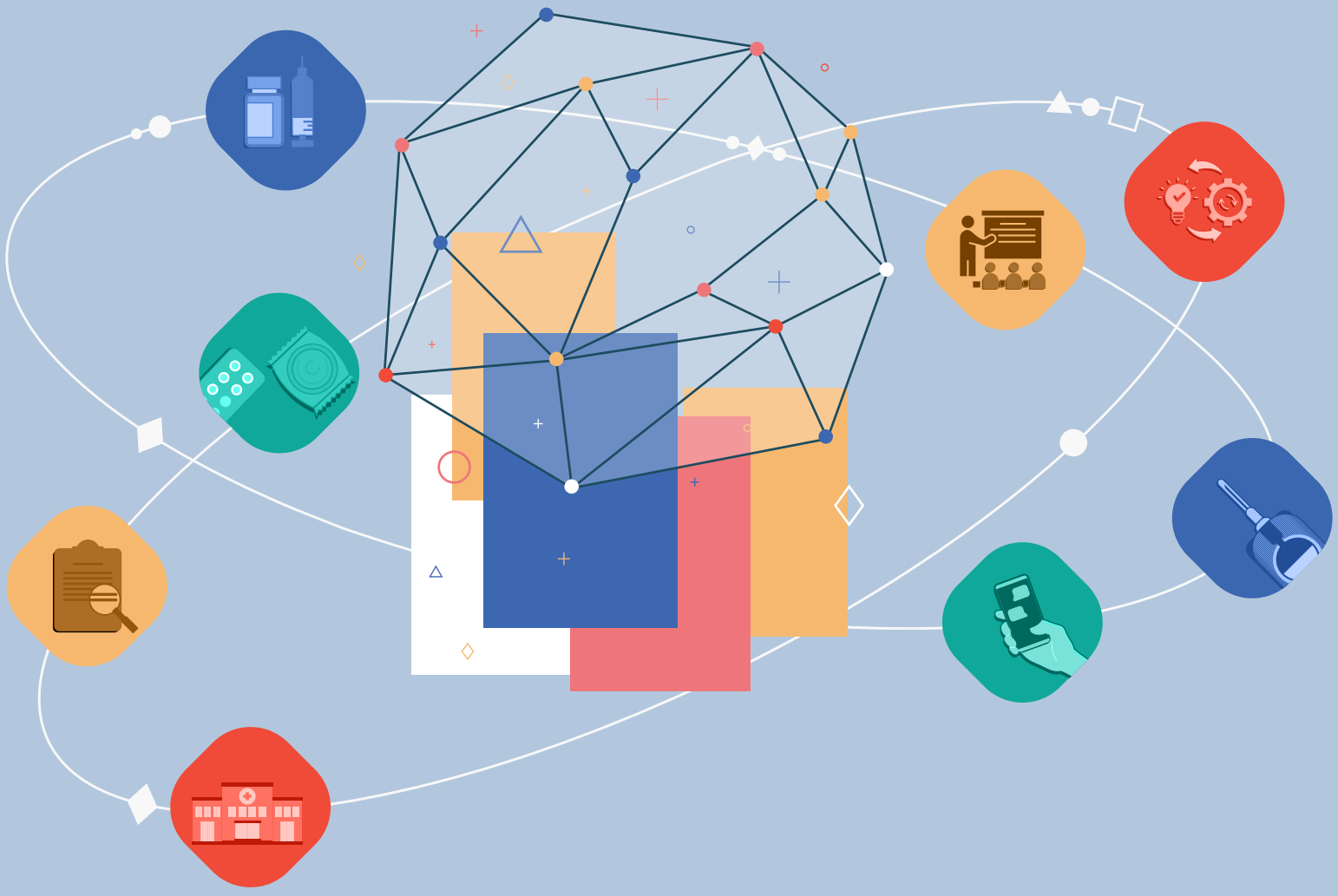
EVIDENCE FOR STRENGTHENING THE HEALTH SYSTEM TOWARDS PROVISION OF CHOICE-BASED FAMILY PLANNING SERVICES

An Exploratory Qualitative Study in 5 States of India

AUGUST 2023



Ipas DEVELOPMENT FOUNDATION

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Citation : Ipas Development Foundation. Evidence For Strengthening the Health System Towards Provision of Choice-Based Family Planning Services: An Exploratory Qualitative Study In 5 States of India. New Delhi: IDF; 2023

Executive Summary

Choice-based Family Planning (FP) services, grounded in principles of informed and voluntary decision-making, are essential in realizing the reproductive rights of individuals, and in ensuring their overall health and well-being[1] [2]. Therefore, it is critical to have an environment that is supportive in the provision of choice to clients. This environment includes policies and their implementation.

In India, the key policies and strategies that govern implementation of the FP program are reflective of the commitment towards adopting a choice-based approach[3] [4]. However, there is limited understanding of how FP policies are translated into action on the ground and what are the practices adopted that enable or hinder provision of choice-based services. Therefore, Ipas Development Foundation (IDF) conducted a study to get an understanding of FP program implementation in India. A total of five states were selected for the study – Jharkhand, Karnataka, Madhya Pradesh, Odisha and Rajasthan[a].

For a comprehensive understanding of FP program implementation across all the levels of the public health system (state, district, facility and community), the study adopted a health systems (HS) framework with seven key components. These components included Institutional Mechanisms, Service Delivery, Commodities, Information and Communication, Health Workforce, Infrastructure and Financing[b]. An exploratory qualitative research design was adopted wherein in-depth interviews (IDIs) were conducted with public health sector employees who are responsible for planning and executing the FP program in the study states. These FP program stakeholders were identified at each of the four health system levels and included state and district health officials responsible for managing the FP program in their states and districts, facility-level officials, surgeons and nurses who are involved in FP service provision at facilities as well as Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs) at the community level. A total of 123 IDIs were completed across the five study states. The health systems framework was applied for analysis, and an inductive approach was used. The responses were coded across themes and insights were then drawn from the findings that emerged.

The study findings provide a unique field level perspective on the FP program. They highlight that stakeholders believe in the importance of FP and recognize the approach of providing choice-based services to women and couples. However, there also exist elements of the historical approach to FP with stakeholders stating the purpose of FP as that of population control. In the context of the history of the FP program in India, which has been fraught with a target-driven, population control approach, this finding indicates that implementation may still somewhat be influenced by residual legacies of past systems. The presence of these conflicting intents puts forth a case for addressing this discord and making salient the intent of choice-based service provision among stakeholders.

From the perspectives shared by stakeholders, the study found that there is largely a uniformity in overall implementation of the FP program across states. The observed differences between Mission Parivar Vikas (MPV) states[c] of Jharkhand, Madhya Pradesh and Rajasthan and non-MPV states of Karnataka and Odisha, are also primarily in terms of promotional activities and incentive schemes which are being implemented as per MPV guidelines. However, the state of Odisha (non-MPV) indicated the inclusion of the 'nayi pehel' kit for newlyweds (which is currently being provided in MPV states) in its next program implementation plan. This indicates a

a) The selection of states was based on ensuring regional diversity, including a mix of MPV and non-MPV states; and on IDF's experience of working with state governments combined with an understanding of their willingness to collaborate for this project.

b) This framework was developed using the WHO building blocks of the health system and learnings were drawn from IDF's work on the sustainable abortion ecosystem.

c) Mission Parivar Vikas (MPV) was introduced in 2016 for 146 high-fertility districts from seven states and later expanded to all districts of these states as well as to an additional six states in the North East. Activities under MPV include organization of 'saas-bahu sammelans' (mother-in-law and daughter-in-law meetings), distribution of 'nayi-pehel' kits (FP information and commodities kit) to newlyweds and creating awareness through 'SAARTHI' vans (equipped with interactive IEC and FP commodities). The scheme also introduced revised incentive structures for FP services.

recognition among states on the importance of delaying pregnancies. Moreover, both Odisha and Karnataka (non-MPV) also reported provision of incentives for Antara in the pipeline (Injectable contraceptive), which are currently only being implemented in MPV states as per guidelines. Overall, MPV activities and incentive schemes seem to be perceived as adding value to the FP program and therefore aspects of it are being included by non-MPV states in their implementation as well.

Within Institutional Mechanisms, which include program planning, monitoring and reviewing processes, the study found that regular review meetings are conducted across levels of the health system. In these meetings, the agenda for FP is reported to be focused on the status of the Expected Levels of Achievement (ELAs). While the use of ELAs is intended as providing maximum coverage of services to the community (as reported by state and district officials), there are reported instances where ELAs cause additional pressure among ASHAs and ANMs. This focus on ELAs can also be limiting in the way that success of the FP program is perceived by stakeholders i.e., only in terms of contraceptive uptake. Mainstreaming the use of other programmatic indicators such as those of informed choice, delayed first pregnancy and spacing between births could also expand the way in which FP programs are evaluated and therefore, implemented. In fact, informal monitoring practices such as those reported in Madhya Pradesh and Odisha, could also be replicated in other areas to provide a more comprehensive review of the program. These practices include back-checks and interviews with clients that provide oversight to district and block authorities on the quality of FP services provided at the ground level.

