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Creating the Conditions for Scale-up of the Men in Maternity Intervention in India

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SUMMARY

The Frontiers in Reproductive Health Program (FRONTIERS) conducted an operations research study, called the Men in Maternity (MiM) study, in collaboration with the Employees' State Insurance Corporation of India (ESIC), the objective of which was to involve men in the antenatal and postpartum care of their partners to raise knowledge and use of postpartum contraception and preventive practices against sexually transmitted infections, as well as improving pregnancy outcomes. The original operations research study is described elsewhere. As soon as it was clear that the intervention was effective, ESIC decided to scale it up within the Delhi Directorate. The scale-up was initiated in January 2003; during the first phase ESIC expanded the intervention from three to 10 dispensaries. Of these ten dispensaries, six participated in the original MiM study and a further four dispensaries were added. Through two more phases ESIC would introduce the MiM model into the remaining 20 dispensaries by adding 10 dispensaries in each phase. The scale-up process began with the training of Master Trainers-nine doctors from two ESIC hospitals and the three original MiM intervention dispensaries.

All Auxiliary Nurse Midwives (ANMs) and Doctors working at the dispensaries were to receive training. However, there were many delays in training due to the inability to release staff for training, key staff transfers, long gaps in appointing a new person on key managerial positions, other priorities (e.g. RCH and DOTS), and inability to foresee the materials and supply demands and allocate resources to print and provide materials to dispensaries in time. These delays forced a change in the strategy and the MiM services were introduced as soon as the core staff providing antenatal and postnatal services was trained.

Training of supervisors and whole site orientation of all clinical and non-clinical staff at each dispensary were conducted as soon as it was estimated that the core staff of program introducing dispensaries had been trained. During the first phase of scale-up it was planned that the Additional Director of Inspections (ADI) from the four zones would take over supervisory responsibilities, under the supervision of Additional Director (PS&CA). This process had to be abandoned due to ESIC restructuring as the whole cadre of ADIs was removed and personnel were transferred to other responsibilities within ESIC. Realizing that supervision of MiM activities needed to be decentralized, ESIC managers organized a one-day orientation workshop on MiM supervision in which all 30 Medical Officers in-charge of ESIC dispensaries in Delhi participated.

FRONTIERS provided all additional BCC materials – posters, brochures, maternity cards and penis models – for the first year of implementation. ESIC committed to print and provide these materials during the second phase of scale-up. All requests for MiM materials were channeled through the AD (PS&CA) so that future demands from dispensaries were made through their routine indenting system. Although ESIC made significant progress in integrating printing of the BCC materials into their routine procurement system, the resources allocated for MiM material production was also considered as 'not mandatory' by the ESIC and so was dropped.

Pre and post test scores from the nine batches of providers trained during first and second phase of scale-up training suggests that the ESIC has been able to implement this component of MiM. However a greater level of commitment is required to meet the training needs on time. Training

of the dispensary providers in MiM was managed and funded independently by ESIC. Four of the master trainers have been co-opted into similar programs by ESIC management because of their counseling and training skills, and so the scaling up has succeeded in building the training capacity of selected ESIC staff.

Supervisory visits to dispensaries included in the first phase of scale-up after a three month period showed a mixed picture. While most dispensaries were able to implement the counseling provided by ANMs, components that required a shift in staff schedules or added equipment had not yet become functional. For instance, male counseling and universal screening for syphilis are still not fully implemented. Monthly reports of MiM related services have been provided by most dispensaries to the headquarters through their normal channels, but not all the 20 dispensaries have been able to completely understand and submit all the information required. Special attention needs to be given to supervisory visits from the beginning of the program. It also is critical that those who are responsible for reviewing MIS forms should appreciate the significance of the information provided in the MIS form and action should be taken accordingly.

The MiM scale-up process worked well in terms of ESIC assuming ownership of the training component of the program and being able to build capacity for training. However, to further scale-up MiM in the remaining dispensaries in Delhi there needs to be commitment from ESIC for supervision and monitoring of the implementation process so that delays can be minimized and MiM can be fully integrated into the dispensary norms for maternity services. To fully institutionalize MiM in ESIC services, limited and continued external support is required, particularly in the area of supportive supervision and MIS. This perhaps could be achieved through expansion, better coordination with implementing hospitals, and reinforcement of similar messages in different venues such as ESIC hospitals.

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INTRODUCTION

The Frontiers in Reproductive Health Program (FRONTIERS) conducted an operations research study, called the Men in Maternity (MiM) study, in collaboration with the Employees' State Insurance Corporation of India (ESIC) over the three year period from March 2000 to March 2003. The objective of the study was to involve men in the maternity care of their wives; specifically in antenatal and postpartum care, in order to raise knowledge and use of postpartum family planning measures and knowledge and preventive practices against sexually transmitted infections, besides improving pregnancy outcomes. This project was launched in three ESIC dispensaries in Delhi with three similar dispensaries in terms of size of antenatal clinics and geographic distribution acting as controls.

The MiM interventions centered on antenatal and postpartum individual and couple counseling, along with screening of all pregnant women for syphilis using the rapid plasma reagin (RPR) test. Providers encouraged women to bring their husbands with them to the clinic where same-sex group counseling and couple counseling were provided on topics related to pregnancy care, contraception, breastfeeding and primary and secondary prevention of sexually transmitted infections (STIs). Individual counseling of husbands also uses the male syndromic approach to manage genital ulcers and urethral discharge reported by them during the session. All women testing positive for syphilis were counseled and treated along with their spouse, and the infant followed up if the parents do not test negative after treatment.

A sample survey of eligible men and women attending the MiM antenatal clinics was conducted in the clinic and then again at home when their infant was six months old to measure the effectiveness of the intervention by comparing women and their husbands to those of eligible couples from the three control clinics. Results showed that the MiM intervention was able to raise awareness and use of family planning (FP) in the postpartum period, and also increased awareness of dual protection for STIs. It showed no effect on exclusive breastfeeding at six months postpartum, however, or on general knowledge about STIs¹ (Population Council 2004).

As soon as it became clear that the intervention was feasible and effective, discussions with ESIC on its scale-up began. A decision was taken by the Director Medical (Delhi) ESIC to scale-up the intervention within the Delhi Directorate of ESIC in September 2002. This was planned over two phases – the first expanding from the three experimental sites to a total of 10 dispensaries, and secondly expanding from these 10 dispensaries to all dispensaries and hospitals run by ESIC in Delhi. Initially, FRONTIERS was requested to provide technical assistance in scaling-up the MiM activities to the 10 ESIC dispensaries; it was expected that afterwards ESIC would have the capacity and technical expertise to scale-up the MiM program in remaining dispensaries in Delhi and in other states.

