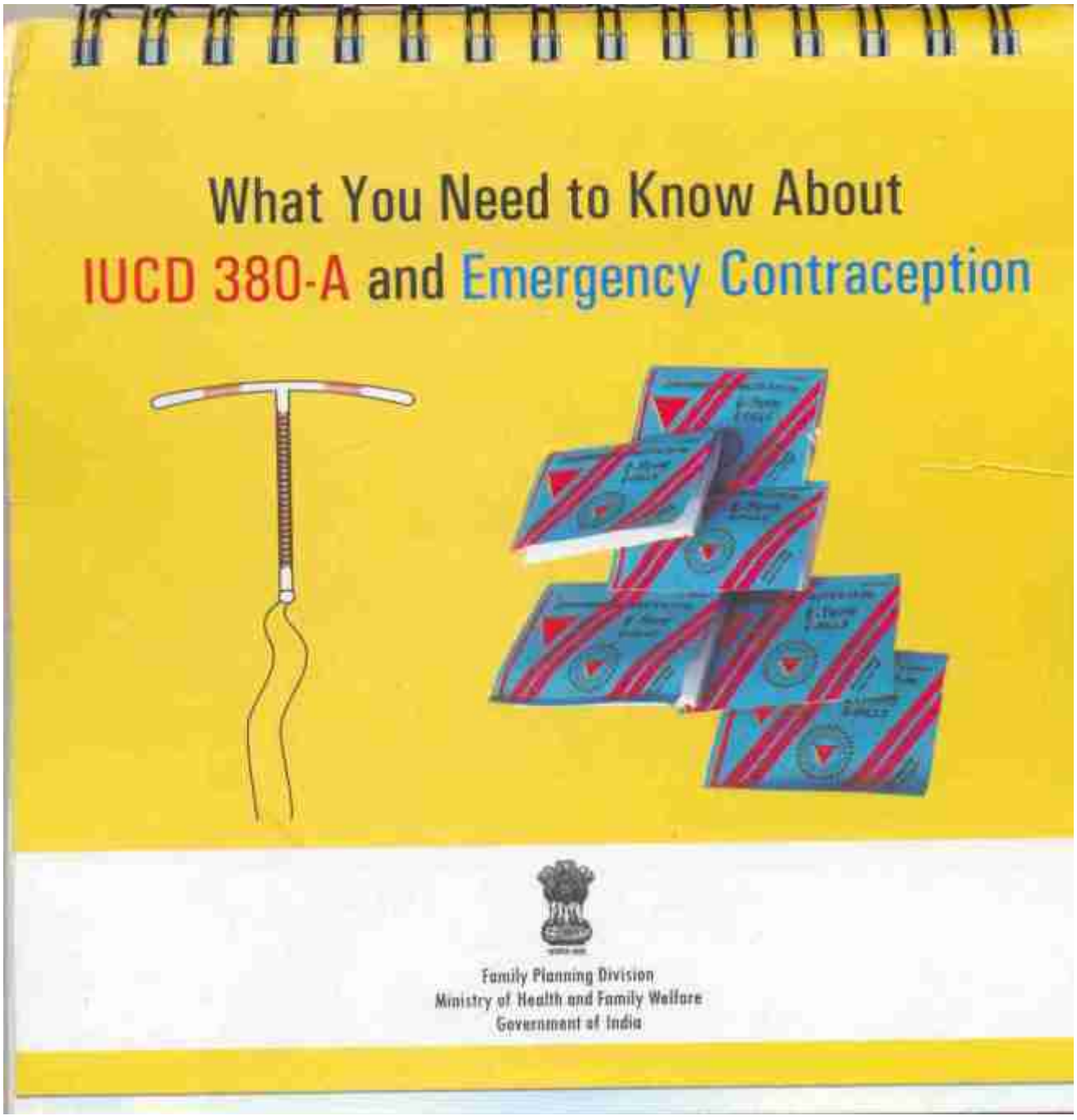
- Competency demonstrated on models
- Competency demonstrated on clients

Certificate to be issued only after the trainer has observed competency, on models and clients, using the checklist and is fully confident that the participant can independently provide IUCD services at her work place.