Service Delivery for FP appears to begin primarily post the identification of newly married couples i.e., 'eligible couples' and continues through the reproductive, maternal, newborn and child health continuum of care. The touch points at which FP services are provided include ante-natal care (ANC) visits, post-partum care at facilities, Village Health and Nutrition Days (VHNDs), Immunization visits and Home-based Newborn Care (HBNC) visits. In Jharkhand, there were reported to be strategies in the pipeline to leverage the post-partum period for providing a kit to mothers which includes condoms to encourage contraceptive use. This is a practice that can be replicated in other areas by adapting the 'nayi pehel' kit into a 'post-pregnancy kit'.

The responses highlight that the focus of service delivery is primarily on 'eligible couples'. This could be limiting focus of FP services on all those that do not get covered under this category (including adolescents). As intended in India's FP2030 vision, FP service delivery should be provided to all people of reproductive age-group and therefore, there is a need to align the vision with implementation at the field level in terms of expanding service delivery to all people, beyond 'eligible couples' and towards 'eligible clients'.

Within service delivery, there are also indications of providers (facility and community stakeholders) prioritizing sterilization services, particularly for women with two or more children. Given the strategic focus at the national level on encouraging reversible methods, this is another area where alignment between the policy and implementation is required to be strengthened. There must be an equal focus on all methods to enable effective delivery of choice to clients.

Findings highlight that it is not just the system and the providers that influence service delivery, but it is also community norms which affect how and what services are provided. Stakeholders reported facing challenges in talking to and in engaging men, which in turn affects the FP information provided to men. Alongside the community activities that are designed to engage men, it is important that capacities of facility and community stakeholders also be built to effectively navigate community and gender norms.

Within Commodities, where the uninterrupted availability of methods and choices is a critical aspect, the findings indicate that commodities are largely being managed through the FP Logistics Management Information

System (FP-LMIS). All states reported using this system but also acknowledged the need for strengthening its implementation given that there are challenges to utilization (such as poor internet connectivity in the field and limited digital literacy among ASHAs). Despite these challenges, uninterrupted stock availability is ensured through redistribution mechanisms. These include identifying facilities where there is excess stock and diverting it to facilities where there may be a shortage in order to ensure balanced service delivery.

Information and Communication, which includes community outreach activities as well as information, education and communication (IEC) material for FP, is reported to receive an extra momentum around World Population Day (WPD) in July and Vasectomy Fortnight in November. Additionally, in MPV states, there are community engagement activities conducted which include actively engaging mothers-in-law since they are influencers in decision-making. All communication activities being conducted are also opportunities for informing and sensitizing the community on their rights and choices within family planning.

In Karnataka, it appears that social networks (i.e., peer-to-peer interactions) are being leveraged to spread information on FP services through community influencers, which is a simple and feasible method of increasing community awareness and has potential for replication in other areas. Besides these activities which require in-person communication, in some areas, the IEC material on FP was reported to be difficult to comprehend by those who have limited reading abilities. A solution to address this could be providing district and facility stakeholders with flexibility to adapt IEC content in the local language or to use more audio-visual content, which also has the advantage of being more engaging for the audience. In Rajasthan, audio clips with information on Injectable-IM contraceptives were reported to be deployed till the sub-centre level for clients to view and understand the information better.

Health Workforce shortages were reported across states, specifically those of surgeons and ANMs. This in turn burdens the existing workforce, thereby limiting the opportunity of clients to have in-depth discussions with providers, an essential factor for ensuring choice-based services. Apart from the numbers in the workforce, findings highlight the need for defining clearer mechanisms for refresher trainings of existing staff members. Trainings are also opportunities for sensitizing the workforce on reproductive rights and choice.

In one of the study districts of Madhya Pradesh, it was reported that active participation of male multi-purpose workers (MPWs) led to men taking greater responsibility in FP (indicated by increase in male sterilization services). The institutionalization of Health and Wellness Centres (HWCs) and inclusion of male MPWs[d], is an opportunity to involve this cadre more actively in FP service provision.

Within the HS component of Infrastructure, the adequacy of facilities necessary for FP was explored. The findings indicate that 'FP corners' or dedicated spaces for FP counselling at facilities exist in many areas and where these don't exist, a need to create these spaces was expressed. These spaces ensure confidentiality and privacy for clients. Additionally, these spaces give clients a clear direction of which area in a facility to approach for accessing FP services, thus easing navigation of the facility.

This study also found that while stakeholders at facilities are instructed to include men in FP counselling, the infrastructure itself can pose as an opportunity barrier for engaging men. To avoid overcrowding, the entry of men may be limited into the maternity wards which is where post-partum FP counselling may take place thus, missing the opportunity of including men in conversations on FP. Navigating this barrier by proactively distributing FP IEC material directly to men or utilizing FP corners at facilities for counselling, could support with provision of information to men.

d) As per Ayushman Bharat guidelines, HWCs are supposed to have a team of at least three service providers – one mid-level provider, at least two (preferably three) MPWs – two female and **one male**, and team of ASHAs at the norm of one per 1000.

Within Financing, budget allocation decisions were reported to be made at the state-level with minimal role of the district levels. The findings provide limited insights into budget adequacy for FP but indicate that in cases of additional budget requirement, approvals are taken, and flexi fund pools are utilized.

Incentives in the family planning program are seen by stakeholders across the system as being important for increasing method uptake and for reimbursing the out-of-pocket expenditures that are incurred in accessing the method. However, findings also indicate that higher incentives for specific methods may influence prioritization of those methods. It is therefore important for the system to balance service provision such that the incentive amounts do not interfere with the choice of clients.

Overall, the research provides strong evidence for strengthening the FP program, particularly as the findings are derived from responses of those who are in the system themselves. For national and state stakeholders, the findings can be used to replicate good practices identified, whereas the challenges can be addressed through programmatic interventions. Together, these could strengthen the system towards provision of choice-based FP services.

In addition, this study is unique in its qualitative exploration of the functioning of the health system in providing FP services. Learnings from this can be used for future research on understanding FP program implementation in India.

Acknowledgement

IDF thanks the state government teams of Jharkhand, Karnataka, Madhya Pradesh, Odisha and Rajasthan for their leadership, support and cooperation in the study. We are deeply grateful to all the study participants for giving us their valuable time and insights. We also appreciate the dedication of all providers who work tirelessly for providing family planning services to clients.

We acknowledge the support provided by the team at Purple Audacity Research and Innovation in implementation of the research study. We are also thankful to the state teams of IDF for their coordination and support in executing the study.

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This study was made possible by the financial support and guidance from the Bill & Melinda Gates Foundation (BMGF).

Introduction

Globally, since the 1950s, the approach towards family planning has been steered towards the need for population control, especially in countries with high fertility[5]. The International Conference on Population and Development (ICPD) in Cairo 1994 resulted in a paradigm shift in policies that moved away from population control towards a rights-based approach for fulfilling sexual and reproductive health (SRH) needs. This shift led to viewing family planning (FP) more holistically that catered towards reproductive health and rights of individual women and men[6] and not merely controlling fertility.

India was the first country in the world to launch a centrally sponsored national FP program in 1952. This program too was initially dominated by the approach of population control. However, since the mid-1990s, the program adopted a change from a vertically-run, target-driven, incentive-based, focused on limiting methods approach to providing a basket of contraceptive choices, focusing on broader family and health concerns through a decentralized, target-free, client-focused approach[7].

The current Family Planning (FP) programme in India is designed to achieve the objectives of the National Population Policy (NPP) 2000[4], and the National Health Policy (NHP) 2017[8]. It is guided by the architecture of the National Health Mission (NHM), as well as key strategic approaches of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) 2013[9], and Ayushman Bharat 2018[10]. Moreover, the FP program aims to achieve commitments of the Government of India (GoI) towards realizing the global vision for FP. Having achieved its FP2020 goals, the FP program is now transitioning towards achievement of its FP2030 goals[3]. These policy declarations and programmatic initiatives clearly articulate the intent of the FP program towards achieving choice-based FP:

- NPP reaffirms the commitment to voluntary and informed choice and consent of citizens while availing reproductive health care services, and continuation of the target-free approach in administering family planning services.

- NHM subsumes the goals of the Reproductive and Child Health (RCH) strategy and provides multiple guidelines for delivery of quality FP services which again recognize the perspectives and needs of the community.

- RMNCH+A strategy focuses on delivering quality FP services along a continuum of care while realizing the importance of meeting the SRH needs of adolescents.

- NHP 2017 and Ayushman Bharat focus on the country's Universal Health Care (UHC) agenda and strengthening primary health care, taking FP services closer to the community.

- FP2030 reaffirms the commitment towards ensuring quality FP services to all people of reproductive age and recognizes the importance of focusing on young people due to a changing demographic.

The policy landscape thus provides an environment that supports the execution of choice-based FP services. In 2016-17, the range of contraceptive methods available in the public sector was also expanded with the introduction of two new methods (Centchroman and Injectable-IM). To complement the introduction of newer methods of contraception, strategies were introduced to provide FP services to the last mile. These included initiatives such

as Mission Parivar Vikas (MPV) which was introduced in 2016 for 146 high-fertility districts from seven states to substantially increase access to contraceptives and FP services in these areas. It was later extended to all districts of these seven states as well as to an additional six states in the Northeast. The MPV strategy was conceptualized as a 360-degree approach that addressed the demand side as well as the supply side in FP.