After scaling up MiM to the 10 dispensaries, FRONTIERS was requested to continue its technical assistance to further strengthen MiM activities in the dispensaries already covered under the program, as well as to extend the MiM model into the remaining dispensaries and

¹ Caleb Varkey, Mishra A., Das A. et al. 2004. Involving Men in their Wives' Antenatal and Postpartum Care, Frontiers in Reproductive Health, Population Council.

hospitals so as to make ANC/PNC services uniform throughout the ESIC system in Delhi. The plan for implementing MiM in four ESIC hospitals was withdrawn shortly after initiation of the second phase of scale-up had started in the dispensaries because ESIC managers were apprehensive that the hospitals would require major structural changes in their ANC service delivery before MiM could be introduced. Some of these barriers included:

1. Clients coming late in their pregnancy to the hospitals. They are usually referred by dispensaries to the nearest ESIC hospital in the third trimester of pregnancy for registration for delivery or in case a woman is having obstetric complications, which leaves little opportunity for providers to do ANC individual and couple counseling.
2. Between 15 and 200 clients attend the ANC clinic in a hospital per day. Any increase in time spent per client due to counseling would require a greater amount of manpower, which hospitals are currently not in a position to spare for ANC clinics.
3. Because of limited resources and infrastructure, 3-4 doctors sit in one room and provide ANC services to 3-4 women simultaneously. Since privacy cannot be assured in this situation, providers are not willing to invite the husbands inside the ANC room.

However after review of the first phase of scale-up, and realizing that the ESIC needed more TA to completely absorb the MiM model into their system and to introduce MiM in the remaining 20 dispensaries, a decision was taken to extend TA to ESIC for one more year, until August 2005. This was again extended till March 2006 because of delays in implementation. This report documents the TA provided by FRONTIERS for creating the conditions for scale-up between July 2004 and March 2006.

OBJECTIVES

The goal of this project was to create the conditions for scaling up the MiM interventions within the ESIC health system in Delhi. The specific objectives were:

1. To provide technical assistance to ESIC to expand the MiM intervention to 10 of its 30 dispensaries in Delhi in the first phase, and expand it to all the dispensaries in the second phase.
2. To focus on capacity building within ESIC for long-term sustainability of the interventions. This would be done by assisting ESIC to establish in-house training, monitoring and supervision, continuous quality control and logistical capacity building in such a way that ESIC could independently take the MiM intervention to scale in its health care facilities in other settings.
3. To document lessons learned on how to create the conditions to scale-up a successful intervention that originated in the FRONTIERS' global agenda projects.

PROJECT ACTIVITIES

The following activities were to take place during the first two years of this project:

- Selection of ESIC managers and sites for the first phase of scaling up
- Simplifying the intervention to enable scale-up
- Preparation of scale-up dispensaries for the intervention
- Development of ESIC management systems to ensure quality and consistency of services
- Training of master trainers
- Training of all doctors and ANMs in scale-up dispensaries to conduct MiM counseling
- Training of Laboratory Technicians/Assistants of scale-up dispensaries to carry out the RPR tests
- Integrating the MiM related supplies and material into ESIC's existing systems
- Training of ESIC managers in monitoring and supervision of MiM services
- Holding orientation meetings at dispensaries with all dispensary staff before MiM services are added to routine ANC and immunization clinics
- Assisting dispensaries to adopt the modified MIS and recording formats and registers
- Documenting the process of implementation and lessons learned.

A. Selection of ESIC Managers and Scale-up Sites

Planning for scaling up took place between October and December 2002, and by January 2003 an official note from ESIC and the Population Council was exchanged detailing the MiM scaling up process and the technical assistance that Population Council would provide. Dr A.K. Kathuria, Additional Director, was designated as the nodal person in-charge of administrating the implementation of the MiM activities. The dispensaries involved in Phase I were:

March 2003 – August 2004	August 2004 – March 2006	
PHASE – I	PHASE – II (A)	PHASE – II (B)
NIA -1 Mayapuri -1 Okhla Modi Mills Kalkaji Factory Rd Mayur Vihar Seelampur Mangolpuri Jwalapuri Rohini Sec V	Najafgarh Mayapuri II Raghubir Nagar Okhla- Ph I Tigri V.K. Nagar Azadpur Palam Subzi Mandi Jahangirpuri	Madipur I- Block Inderlok Tilak Vihar Mori Gate Nand Nagri Pahar Gunj Mehrauli Jungpura Narela Four ESIC Hospitals

It was anticipated that the first phase would require more planning, in terms of training, resources allocation, setting up of system of MiM related supplies and materials, integrating the MiM supervision and reporting into ESIC's existing MIS, than the second phase, which would replicate the approach in the remaining 20 dispensaries. During the first phase of scale-up, ESIC management decided that the original dispensaries where the MiM intervention was in place would continue to provide the new package of services, and seven other dispensaries would be added, including the three that were controls sites in the original experiment.

An initial assessment of these dispensaries was conducted it was found that there were approximately 80 doctors and 75 ANMs in the 10 dispensaries that required MiM training. All except one of these scale-up dispensaries (Rohini-5) had a laboratory. Antenatal clients would be sent to the nearby ESIC Hospital in Rohini to get all the lab tests, including the RPR. The monthly average (based on 2002 service statistics) of antenatal clients attending these dispensaries ranged from 10 clients in Rohini-5 to 51 in the Kalkaji dispensary. The assessment of second phase dispensaries indicated that approximately 200 doctors and ANMs needed to be trained. Accordingly 7 training "batches" were planned for the second phase.

B. Planning for Training of Providers

Results and recommendations from the original MiM study were discussed as a prelude to planning the training. For example, focus group discussions with providers had recommended that all doctors, ANMs and laboratory staff from each participating dispensary should be trained and not just the minimal four doctors, four nurses and one lab technician that were trained during the study. This was decided because of the practice of rotating responsibilities of staff

within dispensaries and the transfers of key personnel trained in MiM, which often led to a shortage of trained staff.

For the first phase, the trainers of the initial MiM project met to plan the training of trainers (ToT) and the training for clinic staff in January 2003. The duration of the MiM training was discussed with the ESIC's Delhi Medical Director and it was decided that a three-day MiM training, instead of the original six-day training, was most suitable as clinics would not be able to spare staff for more than a few days, and much of the basic maternity care and family planning components were covered in the ongoing three-week in-service Integrated Skills Development Training of the national Reproductive and Child Health (RCH) program².