Annexure B

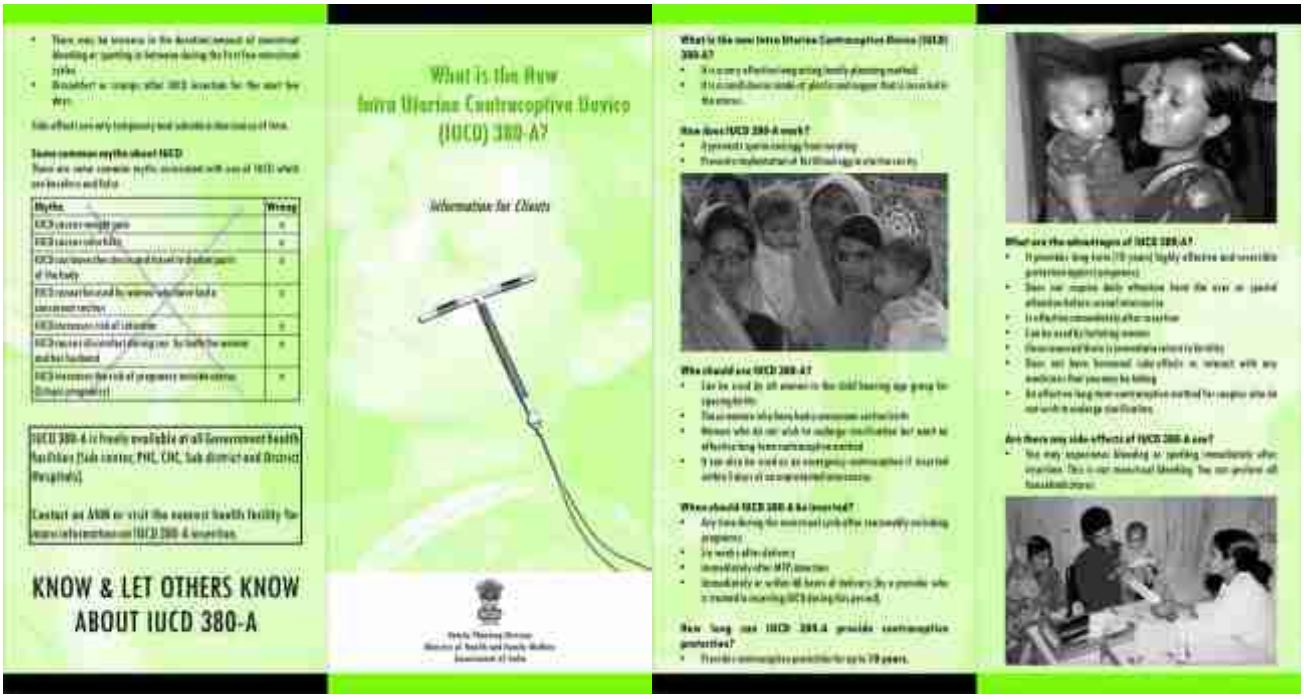
BCC Materials on IUCD developed by the MOHFW

Flipchart on IUCD 380A



IUCD Leaflet for the Providers

IUCD Leaflet for the Clients



Annexure C

Service Providers Trained in Alternative Training Methodology during Phase I

Sl. No.	Name of State	Name of District	No. of Service Providers Trained - category wise	Total Trained upto June 2008 (starting from)
1	Karnataka	Belgaum	MO/SN/LHV-49 ANMs - 90	139 (Nov. 2007)
2	Kerala	Thiruvanantha puram	MO-22 SN-16 LHV-16	54 (Jan. 2008)
3	Gujarat	Sabarkatha	MO-40 SN/FHW-101	141 (Dec. 2007)
4	Delhi**	3 zones	MO-75 Nursing tutors-3	78 (Nov. 2007)
5	West Bengal	Nadia	MO-9 SN-9 LHV-10	28 (March 2008)
6	Assam	Jorhat	MO-28 GNM-26 LHV-13 ANMs-130	197 (Nov. 2007)
7	Uttar Pradesh**	Bareilly, Lucknow and Gorakhpur	MO-36 SN-42 LHV-22 ANM-109	209 (April 2008)
8	Rajasthan	Tonk	MO-7 SN-5 LHV-18	30 (Feb. 2008)
9	Madhya Pradesh	Guna	ANM-15 LHV-3 SN -2	20 (Feb. 2008)
10	Jharkhand	Ranchi	MO-11 SN-6 LHV-8 ANM-110	135 (Feb. 2008)
11	Chattisgarh	Raipur	MO-22 SN-20 LHV-21 ANM-48	111 (April 2008)
12	Maharashtra	Thane	MO - 8 Nurses/LHV-10 ANM - 87	105 (Feb. 2008)

** These States took up more than one district for piloting the IUCD strategy

Annexure D

Performance Standards Assessment in12 Pilot Districts

				Performance Standards Achieved - No.					
				Human and Physical Resources TPS - 10	Client focused BCC Materials TPS - 6	Management System TPS - 3	Infection Prevention TPS - 11	New Client Counselling TPS - 5	Follow-up visit & Management TPS-7
S.N.	**State**	**District**	**CHC/PHC**						
1.	Uttar Pradesh	Lucknow	CHC, Mohanlalganj	10	4	3	11	5	5
2.	Karnataka	Belgaum	CHC, Khanpur	10	4	3	7	5	7
3.	Kerala	Thiruvanat hapuram	PHC, Balaramapuram	6	4	3	8	3	5
4.	Gujarat	Ahmedabad	PHC Kadyadara	10	6	3	11	5	7
5.	Assam	Jorhat	PHC/FRU, Titabur	10	5	3	11	5	7
6.	Madhya Pradesh	Guna	CHC Raniganj	6	3	3	11	4	4
7.	Maharashtra	Thane	PHC andSub-centre Padgha	7	4	3	11	5	7
8.	Delhi	S. Delhi	MCD, Sreenivaspuri	10	4	3	11	5	7
9.	Jharkhand	Ranchi	CHC, Kanke	10	4	3	11	5	7
10.	Chattisgarh	Raipur	CHC, Abhanpur	10	4	3	11	5	6
11.	Rajasthan	Tonk	PHC, Jhalia	5	3	3	8	3	3
12.	West Bengal	Nadia	PP Unit, JNM Hospital, Kalyani	10	3	2	9	4	4

TPS Total Performance Standards

*Performance Assessment has been as per the format developed by MOHFW

**Performance on IUCD insertion and removal could not be assessed at the time of the visit