The impact of these efforts reflects in the increased use of modern methods. As per the fifth round of the National Family Health Survey (NFHS-5) 2019-2021[11], the modern contraceptive prevalence rate (mCPR) is 56.5% compared to 47.8% in NFHS-4, 2015-16[12]. Additionally, there has been a decline in unmet need of contraception to 9.4% as per NFHS-5.

The NPP[4] had also set the goal of attaining a TFR of 2.1 by 2010. As per NFHS-5, India's TFR has declined to 2.0, which is below replacement level fertility. While these demographic goals of the FP program have been achieved, it is important to also focus on the quality of the program and one of the critical components of quality services is the provision of informed choice. The data from NFHS-5 indicates that only 50% of women were informed about three key aspects - (i) possible side-effects or problems of the method they use, (ii) what to do if they experienced side-effects and (iii) other methods of FP they could use. Therefore, it is important to strengthen this area of choice-based service delivery in FP.

As laid out above, the provision of choice has been a vision of the FP program in India. However, there is a gap in evidence on the current implementation practices within FP across states and what are the enablers and challenges that can be leveraged / addressed for strengthening choice.

In line with this goal of understanding and strengthening the implementation of choice-based FP services further, Ipas Development Foundation (IDF) conducted a study in five states of India – Jharkhand, Karnataka, Madhya Pradesh, Odisha and Rajasthan. The objectives were to understand the strategic priorities that govern implementation of the FP program across states, as well as to identify the good practices and challenges within implementation that can be leveraged and addressed, respectively.

This report presents an overview of the methodology used for the study, the aggregate findings that emerged from the 5 states in terms of the implementation practices within FP and discusses the key insights for strengthening choice-based FP in India.

Methodology

STUDY DESIGN

With an aim to understand the implementation of the FP program, the study primarily used an exploratory research design. A qualitative approach was used as it is the best suited method to understand the perspectives and insights on the current FP policies and programs from the stakeholders across all levels of the health system (as shown in Table 1). Given that the FP program is implemented through the health system (HS), a framework that included various components of the HS was adopted for use in building the study tools and conducting the analysis. This framework was developed using the WHO building blocks of the health system[13] and learnings were drawn from IDF's work on the sustainable abortion ecosystem[14] for designing the tools.

The framework used defines seven components – Institutional Mechanisms, Service Delivery, Commodities, Information and Communication, Health Workforce, Infrastructure and Financing (Image 1; see Annexure 1 for details). The framework also recognizes that the HS operates within the larger ambit of the policy landscape.

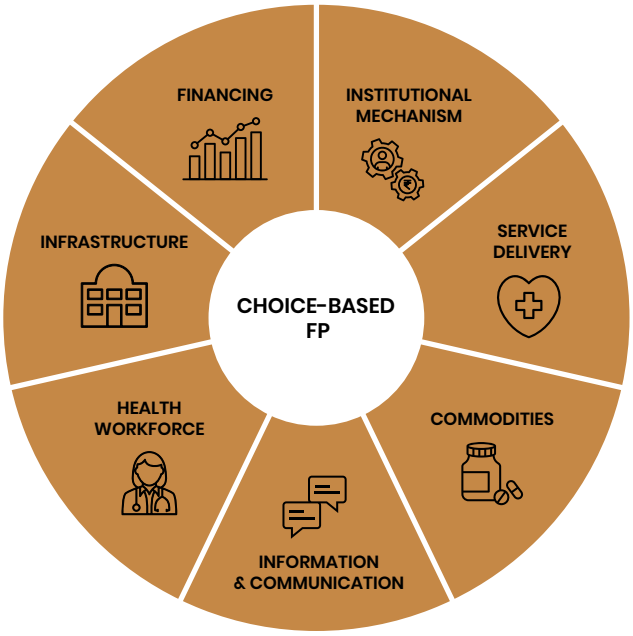

Image 1: HS components that operate towards the outcome of achieving choice-based FP services

SAMPLE

Respondents were identified across different levels of the health system (state, district, facility and community) who were responsible for closely planning and / or executing the FP program at these levels in each of the states. A total of 123 IDIs were completed (see Table 1 on the next page).

SETTING AND DATA COLLECTION

In-depth interviews (IDIs) were conducted across four districts in each of the five states – Jharkhand, Karnataka, Madhya Pradesh, Odisha and Rajasthan. The selection of states was based on ensuring regional diversity, including a mix of MPV and non-MPV states as well as based on IDF's experience of working with state governments and an understanding of their willingness to collaborate for this project. The four districts within these states were selected based on a few parameters including state headquarters, geographical spread, prevalence of contraceptive use and unmet need of family planning. Data was collected from May to August 2022.

STUDY TOOLS

Comprehensive interview guides were used for the IDIs that provided flexibility to obtain open-ended answers as well as probe further where newer responses emerged. Field notes were maintained, and team debriefs were conducted to capture issues and trends that emerged from each interview.

Table 1: Sample distribution

HEALTH SYSTEM LEVEL	STAKEHOLDERS INTERVIEWED	NUMBER OF IDIs
State-level	State-level health officials	9
District-level	District-level health officials	23
Facility-level	Facility-level officials*	20
	Surgeons	12
	Nurses	19
Community-level	Auxiliary Nurse Midwives (ANMs)	20
	Accredited Social Health Activists (ASHAs)	20
	TOTAL	123

***Facility-level officials included Medical Officers In-Charge (MOICs) and Administrative Officers In-Charge**

ANALYSIS

The audio recordings from the IDIs were transcribed and translated into English. The health systems framework was used for analysis, and an inductive approach was used. The responses were coded across themes and insights were then drawn out from the findings that emerged.

LIMITATIONS

The findings in this report have attempted to capture and analyse the perspectives around implementation of the FP program in a selected sample and geography in India and therefore findings may not be generalizable to the rest of the country. Additionally, the study documents data which is self-reported by participants and therefore maybe subject to recall bias. Lastly, the study focused on the public health sector and therefore findings do not capture implementation practices in the private health sector.

Note: The quotes provided to substantiate the findings are representative across the study states. On ethical grounds and in order to maintain confidentiality of the respondents, the state (which is an identifier) has been removed from the quotes and replaced with a coding done at the backend. Quotes where any other identifiers such as district names, hospital names, MPV related activities etc. are mentioned, the requisite details have been masked to maintain complete confidentiality.

Findings

The findings of the study are structured as follows – they begin with the stakeholders' understanding of FP policies and the reported strategies that guide implementation of the FP program in the states. These then lead into the key findings across each of the seven health system components.

FP POLICY AND STRATEGIC INTENT

The policy landscape of the FP program in India has seen a transition from a population control, target-driven approach to that of population stabilization, and a target-free approach. Alongside, with the evolution of the program, greater emphasis has been placed on promoting overall reproductive health and well-being of the family as well as reducing maternal, infant and child mortality and morbidity. The respondents of the study reported a similar understanding of the FP policy intent (children by choice) while at the same time, the responses reflect a few elements of the historic approach to FP (population control).

- The policy intent of providing clients the choice of whether and when to have children as well as preventing unwanted pregnancies was stated and implied by FP program stakeholders.

  "Children by choice, not by chance." – State-level & Facility-level stakeholder, State 1

  "Every eligible couple should adopt a method of contraception as per their need and as per their willingness, but also every eligible couple should adopt some method. Unwanted pregnancy should be as minimum as possible." – Facility-level stakeholder, State 4

- Reduction and maintenance of TFR is widely seen as the aim of FP alongside reduction of infant and maternal mortality rates (IMR and MMR); however, population control also features as the reported intent of the FP program by respondents.

  "The aim is to control population growth. We want to maintain our TFR based on the national guidelines." – State-level stakeholder, State 1

  "Controlling the birth rate is the motive." – District-level stakeholder, State 2

  "The main purpose of the family welfare program is to reduce the fertility rate under Mission Parivar Vikas, as our district falls under it." – District-level stakeholder, State x

  "Family planning is a way to control population, control IMR and MMR, and provide family and financial stability." – Community-level stakeholder, State 4

  "We have to control the population. We have to take care of each and every baby's health." – Community-level, State 5

- There is recognition of the benefits of a small family; these are seen in terms of individual benefits for the family (better education and financial stability) as well as for overall development of nation (better

standards of living, education, resource utilization etc.).

"The mission of the government is to provide quality life to people. There shouldn't be situations of lack of food, water, etc. If the fertility rate is controlled, then automatically all these things will improve." – District-level stakeholder, State 3

"FP is required, as if people don't do family planning and if they have too many children then they will face problems in their upbringing. If they have fewer children, they can spend money on their studies otherwise they will not grow up as civilized people and it will be harmful to our society." – District-level stakeholder, State 1

"Family planning's main goal is to stabilize the birth rate. It is to stabilize population growth and it, directly and indirectly, leads to so many other benefits such as increase in literacy rate, the standard of living and better usage of resources.." – District-level stakeholder, State 5

"Aim is to reduce IMR, MMR, and enable the betterment of the health of the mother and child such that the financial situation and education of kids are maintained." – Facility-level stakeholder, State 1

- There is also a recognition of the importance of spacing between children as well as an acknowledgement of the importance of delaying the first pregnancy.