The RCH training course content for doctors and nurses was reviewed to eliminate any repetition in the MiM training. Topics such as maternity care, family planning and STIs were found in the RCH training and it was possible to modify the content to compress the MiM training into three days by concentrating on counseling practices and covering only those key issues not dealt with in the RCH training. In addition, efforts were made to be more innovative in using adult learning methodologies that allows two or three subjects to be covered in an interactive action oriented session that shortens the training duration. The Additional Director (PS& CA), who had been designated to oversee the MiM activities, was promoted to Director, Family Welfare for six months and was the key person in-charge of conducting the RCH training. Good collaboration between the Manager of the RCH training and the MiM training was essential to ensure both training programs could take place. The transfer resulted in the RCH training director assisting in allowing the use of training facilities and also in ensuring that the RCH trainers understood MiM and could refer to further training when the topics arose.

Considering the total number of doctors and ANMs to be trained, the three-day training would need to be conducted in eight batches of 25 trainees and to cover all doctors and ANMs in the ten dispensaries. It was important to ensure equal numbers of doctors and nurses and coverage of all 10 dispensaries to keep the team development exercise balanced. The training was planned to start from February 2003 and with two batches trained each month would be completed by June 2003. The BCC materials and job aids developed in the MiM study were used as the central teaching and counseling practice tools for the training. These consisted of the clinic-based maternity cards, the client-held maternity brochures and STI brochures and FP/STI posters encouraging male involvement developed for the MiM study. Using the experience gained from the study intervention, the trainers developed learning exercises and case studies that were appropriate to their clinic settings as suggested by the master trainers.

The trainers, with assistance from FRONTIERS, decreased the duration of training from 6 days spread over two weeks to 3 consecutive days. The main thrust of the training shifted from learning and practicing concepts to learning how to adequately use the teaching aids and BCC materials.

² Doctors and nurses are trained separately in the RCH program and the curriculum is standard for all of India. Other training programs held during the year included training under the DOTs program for Tuberculosis and the National AIDS Control Organization. For these reasons, as well as administrative and budgetary constraints, the two training programs could not be combined.

C. Training of Trainers

First Phase of Scale-up: Scale-up activities began in January 2004 with FRONTIERS staff training nine doctors from two ESIC hospitals and the three original MiM intervention dispensaries to become Master Trainers. Selection of the trainers was made after consideration of the following criteria: experience providing the MiM intervention themselves; an interest in promoting the program; and representation of faculty from the referral ESIC hospital and from general ESIC dispensary management.

Besides gaining training skills, the MiM trainer's also gained confidence and many of them were selected to be trained as trainers for other new programs. For example, two staff were selected as trainers and attended the NACO-sponsored HIV/AIDS counseling training workshop at the Indian Institute of Planning and Administration in Delhi. The added responsibilities placed on the MiM trainers in supervising introduction of the MiM activities at the scale-up dispensaries also made them feel fully engaged in the implementation. Not only did the providers develop the capacity to become counselors and trainers, but ESIC also demonstrated efficiency in providing the reproductive health services at other venues by using MiM guidelines and use of BCC materials. ESIC used the MiM brochures, posters, flowcharts and checklists to deliver reproductive health services at their various Health Melas (fairs) and Health Camps.

Second Phase of Scale-up: 20 additional trainers from across the five zones were required to cover all doctors and ANMs in the 30 dispensaries. Selection of the trainers was at the discretion of the AD (PS&CA) who, along with DMD and AD (Dispensaries and Hospitals), recommended the participants for training. A five-day MiM TOT, instead of the original six-day training, was felt to be most suitable as clinics would not be able to release staff for more than a few days. In addition, much of the basic MiM information had already been absorbed as some trainers were from dispensaries where MiM was in progress. The Master trainers TOT was attended by 12 participants and took place in November 2005. Feedback from the participants showed that they were keen to begin working as trainers and there was a marked attitudinal shift in terms of the perceived value of husband's involvement in maternity care and the importance of counseling in the roles of providers.

D. MiM Training for Providers

Considering the number of doctors and ANMs to be trained, six batches of the three-day training were planned in the first phase and seven batches in the second phase. Each batch had approximately 25 trainees as it was important to ensure equal numbers of doctors and nurses to keep the team development exercises balanced. Maternity cards, maternity brochures and STI brochures and posters developed for the MiM study were used as learning tools.

Three doctors and two ANMs from ESIC Hospitals also participated in the training. Medical Officers in-charge and the ANM on duty in ANC were requested to be sent in the early batches on a priority basis; however not all of them were able to attend the training. A FRONTIERS staff person was present during each training and systematically observed the trainers' interactions with the trainees using a standard format developed to evaluate the content and style of training. The training pre-test and post-tests were analyzed by a MiM trainer and periodic discussions were held with master trainers to improve on those topics where the trainees could not report the

current responses. Evaluation of each individual batch through their pre and post test scores was done by the training coordinator from ESIC and the results conveyed to trainers. A summary of the scores is shown below.

Pre and Post Test Scores after the 3-day MiM Training for ESIC Doctors and ANMs

Training Batch	Planned Month of Training	Actual Month of Training	Total No. Trainees completed Pre/Post Test	Average Pre Test Score (max=40)	Average Post Test Score (max=40)	t-statistic and Significance
First Phase of Scale-up						
Batch I	Feb 03	Feb03	20	21.3	31.8	6.14***
Batch II	Mar 03	Mar 03	17	17.5	25.5	2.73**
Batch III	Mar 03	Mar03	19	20.1	30.3	3.96***
Batch IV	Apr 03	Aug 03	16	20.1	30.0	3.12***
Batch V	Apr 03	Mar 04	24	24.2	27.9	1.97*
Batch VI	May 03	Mar 04	24	27.0	27.6	0.54
Second Phase of Scale-up						
Batch I	Mar 05	Mar 05	22	18.8	28.1	3.02***
Batch II	Apr 05	May 05	23	16.9	28.9	4.11***

*p <.05, ** p<.01 ***p<.001

While there was an average change in scores of 20 percent and above in most of the batches, the last two training batches during the first phase of scale-up scored much higher in the pre-test and showed a smaller improvement in scores (5 percent). There was a significant change between pre and post scores in all but the sixth batch of training during the first phase, which also had the highest pre-test score. As the same questionnaire was used in all tests, it is likely that information on MiM and the tests had been communicated to colleagues in the later batches. For future training, a pool of questions should be selected in such a way that no two tests are exactly the same.

Since transfers were frequent, more than a minimum number of doctors and ANMs needed to be trained to ensure that all dispensaries can continue to provide MiM services. During 2003 almost all the mid-and high level management persons working with the original MiM project were transferred. This led to the delays in conducting the training and subsequent implementation of MiM in dispensaries. Delays began to occur in March 2003 when the April training was delayed until August 2003. The delays led to long gaps in the timing of the training. Originally two batches of trainings per month were envisaged so that all providers would have received training as per plan and begun MiM implementation at their dispensaries. Reasons for delays in conducting training and subsequently introducing the program in scale-up dispensaries are given below and represent reasons why scaling-up many new programs, and not just MiM, can be delayed in large public sector implementing organizations.

- Other programs also required in-service training during the year – priority was given to training for curative services and other national programs, especially DOTS.
- Problems in allocating time away from regular services for Master Trainers.
- Long periods of staff vacation.

- A dengue epidemic in Delhi meant that a large number of staff was required to conduct outreach camps to contain dengue fatalities.
- ESIC sites being used as demonstration sites for successful government projects for political reasons.
- Unexpected deployment of key managers in January 2005 to the coastal region and Andaman and Nicobar islands after the Tsunami in December 2004.
- Rapid changes in key administrators and program managers.

The delays meant that there needed to be a change in implementation strategy. A meeting between the DMD, AD (PS& CA) and FRONTIERS was held to review progress and it was decided that the emphasis should shift from ensuring completion of training all staff prior to service implementation, to beginning implementation with the existing staff that had been trained.

E. Change in Scale-up Strategy

After reviewing the process and experiences from first phase of scale-up, it was felt that ESIC needed technical assistance for a longer duration than was originally planned to complete unfinished tasks from the first phase and to further scale-up in the remaining dispensaries. TA to ESIC was extended for an additional year (i.e. until August 2005). The experiences of second phase of scale-up are as follows:

Change of the Nodal Person: Under the scale-up strategy, ESIC management decided that the scale-up process should be managed by the Director Family Welfare, ESIC. This took the organization of MiM activities to a higher level of management within the ESIC. The Additional Director (PS&CA) of the Delhi Directorate continued to be the key nodal person within the Delhi Directorate for the day-to-day handling of the project.

Orientation to MiM for National level ESI Management: A preliminary meeting was chaired by the Director, Family Welfare in August 2004 and a list of activities and timelines were discussed. During these discussions the Director, Family Welfare mentioned that since several key ESI chief managers were new, a short course needed to be organized to orient them to MiM for scale-up. A 6-hour orientation was prepared and presented to 14 top level officials of ESIC. Key experiences and concepts were presented and discussed. Unfortunately some senior managers could not attend the meeting and most of the other senior management who did attend were transferred within the next six months.

Planning for Additional MIM Trainers and Providers' Training: The Master trainers TOT was attended by 12 participants and took place in November 2005. A batch of 10 lab technicians from the same 10 dispensaries as the MOs and ANMs were trained within ESIC hospitals through a one-day training session held in January 2005. However, follow-up in the 10 dispensary clearly showed that supervision and initial indenting of supplies and equipment had not uniformly been taken up by the Medical Officers in charge and only after supervisory visits by the AD (PS&CA) did this process was begin.

SUPERVISION SYSTEMS

The success of the original MiM project was in part due to the care and diligence of an external mentor from FRONTIERS who assisted clinic staff in implementing the intervention and in the use of the job aids. Close follow-up throughout the two years of the OR study helped in identifying and resolving any problems as they arose.

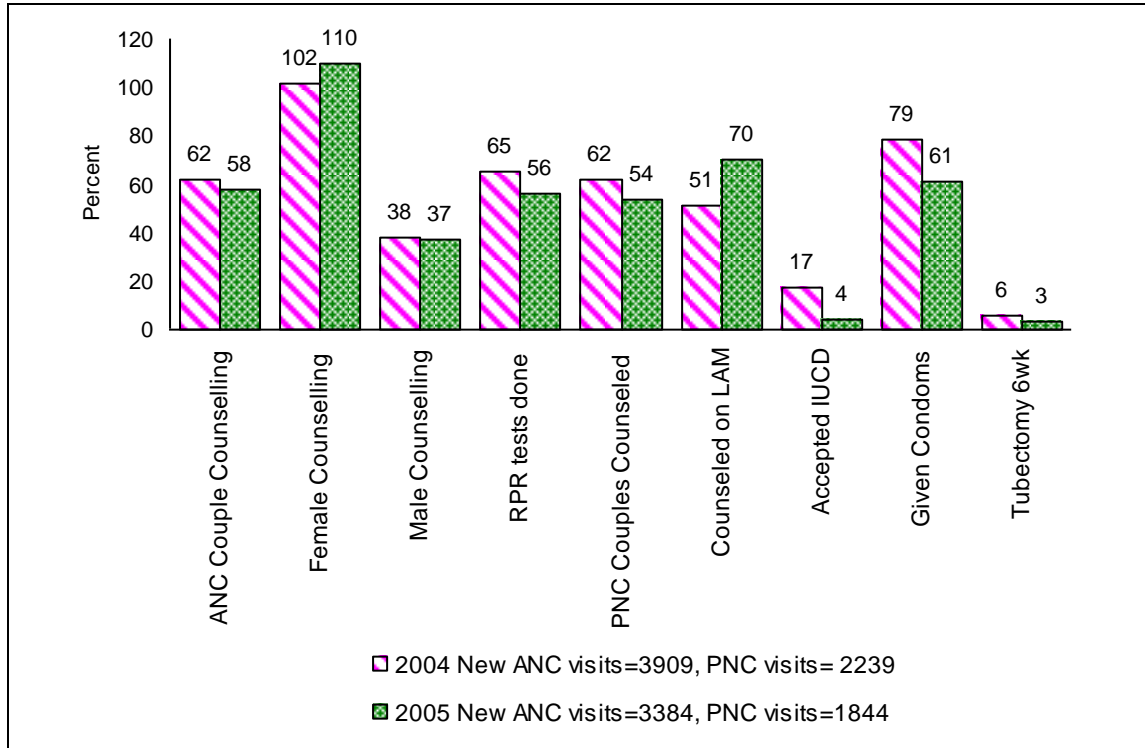
As the study progressed, monitoring responsibilities were handed over to the dispensary in-charge and to the Additional Director Inspection (ADI) for each zone under the supervision of AD (PS & CA) and under the overall responsibility of the Director Medical, Delhi. An initial meeting with the Additional Directors who each supervised dispensaries in a particular zone led to the development of a monthly monitoring tool in February 2003. This tool was further refined with comments from Doctors and ANMs implementing the intervention and they modified the key service statistics to be reported and observations that should be included. After modifications were made based on the clinic staff feedback, this form was then adopted and presented to ESIC Medical Officers in-charge at the one day supervisor's trainings (the format is given in the appendix). They were instructed to forward these to the dispensaries for recording MiM activities. Completed formats were to be returned to the Additional Director (PS & CA) along with other monthly reports. Files of these reports were maintained at the Additional Director's (AD) office. The process of ensuring that complete and accurate reports have been submitted shows that this task requires close attention and dedication.