  "I feel we need to work on spacing and also on adolescents." – State-level stakeholder, State 2

  "A couple should have their first child after two years of marriage so that they are mentally prepared. There should be a three-year gap between the first and second child, so that a woman can recover properly. We need to maintain this gap so that both MMR and IMR are impacted." – State-level stakeholder, State 3

  "The primary objective is to control population. And then gap between 2 children is very essential. If we don't maintain the gap, then it impacts the mother's health." – Facility-level stakeholder, State 4

  "You have to control the size of the family and there should be good spacing in the birth of the babies. You need that much of time to recover from the loss during the first pregnancy and delivery. We need to have those (FP) programs because most of the mothers that you come across when they are pregnant will either be weak or anaemic." – Facility-level stakeholder, State 5

- Responses from specific states also provide insights into the prioritization of the FP program. In Karnataka, the FP program is perceived to have been successful in terms of an increase in the couple years of protection and a reduction of TFR, which were both reported to be at a stage where the FP program need not be prioritized over other health programs. At the same time, there is recognition that spacing between births and quality of services are aspects that need to be promoted further. In Madhya Pradesh, it was reported that the prioritization of FP by facility stakeholders shifts with the priorities decided by stakeholders at higher levels of the health system (the example provided was that of higher priority awarded to non-communicable diseases in one of the study districts).

HEALTH SYSTEM COMPONENTS

Institutional Mechanisms

Institutional mechanisms include the planning and monitoring processes and practices that guide implementation of the FP program. One of the key institutional mechanisms identified based on the responses of the study was 'expected levels of achievement' (ELAs). The target-free approach that was adopted in the mid-1990s, removed centrally determined contraceptive targets. ELAs were subsequently introduced and were to be calculated based on a community needs assessment.

- It was observed that the term 'targets' and 'ELAs' are used synonymously by stakeholders even though there is an understanding of the removal of the target-oriented approach. The method for calculating ELAs largely appears to be based on population estimates and unmet need.

  "We make action plans and timelines for districts. We have fixed the target for every month, quarter, and also annually for every FP service. Even for the activities we have the number of days fixed to finish it up." – State-level stakeholder, State 2

  "We don't give targets—we don't tell staff members that they have to achieve a certain number. Rather, we expect that they will give coverage to the maximum number of beneficiaries." – State-level stakeholder, State 3

  "State gives the target according to the population. States provide targets to the district and districts share those targets block wise. So, the target is coming from the demographic section which must be achieved." – State-level stakeholder, State 4

  "Target is just a calculation..in practice what people are using matters, because we cannot force people." – District-level stakeholder, State 1

  "Whatever are our expected levels of achievement, we need to achieve it, and whatever is the unmet need has to be reduced." – District-level stakeholder, State 2

  "Yeah, there is a target according to estimated population, according to birth rate and that is being done sub-centre wise. This we don't call as target but we call it as expected level of achievement." – Facility-level stakeholder, State 4

  "We have yearly and monthly targets. For example, in 2022-23 our yearly target was 68 and we should reach at least 60. So monthly it will be 5 cases of tubectomy. So, we try to achieve that..this target is given basis the population and eligible couples. Every year we have CNA survey which tracks the population changes basis death and birth. Once this is tracked then basis this data, they give targets for all the services and not just family planning."– Facility-level stakeholder, State 5

- Program review meetings appear to be held regularly where the agenda for FP primarily seems to be centred around status of ELAs. In a few cases, these ELAs / 'targets' appear to lead towards additional pressure among facility and community-level stakeholders.

"From our side to understand which block is performing well and which badly, we look at their HMIS reports. If a block is lagging in achieving their ELA, we give them a warning of strict investigation." – District-level stakeholder, State 1

"We get targets from the state and distribute them to the blocks, after which monitoring is done." – District-level stakeholder, State 3

"They (state) send guidelines and targets that we have to achieve so they review that once in 3 months. Virtual meeting is conducted, and they ask things related to performance, why targets are not achieved, why cases are less and all that. They give suggestions as well. They are continuously monitoring all our activities." – District-level stakeholder, State 5

"The most important focus during monthly meetings at the district level is the achievement of targets—particularly for sterilization after two children—in women more than men."– Facility-level stakeholder, State 3

"...but we are given unachievable targets; it should be reasonable." – Facility-level stakeholder, State 5

"Every Saturday we have a weekly review meeting, so they (ASHAs and ANMs) have to report whatever targets they have achieved." – Facility-level stakeholder, State 5

"We have to answer if our numbers are less in our reports; so we have to achieve targets completely—otherwise they ask for explanation." – Community-level stakeholder, State 3

"I feel scared the moment I see the target, but I continue the work. Suppose if I put more effort then I reach the target." – Community level stakeholder, State 5

- At the state level in Odisha, it was reported that review meetings with officials from 5-6 districts are held every month. A mix of 'high and low performing districts' as per their ELAs are included in these meetings. These provide opportunities for cross-sharing and learning so that practices in 'high performing' districts may be replicated. However, the evaluation against ELAs was reported to pose challenges for certain districts in Odisha where migration is common. Given that the ELAs are calculated based on population estimates, these reportedly set higher numbers for achievement whereas the actual population of the district may be lower.

- At the implementation level, there were also additional monitoring processes reportedly being followed in a few areas. In one of the study districts of Madhya Pradesh, annually / biannually, the block medical officers interview 10 women who are FP clients to get feedback on the FP services provided to them. Similarly, in Odisha, back-checks are done with FP clients to assess service quality at the ground level [See Annexure 2 for learnings on these good practices].

- Platforms such as WhatsApp and Telegram appear to have enabled smoother communication of guidelines, orders and circulars from the state to the community level. Multiple WhatsApp groups were reported to be operational between stakeholders across levels of the health system. In Rajasthan, there reportedly exists a Telegram group of all ASHAs in the district which enables the district authority to have a direct line of communication with ASHAs.

"There are WhatsApp groups on which Block level affairs, District to Block, and Block to Community level

workers' information is shared. Though mail is also used for higher level communication, info is shared via WhatsApp with community level workers." – Facility-level stakeholder, State 1

"We make a letter and forward it on WhatsApp groups because not everybody uses mail. We have WhatsApp groups according to clusters. We have separate groups for Sahiya and Sahiya Sathi.." – Facility-level stakeholder, State x

Service Delivery

The service delivery component of the health system encompasses the strategies adopted for ensuring availability and accessibility of FP services, including provision of FP counselling. This component also explores external factors that influence service delivery such as beliefs and experiences of providers as well as community norms and practices.

- FP services are largely focused on married couples who are first identified as the 'eligible couples' (ECs). The findings indicate that service delivery occurs along the reproductive, maternal, newborn and child health continuum of care which ensures multiple touch points with clients. These touch points include antenatal care (ANC) check-ups, immunization days / Village Health and Nutrition Days (VHNDs) and Home-based Newborn Care (HBNC) visits.

  "We usually begin counselling from the first ANC. We ask the beneficiary how many children she has and if she wants to have more. If she already has children, we tell them about permanent and temporary methods." – Facility-level stakeholder, State 3

  "For immunization days also we keep all (commodities) and we show this family planning basket." – Facility-level stakeholder, State 5

  "Firstly, we collect the data of newly married couples in our area, so the ASHA worker informs me that. They say there are so many newly married couples in this particular area. Suppose if a man belongs to this area and gets newly married then we consider it as EC and register their name and during their first visit we do not discuss family planning. We meet them and talk 2 to 3 times and then we explain family planning. They are known as the new EC. We get to know the age of the girl, so if she is married at the age of 18 years so then we say to move on slowly and not have a child at an early age." – Community-level stakeholder, State 5

  "We go for field visits to see a new-born child as a part of HBNC visit. During that time, we ask the new mother which FP method she would like to use for protection. We give her details of all the methods we have available and allow her to choose." – Community-level stakeholder, State 3

- 'Eligible couples', who are the focus of FP service delivery, are primarily offered condoms as contraceptives while other temporary methods are offered after the birth of the first child. Spacing methods such as IUCDs seem to be the focus for women who are pregnant with their first child to ensure adoption of the method after birth, and limiting methods (specifically female sterilization) dominate the choice offered to couples after the birth of 2 children.

  "Counselling happens somewhat during the pregnancy and after that the final discussion is at the time of delivery. They are given the option of PP-IUCD during delivery to maintain a gap between their first and second child." – Facility-level stakeholder, State 3

"I meet women in the village. Those who are newly married, I asked the woman to have a gap of two years between the children. Suppose a woman is brought to the CHC for delivery, I already keep her informed about PPIUCD to be used after delivery which will help her having a gap for the second child. If someone is using tablets, and is heavily bleeding, either we ask them to use condoms or once the child becomes a year old, we can give them Mala N as well. Mala N affects the breast milk of the mother. Another option is Antara in temporary methods. There is an option of vasectomy, like when they have two children, they can avail this option. Once the second child becomes 2+ years old, then we recommend vasectomy or tubal ligation." – Community-level stakeholder, State 1

"They had sent this instruction from the block asking us to pay attention to the fact that parents have two children, and not more. That is considered as our target." – Community-level stakeholder, State 3

"Suppose it is the first pregnancy, I mean for newly married couples we recommend CC and do not advise OP and Chhaya. Suppose if they have delivered a child then we recommend IUCD and for second pregnancy we recommend LTT or operation. Suppose if they have done cesarean for the first time and second also cesarean is done so at the same time, I say to get operated." – Community-level stakeholder, State 5

- A few responses are also indicative of provider bias among facility and community level stakeholders which is a predictor of the kind of services offered to clients and how they are offered.

"But the thing is that the acceptance of PPIUCD is more in delivery case because when we insert it during delivery, the patient is then in severe pain. During that period whatever we ask them...they do that." – Facility-level stakeholder, State 4

"Otherwise, they will not accept the PPIUCD service. If they want to get caesarean done, then they have to get the insertion done.. So, it is one way to convince them."– Facility-level stakeholder, State 5

"..Those who are uneducated, we tell them to use copper T. Mala-D has been used for a long time, so they remember to take it. Some also have Antara - those who are educated. Those who are educated have Chhaya but those who are not educated we want them to use copper T." – Community-level stakeholder, State 1

"Suppose there is a newly married lady, I can go to them and ask them to use condoms. Other methods aren't applicable for them." – Community-level stakeholder, State 4

- Community norms and experiences cause challenges in service delivery for providers (facility and community stakeholders), which sometimes leads to selective recommendations by them. This is particularly reported in provision of services to men as gender norms make it uncomfortable for providers to discuss FP with men.

"See right now we are tracking the condom users, so we tell them how to utilise it. For example, we have the models of the penis in health care facilities and we need to show men how to utilise condoms...this is there but I still doubt that it is reaching the end user...The reason for that is number 1, the hospitals are crowded... we have the ASHA workers but if you ask me they may not be able to talk about it..I hope you understand that it won't be easy to go to a male and tell him how to use a condom and show a penis model. Somehow I think it may not work." – State-level stakeholder, State 5

"It is difficult to promote NSV and motivate them. We have conducted a meeting for males as well (to promote it). In each block, we conducted 10 male meetings—but we did not expect results from that. NSV is not accepted by society." – District-level stakeholder, State 3

"Let's assume that we have to search for an NSV patient - we have to search for male vasectomy but to find a male patient is a Herculean task so you won't have output...For male vasectomy we have to counsel them, we have to motivate them and we have to keep a vigil that they don't run away even from the hospital bed right before the vasectomy as there is lot of fear despite so much explanation." – Facility-level stakeholder, State 2

"We cannot talk to males, we feel uncomfortable." – Community-level stakeholder, State 1

"Sometimes using Chhaya & Antara causes hormonal changes. Some women cannot accommodate it. Periods are irregular, there is excess bleeding. They are not allowed to go to the kitchen or do puja, this happens in my house too. Another complication is that periods do not come because stomach gets swollen, sometimes vision blurs – health deteriorates. So, it gets difficult for us to counsel them for this method, we don't know how to explain. So, I suggest Mala-N & condom mostly." – Community-level stakeholder, State 1

"It is difficult to talk about condoms. They ask the method to use it, so if there is a male person present there then I hesitate to talk about it. If it is only a woman, then I can explain it to her." – Community-level stakeholder, State 2

"It is difficult to talk about NSV. There are different people in the village, we speak to ladies, and then they speak to their husbands." — Community-level stakeholder, State 2

"We give commodities to women, but at times they don't take it. When we ask why, they say their husbands don't want them to." – Community-level stakeholder, State 3

- Sterilization services are largely conducted during the winter months of the year due to preferences of the clients however, there was a reported need for spacing them out through the year. Additionally, the guidelines surrounding Fixed Day Static (FDS) services for sterilization were reported to have benefitted the system in terms of being able to ensure quality. The term 'camps' and 'FDS services' were observed to be used synonymously as well as jointly ('FDS camps') by stakeholders.

"Govt. should keep off season incentive and winter incentive separately." – District-level stakeholder, State 1

"We should have separate OT for FP, since we have only a single OT in the entire hospital. This way patients won't have to wait, especially in winters when workload is higher." – Facility-level stakeholder, State 1

"There needs to be an active effort to change this mindset such that sterilization cases are more spaced out throughout the year." – Facility-level stakeholder, State 1

"Earlier, during an FDS camp, we used to get 50 to 60 cases done. But now, the government has mandated that one surgeon can only do 30 cases. If you have more beneficiaries, you need to have two surgeons available. This way, the quality is ensured." – District-level stakeholder, State 1

- In MPV states, Antara services were reported to be available till the sub-centre level in districts which were earlier categorized as MPV (as per 2016 guidelines) with plans to ensure availability till the sub-centre level across all districts (as per the 2021 MPV guidelines).

  "We launched Antara in a phased manner. In the xx high-TFR districts, Antara has been active at the sub-centre level; in other districts, it's available at the CHC level. But now that this is an MPV state, Antara will reach the sub-centre level in all districts." – State-level stakeholder, State x

- Service provision for FP in MPV states also includes providing 'nayi pehel' kits to newly married couples. These kits have contraceptives (condoms and pills), and a pamphlet with information on FP as well as a marriage certificate, pregnancy testing kit and grooming set. Even in non-MPV states such as Odisha, it was reported that there are future initiatives in the pipeline that include introduction of 'nayi pehel kits' for delaying the first pregnancy.

  "We have made the nayi pehel kit into a red box now, so that the lady can use it in front of males in the family. It is also attractive this way. We keep a marriage certificate which young couples will need and add all types of make up materials like bindi, sindoor in it. FP pamphlet and condom is also there." – State-level stakeholder, State x

  "Nayi pehel kit has started. We purchase vanity boxes, put bangles, bindi, make-up items, other small items with a pack of condoms, etc." – District -level stakeholder, State x

- Certain adaptations in service delivery are being made in some of the study states to ensure availability of services as well as compliance to chosen methods by clients. These include – involvement of private providers in performing sterilization services (where unavailable through the government); providing an extra month of oral pills to clients who may be travelling out of station as reportedly done in Karnataka; setting up cues linked to cultural practices that act as reminders for clients to comply with taking pills, as reported in Madhya Pradesh; and stakeholders using personal examples / experiences with adoption of methods to build trust in method and encourage adoption by client [See Annexure 2 for learnings on these good practices].

Commodities

Commodities include the range of contraceptive methods available in the public health system, and their management process which is ensured through an instituted supply chain mechanism. The Family Planning Logistics Management Information System (FP-LMIS) which was rolled-out in 2017 aims to ensure uninterrupted supply of commodities and reduce stock-outs.

- Stakeholders reported keeping buffer stock of commodities to ensure availability. While it seems that availability of commodities is largely not an issue, few instances of stock-outs or excess stock were reported. Local mechanisms have been devised to manage stock (in case of challenges) and divert it to areas where there may be a shortage.

  "We divert this stock to other areas. So that it doesn't go to waste. We know the over stock materials in the portal at that time we distribute it in other sub centers so that it doesn't go waste. Automatically the portal will show where additional stocks are available." – District-level stakeholder, State 4

"We keep 10% additional stock and we have utilization rates plus 10% wastage and 10% buffer stock. If initial utilization rates are coming to an end, they are supposed to get new commodities." – Facility-level stakeholder, State 5

"I ordered some medicines on FPLMIS, but they did not get delivered. So, I just tell my supervisor or ANM 10-15 days in advance. We divide the stock received amongst ourselves." – Community-level stakeholder, State 1

- The efforts to scale-up FP-LMIS reflect in the responses and its use was widely and positively acknowledged, particularly in terms of increased visibility for the state and district level stakeholders.

"Before we couldn't know if a problem arose at the sub-centre level..but now we get an update in the portal about the community supply." – District-level stakeholder, State 4

"For FP, indenting takes places using FPLMIS only..This system is good, takes less time and we do not need to write anything down. Everything is recorded so no one can question the work, we can also see the status of stock easily." – Facility-level stakeholder, State 1

- However, gaps remain in the permeation of FP-LMIS with community and facility-level stakeholders continuing to use manual methods of indenting. The reported barriers to using FP-LMIS include connectivity issues, limited digital literacy of community level stakeholders and lack of adequate training.

"It's (stock is) manually maintained in a register by ANM." — Facility-level stakeholder, State 2

"For this FP indent now they had started FPLMIS, but that we still did not start; we indent through books only manually." – Facility-level stakeholder, State 5

"I have not heard about FPLMIS. I use manual methods for indenting." – Community-level stakeholder, State 1

"Stock is maintained by ANM staff. We do it in our register. We take the calculation in the month, how much was received, how much is there, and how much is still left." — Community-level stakeholder, State 2

"For stock management, we do not do data entry. They maintain a book for it... we are still not using FP-LMIS." – Community-level stakeholder, State 5

"FPLMIS is accessible on older phones but is not updated at all levels. Training is required at the ground level." – State-level stakeholder, State 1

"FPLMIS is a good system – we can see from here who took what material, how much is consumed, etc., but all workforces do not use it properly so that's a problem. ANMs are not doing, they are not using it properly at the block level." – District-level stakeholder, State 1

"We give training to community health workers for using FPLMIS. For instance, we had a wonderful 4-hour meeting about the software process, we also sent small videos on WhatsApp. But we see that they don't open the applications for 2-3 months. Interest is difficult to build." – District-level stakeholder, State 1

"ASHAs who are illiterate can't handle it (FP-LMIS) well. So ANM or data entry operator can upload in the FP-LMIS." – District-level stakeholder, State 3

- State and district-level stakeholders agreed that FP-LMIS has made monitoring and indenting of stock easier, however a need for more access to add users or make any changes in reporting details was highlighted.