All first phase dispensaries began sending complete data by May 2004 in the required format. Six out of 10 second phase scale-up dispensaries had started sending the reports on prescribed forms by October 2005; the remaining four had not submitted the MiM reports till January 2006, despite reminders from the AD's office. There is still a need to continue to work towards integrating the MiM reporting within the existing MIS for maternal and child health care. The current supervisory structure does not allow for individual mentoring and this needs to be encouraged, because ultimately it is individuals who are motivated and feel accountable that provide the services.

The feasibility of the MiM MIS for recording and reporting antenatal and postpartum services was reviewed by the AD (PS&CA), who kept the MIM reports before passing on the complete FW report to the ESIC Director Family Welfare. Once the MiM key nodal person became the Director FW it was possible to ask the dispensaries to route the report in exactly the same manner as all other Family Welfare reports.

Analysis of the monthly MiM service statistics for the 10 first phase dispensaries for the years 2004 and 2005 are shown in the graph below. Because group counseling, when observed, did not differentiate women based on whether it was a first or second visit, the denominator for the total numbers of clients counseled was the total number of women attending any ANC visit and not just first visits. The totals of 6,872, of which 3,909 were new ANC visits, in 2004, and 5,845, of which 3384 were new visits in 2005, suggests that, on average, women made two visits to the dispensary before being referred to the hospital.

Figure 1: Annual Services provided through the MiM model for the first 10 Dispensaries



DISPENSARY LEVEL SUPERVISION OF MiM ACTIVITIES

During the first phase it was planned that the Additional Directors of Inspections (ADI) from the four zones would take over supervision responsibilities, under the supervision of the Additional Director (PS&CA). Following this, the ADIs received a one-day MiM supervision training in July 2004. During July to November 2004, FRONTIERS staff accompanied the ADIs on their supervisory visits to mentor this process. A meeting of all the ADIs and the Director FW was held in October 2004, which led to a better understanding of the issues that needed particular attention – such as continuing orientation and training to providers that are transferred in as trained providers move out – as well as the usual issues of privacy during client-provider interaction during counseling. This process had to be abandoned in March 2005 due to ESIC restructuring. The whole cadre of ADIs was removed and personnel transferred to other responsibilities within ESIC. Under the current system of inspection of dispensaries, Medical Officers in-charge have been given more supervision responsibilities and they now directly report to Additional Director (PS&CA). This means that a whole level of supervisors is no longer available in the system. Realizing that supervision of MiM activities needs to be more decentralized, ESIC managers organized a one-day orientation workshop on MiM supervision in which all 30 Medical Officers in-charge of ESIC dispensaries in Delhi, as well as the Medical Superintendent of the ESIC Hospital at Basaidarapur, participated. This meeting was chaired by the Director FW along with Master Trainers and AD (PS&CA) and the original results of the MIM Study emphasizing the impact of the intervention were presented.

Key issues of staff replacement during training, supervision, the message of MiM and the question of whether this was an externally funded or ESIC program came up in frank discussions. The responses by Master Trainers as well as the Director Family Welfare and the Medical Superintendent of ESIC Hospital at Basaidarapur made it clear that MiM was considered an integral part of ESIC's efforts to improve maternity, family planning and STI prevention efforts.

MANAGING DISTRIBUTION AND REPRINTING OF BCC SUPPLIES AND EQUIPMENT

One component which has been well integrated in routine services during scale-up and did not require major input from supervisors after initial training was the use of BCC materials and job aids, especially the Maternity Card. ANMs and doctors alike used the BCC material and job aids as soon as they received supplies at the dispensary. A few of the scale-up dispensaries started using the material even before the formal start of the MiM program.

As part of the agreement with ESIC, FRONTIERS provided all additional BCC materials – the posters, brochures, maternity cards and penis model for condom demonstration for the first year of implementation. After this initial support, ESIC committed to print and provide all the MiM related material to all 30 dispensaries within their existing budget for printing. All requests for MiM materials were channeled through the AD (PS&CA) so that future demands from dispensaries would be made through their routine system. The other materials required for MiM provision of services were minimal. The RPR kits and slides and a rotator for conducting screening tests for syphilis were the additional equipment requirement for the laboratories.

The AD (PS&CA) ESIC requested information on the future requirements for BCC materials and job aids from the 10 scale-up dispensaries. The cost of these materials was estimated at less than US\$1,200 to meet the needs from all 10 dispensaries. Based on this, the AD (PS & CA) requested their Central Stores to reprint the materials. Although ESIC had made significant progress in integrating the printing of BCC materials into their routine procurement system, the annual accounting review in late 2004 estimated that the ESIC Delhi Directorate was overspending its budget, and so in 2005 financing of all expenditures that were not considered mandatory was either stopped or cut substantially. The resources allocated for MiM materials was considered as 'Not Mandatory' by ESIC. In 2005, FRONTIERS staff raised this issue with ESIC managers and it was anticipated that in 2006 ESIC would allocate a budget for printing and procurement of MiM-related material. Considering the problems faced, FRONTIERS decided to support the printing of materials for another six months, that is, until the beginning of the new financial year.

CASE STUDY OF THE FIRST PHASE

This section identifies why the early momentum could not be maintained and how the political environment and government priorities could make adoption and institutionalization of this innovative program difficult. The table below compares implementation of the MiM intervention across the 10 dispensaries in the first phase. The observations indicate that the original three dispensaries are still satisfactorily conducting the female/couple counseling sessions and screening the antenatal women for syphilis (in one dispensary the RPR could not be done because of shortages of kits, although the RPR register showed continuity in the intervention). The male counseling was virtually non-existent in these 3 dispensaries. In 5 of the 7 new dispensaries, female/couple counseling and RPR tests are being done moderately well and in one of these 7 dispensaries no MiM activities at all are being carried out. Except for a lack of maternity cards and brochures, all the dispensaries had the necessary materials and supplies required to carry out MiM activities.