  "In FPLMIS, Indian government has all the rights. We want these rights to be given to the state for correction because there are issues. If an ASHA has been replaced, a new ASHA has joined, or they are associated with a new PHC, then updates are done by the Indian government. If we send it from here, it will take time." – State-level stakeholder, State 3

  "District doesn't have the power get an ID created or get names updated. We send requests to the Centre. Even if it goes through the Government of India, the power should be given to the district that if something new comes we can get it done." – District-level stakeholder, State 3

- Commodities such as 'nayi pehel' kits (which are being supplied in MPV states) were reported to be fewer in number than the demand in the community. In Madhya Pradesh, community level stakeholders reported that only two kits are provided to them a few times a year whereas the number of married couples are much higher.

Information and Communication

The information and communication component includes dissemination activities that are conducted as well as the relevance and comprehensibility of information, education and communication (IEC) materials developed and used for FP clients.

- A range of IEC activities are conducted as part of the FP program, particularly in MPV states. This includes involving influencers (mothers-in-law) in conversations around family planning through 'saas-bahu sammelans' as well as involving men through 'pati sammelans'.

  "Saas, Bahu and Pati Sammelan is good for community interventions where we felicitate people who are ideal couples like a good husband who has supported his wife for delaying pregnancy. We honor them in front of entire village so that they feel good about it and it will give a good message as well." – State-level stakeholder, State x

  "We invite mothers-in-law with their daughters-in-law to an Anganwadi Centre or any other appropriate place in the village, and explain about family planning to both of them." – District-level stakeholder, State 3

  "Saas bahu sammelan has started last year. It is a play through which things are explained. The mother-in-law and daughter-in-law come to attend this program. I explain about family planning, to keep a gap of 2-3 years, once the second child is born then get the IUCD or Antara. We also have meetings with Sarpanch, Sachivs and other people. We address FP here." – Community-level stakeholder, State 1

  "We have done saas bahu sammelans twice – nukkad nataks in slums. We got instructions to conduct it on our block WhatsApp group. It was a success. Keeping good contact with mother-in-law helps." – Community-level stakeholder, State 1

- Some stakeholders reported that the activities undertaken are often in campaign mode i.e., centred around World Population Day (WPD) in July and observance of Vasectomy Fortnight in November whereas during the

rest of the year the focus on IEC remains limited.

"Street plays mostly happen during the fortnightly event and it all happens under the guidelines from the state. Even the teams are from the state. We just send a micro plan on where all it'll be beneficial to do them." – District-level stakeholder, State 2

"Family planning activities include World Population Day in July and even in November we celebrate." – District-level stakeholder, State 5

- IEC material in many areas was reported to be less comprehensible since it is not in the local vernacular language nor legible by audiences with limited reading abilities.

"Those people who are not literate they cannot understand written material. They can understand pictorial." – Facility-level stakeholder, State 2

"We need it in local language. IUCD charts are in English or some of them are in Hindi but not in xxx (local language)." – Facility-level stakeholder, State x

"These IEC materials are also primarily in Hindi, which makes it difficult for beneficiaries who can't understand or read the language to comprehend." – Community-level stakeholder, State 3

- There are varied practices for how IEC material is implemented across states. In Jharkhand and Madhya Pradesh, the materials were reported to be mostly provided by the state along with directives for implementation.

"Mainly we use hoardings and posters which we get from higher levels. Changes can be made only in Bhopal. Nayi pehel kit is also an IEC. We make pamphlets, wall writing in the block from our side, and we make flex for special campaigns. We use ink to write on the wall." – District-level stakeholder, State x

"Everything is already made (by the state). There should be a board of this size, a pamphlet of that size. We cannot make any modifications or make our own stand or basket." — District-level stakeholder, State x

- Innovative practices are adopted for spreading information and creating awareness. In Karnataka, this includes leveraging existing social networks within communities wherein information on FP services is seeded within key influencers who then spread the information among their relatives and neighbours. Additionally, technology is increasingly being leveraged for spreading information by using platforms such as WhatsApp and through developing engaging audio content for clients. [See Annexure 2 for learnings on these good practices].

Health Workforce

The health workforce component includes the availability of adequate human resources for implementing the FP program, and the training provided to the workforce for delivering services.

- Many areas reported a shortage of the workforce. While positions may be sanctioned, it appears that the appointments for the posts that do not take place. This impacts quality of FP service delivery as well as

motivation of the existing staff members who in some cases may be overloaded with work. The shortage of ANMs and surgeons is reported across states.

"My medical officer the entire year wouldn't have uttered the word vasectomy. I am sure about that. Even my ASHA or ANMs could just have spoken about it but nothing concrete has been taken forward because she doesn't have the time. Everybody is running around helter-skelter trouble shooting all with the schemes, day to day events happening. Until we get HR it is quite difficult to progress."– State-level stakeholder, State 5

"They don't recruit new people. Surgeons are very less in our district even not even a single surgeon is there for LTT, only 1-2 surgeons are there.." – District-level stakeholder, State 1

"Even today the ANM positions are vacant in x district. They have increased the sub centers, but you don't have ANMs there." – District-level stakeholder, State 1

"ANMs are less. If the sub centre is empty then the whole area will be empty. The need grows. There are a lot of centres which are empty. Some ANMs are retiring and there are no fresh recruitments or appointments." — District-level stakeholder, State 2

"Seat is sanctioned but posting isn't happening." – District-level stakeholder, State 2

"Shortage of ANMs impacts beneficiary counselling. Deliveries are around 120 here, they are not getting the time." — Facility-level stakeholder, State 2

"In some places because of vacancies, ASHAs have to travel for 80 to100 kms to visit. They have to go two to three times a month. There are two sub centres, where there are no ANMs." — Facility-level stakeholder, State 3

"If they will send me for training, I am refusing because I know this will be added to my existing workload, I will have to go throughout the district and if needed I will have to go throughout the state. So, along with my existing work, why shall I add this? That is why I said when manpower will be increased, everything will be solved." – Facility-level stakeholder, State 4

"There is only one Laparoscopic surgeon in the entire district who has to travel to all the blocks to do the operations..." – Facility-level stakeholder, State 4

"Surgeon shortage is impacted much more in family planning. Because family planning permanent methods get hampered. We hire an outside surgeon. We provide this service on Monday and Thursday for 30 beneficiaries but at that time we face problems due to shortages of surgeons." – Facility-level stakeholder, State 4

- Stakeholders in Madhya Pradesh also reported that data entry and monitoring processes add to significant workload and there is a need for specialized teams for this work. The presence of male health workers was reported to positively influence male engagement in FP in terms of the increased adoption of non-scalpel vasectomies (NSVs), as reported in Madhya Pradesh. Other areas where male workers are absent, the need for this cadre of the workforce was reported.

- Refresher trainings which are meant to be done on the basis of needs assessment, seem to be infrequent.

Additionally, the training plan for new appointees appears to be unclear.

"We do refresher training on the basis of demand and when we feel they are not able to grasp or if there are gaps. We ask the districts to do gap assessments—if you feel, they are not skillful and you need more training then we will arrange for the training program. For IUCD training, if any doctors feel that ANM are not able to do it independently, then we ask the trained doctors to support them." – State-level stakeholder, State 2

"There should be refreshment training regularly, say at an interval of every 4-6 months. ANM and Sahiya need refresher courses." – District-level stakeholder, State x

"The state level provides instructions like there should be four batches and per batch, you have to train 30 members. So, in a year whatever number of batches we receive, we train them and after that follow up is taken in sector meeting or block meetings." – District-level stakeholder, State 3

"We do an integrated training for PPIUCD for five days, which takes place at a facility where the maximum number of deliveries takes place. We send good trainers there and the base size is 10, consisting of medical officers, paramedical and medical staff. We also do a one-day training for Antara." – District-level stakeholder, State 3

"CHO is new here; she has not been given any training." – Facility-level stakeholder, State 2

"Suppose new trainee has come so she doesn't know the procedure and what work we do here, then we have to teach her everything." – Facility-level stakeholder, State 2

- A lack of NSV trained surgeons (due to the lack of demand from the community) was reported. Additionally, there was a reported need for training at the medical college level in order to ensure higher quality of services as well as for early sensitizing of doctors on FP.

"But it's training has not been given for so many years now. People are not interested in NSV now. I was also interested in its training; I have written about it, but I did not get any training." – District-level stakeholder, State 1

"..but in the case of NSV, none of the surgeons are trained so I feel that is the deficit.." – District-level stakeholder, State 5

"Medical colleges should take students on field visits and especially FP camps to help them increase motivation and dedication towards the cause. I have seen that students of gynecology of today think of FP as a little lower than deliveries and all, because of a lack of exposure. They deny seeing it as a responsibility of the doctors by saying it is the job of the FP department to control the population." – Facility-level stakeholder, State 1

"Where the quality of training really suffers is at the surgeon level. Surgeons are trained at the DH for sterilizations; however, the modules are not at par with the kind of training they can receive at medical schools...Quality of training is poor because in the surgical part, the surgeon is not able to confidently support his trainee. The trainer is unable to give outright exposure to the trainee; if these trainings are conducted in medical colleges, it'll be better because any complications can be dealt with confidence." – Facility-level stakeholder, State 3

- In Jharkhand and Odisha, district and facility stakeholders reported that the active involvement of private providers (surgeons) for sterilization services addresses the gap in the workforce from the public sector.