The differential level of MiM activities clearly indicates that the program is sustainable once it is fully implemented and a high standard of supervision is provided in the initial phase. After the OR phase, only minimal supervision was provided to these 3 dispensaries and attention was more focused on establishing the intervention in the seven new dispensaries. This was also evident from group discussions and in-depth interviews with providers in the 3 original dispensaries – once the intervention was fully established and attitudinal changes among providers and supervisors are made, providers tend not to revert back to the old process of providing ANC/PNC services. The review of these pilot dispensaries also indicated that the shortage of staff in dispensaries only affects the MiM activities minimally if alternate support from the dispensary in-charge and other staff is available during the ANC clinic days. The difference in activities also indicates the need for supportive supervision, meeting the training needs and demand for materials, and setting accountability for all levels of providers.

MiM Activities in 10 Scale-up ESIC Dispensaries

	Dispensary	ANC				
		Dispensary readiness	Female/couple counseling	Male counseling	RPR tests	Use of BCC/job aids
Original MiM Dispensaries	One	✓✓	✓✓✓	x	✓✓✓	x
	Two	✓✓	✓✓✓	✓	x	x
	Three	✓✓	✓✓	x	✓✓✓	x
Added Scale-up Dispensaries	Four	✓✓	✓✓	x	✓✓	x
	Five	✓✓	✓✓	x	✓✓	x
	Six	✓✓	✓✓	x	✓✓	x
	Seven	✓✓	✓✓	x	x	x
	Eight	✓✓	x	x	x	x
	Nine	✓✓	✓✓	x	✓✓	✓
	Ten	✓	✓✓	x	✓✓	x

✓✓✓ Satisfactorily carried out (more than 75% of the time)

✓✓ Moderately carried out (40 – 75% of the time)

✓ Only rarely carried out (Less than 40% of the time)

x Not carried out

An assessment of the services provided is based on observations of 61 ANC clients across 7 functioning dispensaries, and discussions with the ESIC providers and managers.

ANC Counseling: Staff were observed asking the woman about her husband's presence in 80% of the observed consultations, and if he was available, only 26% invited him inside the ANC room. Female counseling has been integrated into the dispensaries' antenatal care service delivery. Of the 61 ANC women observed, 89 percent were counseled by ANMs, either individually or in groups of 4-6 women at a time. Couple counseling is also offered in dispensaries. However, this practice is infrequent because of the poor attendance of husbands during ANC. The counseling contents and coverage of topics do not vary between couple and female group/individual counseling.

A number of constraints in conducting counseling sessions were noted during the discussions with doctors, ANMs and dispensary in-charges. The lack of time and shortage of staff, particularly doctors, were the main reasons reported by doctors and in-charges of dispensaries for not being fully able to comply with the MiM guidelines. Commenting on this one dispensary in-charge said: *"We are short of at least two doctors. When we do not have sufficient staff to attend all OPD clients properly, how can I ask the doctors to do counseling?"*

Another impediment was the lack of understanding of the MiM program among the dispensary in-charges. In 4 of 10 dispensaries, as a result of staff turnover, the in-charges have not been trained in MiM and therefore did not feel a commitment towards the approach. This lack of commitment can be demonstrated as MiM-trained ANMs are rarely assigned to the ANC clinic. Commenting on this one ANM said:

"Sometimes the in-charge put us in registration or in other activities even on the ANC clinic day. When we say that we have to do MiM activities, in-charge says that managing registration and other work is more important than MiM, you can do MiM next week also."

A majority of ANMs felt that the shortage of materials, especially the maternity card, maternity brochure and STI brochure, affects the smooth conduct of counseling as they are used as job aids. According to the ANMs, female counseling has been the norm, but without the material they are not able to do the counseling as effectively.

Male Counseling: Male counseling during antenatal visit was unusual in the scale-up dispensaries because of: (1) non-availability of a male doctor, (2) lack of accountability among male doctors, and (3) lack of time and privacy. Commenting on the lack of accountability one female doctor said:

"Whenever we send the husband to him for counseling, he will either send him back or ask husband to come some other time, or will only sign the register and send the husband back."

The male doctors reported the lack of time and privacy to counsel the husbands during the general OPD clinic. One male doctor commented:

"Unless the doctor is assigned to do only counseling, the privacy cannot be maintained. Usually two doctors sit in one room and see the patients. How can we do male counseling and demonstrate condom use, when other doctor is attending another patient."

Condom Demonstration: Condom demonstrations could not be sustained during scale-up and was rarely done by providers during counseling sessions – only in 28% of consultations observed. It was only done by ANMs during female group counseling sessions. Condom demonstration was only done in detail in 19% of consultations (i.e. followed MiM guidelines and used a penis model). In 9% of consultations, the ANMs took the condom out of packet and showed it to clients with a brief mention of its use. Episodic shortage of condoms also affected the condom demonstration. When there was a shortage, providers did not demonstrate condom use as they could not provide condoms after the demonstration. One ANM noted:

“Clients ask for condoms after the demonstration. We do not have any, not even for demonstration.” The in-charge said *“We are short of condoms for last three months. Actually Delhi administration provides condoms to ESIC, and they are also running out of stock. They have not received condoms from Ministry of Health.”*

Socio-cultural barriers to using a penis model also contributed to the lack of sustainability of condom demonstrations; many providers, especially the ANMs, hesitated to do a condom demonstration on a penis model. Expressing the cultural sensitivity in using a penis model, one officer in-charge said:

“To tell you the truth, the use of a penis model is culturally inappropriate. People get shy after seeing the model. They do not even look at the demonstration, they smile and look elsewhere.”

Screening Women for Syphilis using RPR Kits: The screening of all women for syphilis using RPR test kits has been continued in all the dispensaries with laboratory facilities. The integration of this component did not require changes in their systems as dispensaries were already routinely conducting the VDRL test for women with first pregnancy. For higher parity clients only a hemoglobin test was being done. ESIC was only required to: (a) replace the VDRL kit with RPR kit which is considered more accurate, and (b) screen all antenatal women regardless of their parity, which confirms the observations that incremental improvements are easier to introduce than major changes in practice.

ANALYSIS OF PERFORMANCE AT THE ORIGINAL MiM DISPENSARIES

An assessment was made of the performance of the three original dispensaries on MiM activities over five years of implementation to assess how the change in supervision intensity had influenced productivity. The project began in 2001 and was intensively supported and monitored by FRONTIERS staff in 2002, which was phased out in October 2002. In 2003 supervision was maintained by ESIC authorities, primarily by each dispensary’s Medical Officers in-charge and also by the additional director of inspections for the zones.

The annual number of couples counseled has leveled off at a slightly lower level than when it started but continues in all three dispensaries, which indicates that couple counseling is sustainable once it has been introduced and that providers find it useful to continue it even after the project staff is withdrawn. The antenatal RPR testing component has also continued in all three original clinics. The male counseling component is the most sensitive to the availability of male doctors, as this is the one component where female ANMs are a limitation to offering the service. As a result, a decline in the number of men counseled in two of the three dispensaries

was seen after their male counselors were transferred. The ESIC management needs to continue to look at the issue of allocating male doctors' time for counseling, or suggest other personnel who can take on this task.

In conclusion, once established the intervention works well if there is adequate, appropriate and trained staff to conduct the counseling. To achieve sustainability, the intervention requires commitment from ESIC in terms of allocation and monitoring of provider time as well as sustained supervision.

MiM IN HOSPITALS

Although men are welcomed inside clinics at dispensaries, they are strictly barred from access to the maternity care areas within the hospital when their wife attends for ANC/PNC services. The request for male involvement from clients was also instrumental in ESIC's plans to implement the MiM program in their hospitals. There were numerous instances during supervision visits at dispensaries when husbands of pregnant women would come to the supervisor and request that similar access to maternity care providers be available at hospitals. As one husband said during antenatal clinic supervision visit: *"Doctor, whatever you are doing here is very good. But in hospitals, the providers do not even let us stand nearby, how will they listen to me? Please tell the hospital's doctors also to let the husbands go inside antenatal and postnatal clinics."*

This led to the decision from ESIC to request technical assistance in implementing the MiM program in all four hospitals in Delhi. A review of efforts to integrate MiM within antenatal and postnatal care in hospitals suggests that integration is difficult unless major structural changes are made in ANC/PNC service delivery. The hospitals exercise far more autonomy than dispensaries so that the decision to take up MiM did not follow the same approach as in the dispensaries. Each hospital's maternity, gynecological and pediatrics departments needed to be individually convinced about the feasibility and value of MiM, and there was far more reluctance in opening up antenatal clinics to men than was experienced at dispensaries. This was in part due to the general nature of gynecological OPDs, where women with morbidities were not seen separately from antenatal and postnatal clients. There was also more frequent need for pelvic examinations in hospital clinics during women's visits than in ANC clinics, leading to the reluctance to have men in the room.

In early 2005, all the senior managers in all the ESIC hospitals, including Director General, Medical Commissioner, DMD and Medical Superintendents, were changed due a major reorganization within ESIC. This led to fresh discussions on introducing MiM in the hospitals and ESIC decided that unless major structural changes are for the ANC/PNC clinics in hospitals, the MiM model could not be introduced. Consequently, FRONTIERS decided to withdraw support for plans for MiM implementation in hospitals.

CONCLUSIONS AND RECOMMENDATIONS

The MiM experimental study and subsequent scale-up process has been an important experience in identifying the issues that need to be considered when designing and introducing interventions that are likely to be taken to scale. The opportunity to work with a large social security health care delivery system was one of the first and most important decisions that ensured the initial success of this endeavor. The same dynamics of large scale institutions, with frequent changes in managers and cumbersome bureaucratic processes for implementation, also slowed the scale-up efforts considerably. At the systems level, such initiatives require the buy-in of each person who takes on the management role. At the client level, it is likely that demand for male involvement from clients will be more instrumental in ESIC's decision to continue MiM program, but the MiM model needs to ensure a much wider communications campaign if it is to reach the general public.

To conclude, the MiM scale-up process worked well in terms of ESIC assuming the responsibility for the initial training component of the program and was able to build capacity for training. However, to further scale-up MiM in the remaining dispensaries in Delhi, there needs to be further commitment from ESIC for supervision and monitoring of the implementation process so that MiM can be fully integrated into the dispensary norms for the provision of maternity services.

APPENDIX: SUPERVISION AND MIS FORMS

(A) MiM PROJECT SERVICE QUALITY ASSESSMENT CHECKLIST

ANTENATAL CARE

DIRECTOR MEDICAL, ESIC - DELHI

1. _____ Observer
2. _____ Dispensary
3. _____ Date

Couple counseling

4. _____ Provider

Did the provider

5. YES _____ NO _____ Discuss the type of foods to include in diet during pregnancy?
6. YES _____ NO _____ Explain the importance of regular Antenatal checks?
7. YES _____ NO _____ Explain danger signs, which require immediate attention?
8. YES _____ NO _____ Tell couple to keep arrangements ready for taking the woman to a hospital in case of obstetric emergency?
9. YES _____ NO _____ Discuss their plans for the delivery?
10. YES _____ NO _____ Explain about the care of the newborn?
11. YES _____ NO _____ Explain the benefits of breastfeeding?
12. YES _____ NO _____ Ask couple about future reproductive plans?
13. YES _____ NO _____ Discuss the various methods of contraception suitable for the postpartum period?
14. YES _____ NO _____ Explain the importance of the postnatal check at 6 weeks for mother and baby?
15. YES _____ NO _____ Tell husband to accompany wife and baby for PN check?
16. YES _____ NO _____ Review Maternity card records for follow-up ANC clients?

Individual female counseling

17. _____ Provider

Did the provider

18. YES _____ NO _____ Explain how STIs are transmitted?
19. YES _____ NO _____ Enumerate the signs/symptoms of STIs in both sexes?
20. YES _____ NO _____ Explain the effects of STIs on the newborn?
21. YES _____ NO _____ Discuss how STIs can be prevented?
22. YES _____ NO _____ Demonstrate correct use of condoms on the penis model?
23. YES _____ NO _____ Ask woman if she has genital ulcers?

Individual male counseling

24. _____ Provider

Did the provider

25. YES _____ NO _____ Explain how STIs are transmitted?
 26. YES _____ NO _____ Enumerate the signs/symptoms of STIs in both sexes?
 27. YES _____ NO _____ Explain the effects of STIs on the newborn?
 28. YES _____ NO _____ Discuss how STIs can be prevented?
 29. YES _____ NO _____ Demonstrate correct use of condoms on the penis model?
 30. YES _____ NO _____ Ask man if he has genital ulcers or urethral discharge?
 31. YES _____ NO _____ Provide him condoms?