Infrastructure

Infrastructure includes the availability of adequate facilities for provision of FP services.

- Some areas reported a lack of adequate infrastructure within their existing facilities. This is in terms of equipment required for IUCD and sterilization procedures, as well as beds for clients of sterilization at the facilities.

  "When our surgeon team goes to the OT, they carry their own equipment. They think I will take my own equipment which is sterilized, because if the case fails, it might create a problem." – District-level stakeholder, State 3

  "We do the IUCD camp also and we have also put up a board there and we identify the beneficiary and bring them here because they get sterile equipment but if we go to sub centre levels you don't find this so if they bring them to PHC weekly one day, we have made the arrangements for that." – District-level stakeholder, State 5

  "There is not much equipment over here, and we have to sterilize it again and again. For the complete sterilization process, we need one hour for each piece of equipment but we cannot count the time as there are 30 patients to whom we have to do operations. We try to warm the equipment and do the best as possible." – Facility-level stakeholder, State 2

  "Then the problem comes with the intra OT care. For example, there are six tables in a room at the same time. Then we operate the first patient then we switch to the other patient, as we have the pressure to complete 30 patients in a day so we have to do it a little fast as we have to complete all the cases. Even the patients suffer because they are empty stomach so the person at the 30th number has to wait till the evening." – Facility-level stakeholder, State 2

- Overcrowded facilities unintentionally seem to create opportunity barriers in engaging male partners (as men are discouraged to enter wards).

  "We are supposed to involve spouse and partner for communication but the crowd in the OPD is too high, so we hardly allow male attenders inside." – Facility-level stakeholder, State 5

- As per directives from the centre, some facilities appear to have a dedicated corner for FP counselling ('FP corners') to provide confidentiality and privacy to clients whereas other facilities lack these spaces. The ones that lack these dedicated spaces, expressed a need for having them.

  "We have counselling corners available in all institutions. What is the space is not our concern; there should be a table and chair so that a person can do counselling. We need that much space, and so in many places there is no room, but there is a corner for privacy". – State-level stakeholder, State 5

  "It's missing from few places. Areas where we have buildings...they have separate rooms for counselling." – District-level stakeholder, State 2

"For family planning, we have provided rooms in the corner...This is available in 99% of our facilities." – District-level stakeholder, State 3

- Additionally, designated spaces for FP provide clear indications to clients on where in the facility they can access these services without them having to stand in queues for general health issues, thus easing the process of navigating facilities.

"We can give better services to the patient and quick services because if they sit here then we cannot tell if the patient has come for common cold and flu and if a separate counter is there for copper T..then she will go there directly and approach the concerned person and not needed to stand in the queue the whole day." – District-level stakeholder, State 5

Financing

The Financing component within the HS framework includes the processes that govern budget allocation and utilization for the FP program and the incentive structures that exist for providing / availing FP services.

- Budget allocation decisions were reported to be made majorly at the state-level with minimal role of the lower levels of the health system. In cases of additional budget requirement, approvals are taken, and flexi fund pools are utilized. The E-Vitt platform appears to be actively used in Madhya Pradesh for managing budget expenses.

"Mostly it is incentives, promotional activities, and campaigns and all that is allocated as per the number of facilities. The remaining is procurement which is also as per need. We ask them (districts) what is the need and leave certain margin and increase around 10 to 20% from previous year." – State-level stakeholder, State 2

"Allocation is done on the basis of services as per targets, based on the previous few years' experience. Most of the implementation is on activities so as per number of facilities we allocate the budget." – State-level stakeholder, State 5

"Budget is from the government directly. If we need more budget, we can demand from the NHM." – District-level stakeholder, State 1

"We get a budget for IEC, compensation, and fixed day approach. All these are separate. There is also a separate budget for incentives, prize distribution, and camps." – District-level stakeholder, State 2

"Sometimes we face problems in the requirement of major equipment / instruments. Last year the PIP budget was 50,000 rupees for laparoscopy but we required more equipment so we needed more budget at that time and so we faced a problem. Again, we approved it and we utilized other available fund." – District-level stakeholder, State 4

"The budget is relayed by CMHO. If we find the budget is low, we write an application to CMHO and they accordingly assign us a budget." – Facility-level stakeholder, State 1

"It is decided by the State. We are just informed that this much money is allotted for this program, you spend

it accordingly." – Facility-level stakeholder, State 2

"We do not have any role in it (budget planning). We just have one role; whenever we do the work—either in a month, in a pakhwada, or in a year—the numbers are checked in the review. On the basis of those numbers the budget of the next year is made." – Facility-level stakeholder, State 2

- Incentives are perceived to be important for increasing method uptake; and in compensating clients and community health workers for out-of-pocket costs incurred. Higher incentives for sterilization (for both clients and motivators) compared to other methods are believed to be contributing to higher uptake of this method compared to other methods.

"Beneficiaries have started to move on to LTTs more as there is more incentive for that. In rural areas, people have started to adopt the same." – Facility-level stakeholder, State 1

"Women are always ready for sterilization as compared to men. We tell them (about the method) after they have two children or they come to us themselves. They ask about how much money they would get and we tell them that they'll get Rs. 2000." – Facility-level stakeholder, State 3

"..there was a time when labour room residents were getting incentives..that month we had the highest number of PPIUCD as incentives play a role." – Facility-level stakeholder, State 5

"Beneficiary gets Rs 3,000 if they get sterilization immediately after delivery. If they get it done later, then they get Rs 2,000." – Community-level stakeholder, State 2

- Delays in incentive payout were reported to impact motivation of providers. In Karnataka, the ASHA Nidhi portal was reported to be actively used for filing incentive claims and for disbursement of funds to ASHAs.

"There are incentives for beneficiaries which is motivating but after covid transfer happens via UPI and it takes almost a month to happen and people get demotivated due to that. Incentives should be received immediately" – Community-level stakeholder, State 1

"Sahiya people probably did not get it (incentive) for 2 to 4 months. So they are a little tensed because the money is also less. If they receive it on time then they will give their 100%." – Community-level stakeholder, State x

- In MPV states, the increase in financial incentives is perceived as having led to the success of the MPV scheme. In Karnataka (non-MPV state), approval for providing incentives to the client for Antara (Injectable contraceptive) was sought.

"Every incentive for ASHA and ANM has increased by Rs. 100. Increased incentives improve beneficiary motivation. For instance, if a lady gets Rs. 3000, it will cover the cost of traveling, and healthy food. The same applies for ASHA since they have been using their own transport to travel in their field everyday." – District-level stakeholder, State x

"We pay incentives to service providers in case of Tubectomy and PPIUCD. We do not pay incentives for other services like Antara and interval IUCD, but they are saying we have to pay for Antara service providers. Earlier they had said to pay only to the beneficiary so we would pay to them. We do not have the budget; I

mean district doesn't plan a budget for family planning. We plan the budget and submit it. We give guidance to them and accordingly they utilize and whatever amount is spent they maintain a record of it and at district NHM unit is there so they extract the data." – District-level stakeholder, State x

"MPV in our time started in xx districts. But now it is working for the whole state...MPV works well because of increased financial incentives. From Rs. 1400 for LTT surgeries, the amount has increased to Rs. 2000. From Rs. 2200 for Postpartum sterilization, the amount has increased to Rs. 3000. Male sterilization, from Rs. 2000 has increased to Rs 3000." – District-level stakeholder, State x

- In one of the study states, there were reported to be significantly higher financial incentives for motivators who bring clients for sterilization after two children (compared to sterilization after more than two children). In Odisha, the state has reportedly introduced an additional incentive (of Rs. 250) for male MPWs for every five cases they bring for male sterilization. This is over and above the existing incentive for motivators.

  "Post sterilization, women get Rs 3,000. ASHAs get Rs 400 and if the sterilization was after two children, then they (ASHAs) get an extra Rs 1,000." – Facility-level stakeholder, State x

  "So, we get Rs 1,200 for two kids and if someone has 3 to 4 kids, then we get Rs 200 to motivate (for sterilization)." – Community-level stakeholder, State x

Discussion

The study aimed to understand the policy intent and strategic priorities that govern implementation of the FP program at the ground level, to identify the ongoing good practices that could be leveraged and the challenges that could be addressed to improve implementation. The overall goal was to provide evidence on how we can strengthen the provision of choice-based services. **This section discusses the key insights that can be drawn from the findings alongside the potential application of these insights for an improved FP program that focuses on choice.**

INTENT OF THE FP PROGRAM AMONG STAKEHOLDERS

- The findings uncovered from the research become critical in understanding the intent with which stakeholders operate in planning and implementing the FP program across states and health system levels. Given that there exist elements of the historic approach to FP with stakeholders in many cases believing that the intent of the FP program is to control the population of the country, it is imperative to address this belief which may otherwise contradict the provision of choice to clients. However, the findings also indicate that stakeholders believe in the importance of FP for improving women's health and overall well-being of the family. This provides the opportunity of making choice, overall health and well-being a salient intent and shifting focus away from FP as population control. **Aligning intent at all levels and among all stakeholders** – not just with the providers who are delivering services at the facility and community levels, but also with the state and district program officials – is **important as action (provision of services) is guided by intent.**

ALTERNATE METRICS OF SUCCESS WITHIN FP

- **The success of the FP program has largely been seen from the metrics of reduced TFR, increased contraceptive prevalence and decreased unmet need. Given that these demographic successes are being achieved in majority of the states in India, there is now a greater opportunity to focus on other metrics of success within FP. It is important for the system to place emphasis on viewing the success of FP through indicators of informed choice, delayed first pregnancies and spacing between pregnancies.**

MEASUREMENT OF INFORMED CHOICE

- Findings from this study indicate that the review meetings for FP primarily focus on the ELAs achieved which is seen at the higher levels of the health system (state and district) as a way to ensure maximum coverage of clients. However, at the facility and community levels, this also appears to cause additional pressure in achieving numbers which is what seems to be driving service delivery. In order to focus on a more choice-based service provision, it is **important for the system to include and institutionalize a program indicator that frequently assesses choice and builds on this as a metric of success within FP**. For what is measured, is what is assessed and prioritized.