RPR testing

32. _____ Provider

33. YES _____ NO _____ Does he store the RPR kits in a refrigerator?
 34. YES _____ NO _____ Is he using the correct method for RPR testing?
 35. YES _____ NO _____ Is he able to interpret the results correctly?

Supplies

Ask the ANM/LHV in charge about the following supplies

36. YES _____ NO _____ Maternity cards
 37. YES _____ NO _____ Maternity brochures
 38. YES _____ NO _____ STI brochures
 39. YES _____ NO _____ RPR kits
 40. YES _____ NO _____ Condoms

Review of health records

Check the following records and see if they are being filled in correctly and legibly

41. YES _____ NO _____ Check at random 5 Maternity cards.
 42. YES _____ NO _____ Male counseling register
 43. YES _____ NO _____ RPR register
 44. YES _____ NO _____ AN register

Interview with clients

Mark yes if the respondent answers correctly

45. YES _____ NO _____ What are the danger signs during pregnancy that requires medical attention?
 46. YES _____ NO _____ What are the benefits of breastfeeding your baby?
 47. YES _____ NO _____ How can STIs be prevented?
 48. YES _____ NO _____ Which FP methods can be used in the postpartum period?
 49. YES _____ NO _____ When is your next antenatal check

(B) MONITORING OF POSTNATAL SERVICES

DIRECTOR MEDICAL-ESIC, DELHI

Observer:

Dispensary:

Date:

Time:

Personnel and supplies:

No. of trained ANMs/LHV present	—
Adult weighing scales in working order	Y/N
Baby weighing scales in working order	Y/N
BP instrument in working order	Y/N
DPT vaccine	Y/N
Oral Polio vaccine	Y/N
Disposable/sterilized needles and syringes	Y/N
Provision for sharps disposal	Y/N
Condoms in PN room	Y/N
IUDs with insertion kits	Y/N
Surgical gloves	Y/N

Observations:

For one client, observe:

Is the Maternity card being filled	Y/N
Is the woman's history being recorded	Y/N
Is her weight taken	Y/N
Is her BP taken	Y/N
Are her breasts examined	Y/N
Is a per-abdominal examination done	Y/N
Is the baby weighed	Y/N
Is the baby immunized-DPT and Polio	Y/N
Is woman (if alone)/couple counseling done	Y/N
If yes, are these topics covered:	
Care of the mother	Y/N
Care of the infant	Y/N
Breast-feeding	Y/N
LAM	Y/N
Family planning	Y/N
STIs	Y/N
Did the woman/couple decide on a contraceptive method	Y/N
If yes,	
Was she/the couple provided the method chosen	Y/N
Was she/the couple explained how to use the method	Y/N

Additional remarks:

(C) MIM PROGRAM CLINICS CHECKLIST

S.No	TASKS	STATUS											
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
	Dispensary Name:												
1	Visit and briefing of Mo i/c by ADI												
	MiM training: for	MO i/c											
		MO i/c FW											
		ANM (s) i/c ANC clinic											
		LAB Tech/Asst.											
		No. of Doctors trained											
		No. of ANMs Trained											
3.	Dispensary Readiness check for equipment and supplies	AVAILABLE				Available/ In use				Available/In use			
	Lab Supplies	RPR Kits											
		Rotators											
		Centrifuges											
	ANC Clinic	Blue Maternity Cards											
		Green Maternity Brochure											
		Red STI Brochure											
		Penis model and condoms											
		FP supplies for demo											
	Laminated Job Aids	Pregnancy checklist											
		IUD checklist											
		Syndromic Management of GU											
		Syndromic Management of UD											
		Management of RPR positive											
	Posters	LAM											
		Husbands invited											
		Condoms for F											
		Condoms for prevention of STI transmission to fetus											

S.No	TASKS	STATUS											
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
	Dispensary Name:												
	Responsible Husband helping in the home												
	AVAILABLE												
4.	Modified Recording Formats in registers	ANC Register with correct Columns											
	ANC Male Counseling register												
	Lab register for RPR results												
	PNC Register with correct Columns												
	FP registers with age of youngest child for acceptors												
	SENT												
	Modified Reporting Formats												
First Modified Monthly Reports sent to ESIC Directorate													

NOTE: DISPENSARY IN-CHARGE TO FILL THIS REPORT MONTHLY TO ASSESS THE LEVEL OF SUPPLIES, TRAINING NEEDS ETC, AND FORWARD IT TO ADI (ZONE) /DMD OFFICE, DELHI.

(D) MONTHLY REPORT FROM DISPENSARIES

DISPENSARY:

MONTH

YEAR

S. No.	DESCRIPTION OF ACTIVITY	
ANC REPORT		
1.	No. of new ANC women registered	
2.	No. of old AN clients visited	
3.	No. of AN couple counseling sessions	
4.	No. of women received counseling in group (Female)	
5.	No. of husbands counseling sessions	
6.	No. of cases of genital ulcer/urethral discharge	
	Treated and counseled	
	Partner treated and counseled	
7.	No. of RPR tests done for syphilis screening	
8.	No. of RPR positive cases	
	Woman treated and counseled	
	Man treated and counseled	
PNC REPORT		
9.	No. of postnatal checkup of mother and baby done	
10.	No. of PN couple counseling sessions	
11.	No. of family planning acceptors at 6 weeks PP. TOTAL	
	LAM	
	IUD	
	Condoms	
	Tubectomy	
	Vasectomy	
	DMPA/ Injectables	
	Others	

FP RECORD

S.No.	DESCRIPTION OF ACTIVITY	
	No. of FP acceptors at 6 weeks to 6 Months PP by method	
1	Oral Pills	
	IUD	
	Condoms (no. of clients)	
	Tubectomy	
	Vasectomy	
2	Total No. of Family Planning acceptance	
	Oral Pills (pieces)	
	IUD (pieces)	
	Condoms (no. given)	
	Tubectomy	
	Vasectomy	
	DMPA/ Injectable	
	Other (specify)	

STOCK POSITION

S.No.	ITEM	
1	Opening balance-RPR	
	Received	
	Tests done	
	Closing balance	
2	Opening balance- Oral Pills packets	
	Received	
	Distributed	
3	Opening balance- CuT	
	Received	
	Inserted	
	Closing balance	
4	Opening balance-Condoms	
	Received	
	Distributed	
	Closing balance	