- NFHS measures informed choice through the Method Information Index (MII) which consists of three questions: (i) were you informed about other methods, (ii) were you informed about possible side effects or problems you might have with the method used, and (iii) were you told what to do if you experience any side effects or problems (asked among those who were told about side-effects). Women who respond 'yes' to all three questions are considered to have received full information. The **data from these indicators in NHFS must be**

highlighted and discussed by stakeholders of the FP program to drive implementation that focuses on this key aspect within FP.

- Additionally, there is a need for reviewing how informed choice is measured in order to provide a comprehensive understanding of what is working well and where the gaps are in choice-based service provision. **Newer measures have been developed by researchers** that take into account the contraceptive autonomy of the individual and can be measured with users and non-users of contraceptives alike.[15] These must be r**eviewed for inclusion in the family planning program**.

PRACTICE OF GATHERING FEEDBACK ON SERVICES FROM FP CLIENTS

- The study highlights that in Madhya Pradesh and Odisha, district and block level officials sometimes conduct field visits to collect feedback from clients so that they are able to get insights into the quality of service provision. It is important that practices such as these are replicated and strengthened so that those who play a key role in program planning (specifically district officials), get first-hand visibility into the community's needs and their feedback on services being provided. **Direct inputs from clients on perceived quality of service provision is a way of providing feedback to the system on what is going well and where the challenges lie, thus, paving way for improved service provision that is focused on the community's needs and choices**. District and block level authorities can institutionalize inclusion of these feedback visits to the community in their planning for the year and the feedback received can become a part of the agenda for program review meetings.

SERVICE DELIVERY FOR ALL PEOPLE, WITH AN EQUAL EMPHASIS ON ALL METHODS

- The findings clearly indicate that the focus of FP service delivery begins upon the identification of newly married or 'eligible couples' and continues through the reproductive, maternal, newborn and child health continuum. While the study did not explore service delivery to specific groups, the responses suggest that at the ground level, implementation is focused mostly on married women and men, which inadvertently may leave out other groups that require contraceptive services (including adolescent girls and boys, as well as unmarried women and men). The current FP policies and strategies intend to provide services to all people, as seen in the FP2030 vision as well as in the integrated counselling manual on Reproductive Maternal Newborn Child Adolescent Health and Nutrition (RMNCAH+N)[9]; however, this does not appear to translate into action in the ground in terms of service delivery to other groups. This clearly indicates a need for **expanding focus of FP service delivery beyond 'eligible couples' to 'eligible clients'**, particularly to young people to promote and meet their contraceptive choices and needs.

- Additionally, despite the strategic focus at the national level on encouraging reversible method use, the focus on the ground level continues to be on female sterilization, particularly for women with two or more children. The data from NFHS-5[11] also shows the continued domination of female sterilization among the modern methods used by married women. This could be in part due to the programmatic focus (through the ELAs that are set out) as well as the intention among stakeholders to provide FP services as population control measures. This in turn may lead to service provision that is influenced by the system's choice rather than the client's choice. Therefore, there is also a need to **strengthen the focus on reversible methods at the ground level.**

POST-PARTUM OPPORTUNITIES TO FACILITATE CHOICE-BASED FP

- The study found that in Jharkhand, clients who deliver at institutions are offered post-partum IUCD (PPIUCD)

services. However, in case they do not choose the method, they are provided condoms and pills. Moreover, there are plans to package these contraceptives in attractive purses to encourage adoption of PPFP. This practice highlights how the postpartum period is leveraged for family planning. Moreover, **providing options from various categories of contraceptives – permanent, long-acting, and short-acting, along with counselling, is important in enabling clients to make an informed decision**.

- Adapting the 'nayi pehel' kit as a post-pregnancy care kit, that includes FP information and contraceptives, can be a way forward to strength PPFP acceptance.

BEHAVIOURAL INTERVENTIONS TARGETED AT PROVIDERS

- This study found indications of provider bias (among facility and community stakeholders) particularly emanating from the belief that couples should not have more than two children and that the population needs to be controlled. Provider bias in selectively offering methods is likely also resulting from the programmatic expectations (such as the numbers defined in the ELAs). While aligning the intent of FP policies with providers would be an important pathway to address this bias, there is also the **opportunity of introducing interventions that specifically target the behaviour of providers and enable them to effectively offer choice-based services**. These can include workshops that are based on the methodology of Value Clarifications and Attitude Transformation Training (VCAT)[16], which have the potential of enabling providers to deliver high-quality, non-judgemental services. Also, as the findings of this study indicate, groups on WhatsApp and Telegram are actively being used across levels of the health system, and therefore, these groups can be leveraged for delivering messaging interventions that are targeted at provider behaviours.

MEN ENGAGEMENT IN FAMILY PLANNING

- This research sheds light on the challenges faced by ASHAs and ANMs in navigating the social norms, with respondents expressing discomfort in talking to men. Moreover, past experiences with male engagement that yield no or low successes in terms of male contraceptive uptake (specifically NSV), lead to reduced efforts in engaging men. Given that the area of male engagement is gaining momentum as part of India's FP program, it is **important to build capacities of ASHAs and ANMs in effectively navigating the social norms that very often impede the FP services offered to men**. This would help the community stakeholders in developing comfort with engaging men and in organizing the various community activities that are being organized for increasing men's role upfront as responsible partners in FP.

- In Madhya Pradesh, one of the study districts reported a significant increase in male sterilizations conducted and attributed it to counselling of men by male multi-purpose workers (MPWs). This provides learnings into how **active participation of male MPWs in the workforce can lead to increased male engagement** in taking responsibilities for FP and reproductive health. The institutionalization of Health and Wellness Centres (HWCs) and under them the inclusion of male MPWs, is an opportunity to involve this cadre more actively in FP service provision.

- This study also found that while stakeholders at facilities are instructed to include men in FP counselling, the **infrastructure itself can pose as an opportunity barrier for engaging men**. To avoid overcrowding, the entry of men may be limited into the maternity wards which is where post-partum FP counselling may take place thus, missing the opportunity of including men in conversations on FP. Navigating this barrier by distributing FP IEC material directly to men or utilizing FP corners at facilities for counselling, could facilitate information provision to men.

DEDICATED 'FP CORNERS' AT FACILITIES

- Dedicated spaces for providing FP counselling ('FP corners') at facilities were reported to be utilized in some places and where not present, there was an expressed need for institutionalizing them. Given that t**hese spaces are important for providing confidentiality and privacy for clients** (which are both necessary elements for facilitating choice[1]), there is a need to ensure that such 'FP corners' are created and utilized at each and every facility.

MANAGEMENT OF COMMODITIES THROUGH FP-LMIS

- A relatively wider range of contraceptive commodities are now available across all states in India. This includes the two new methods of Injectable-IM and Centchroman that were introduced in the public health system in 2016. The responses from the study indicate that **commodities are being managed to ensure that availability of options for clients is not restricted**. Moreover, with the introduction of FP-LMIS, there appears to be a more effective supply mechanism for FP commodities. In Odisha, FP-LMIS is being actively used to track where there is additional stock so that it can be redistributed to other sub-centres where there may be limited stock. **Strengthening the use of FP-LMIS** in this way **to monitor and ensure balanced service delivery** can lead to ensuring both uninterrupted availability and reduce wastage.

- However, there are a few gaps in the use of FP-LMIS due to barriers such as limited digital literacy among ASHAs, poor internet connectivity in some areas and a bias towards using manual method of indenting - a method they have been accustomed to using. There is acknowledgement at the higher levels of the health system regarding the need for a greater effort to ensure utilization of FP-LMIS by all stakeholders. It is critical to action this and **build capacities among community level stakeholders (particularly ASHAs) to effectively manage FP commodities** such that there is uninterrupted choice of methods for clients.

FINANCIAL INCENTIVES AND SERVICE DELIVERY

- Incentives in the family planning program are seen by stakeholders across the system as being important for increasing method uptake and for reimbursing the out-of-pocket expenditures that are incurred in accessing the method. While incentives are perceived as important, it is **also critical to understand to what extent these affect the choices offered to clients**. In one of the study states, it was reported that there are higher incentives for motivators of sterilization of women with two children (compared to motivators of sterilization of women with more than two children). Findings from another qualitative study conducted17 in India indicates a tendency among ASHAs and nurses to promote methods which have more financial incentives linked with them. These findings highlights a need for the system to ensure that incentive structures do not interfere with the clients' choice as a balance needs to be maintained between compensating expenses and subtly encouraging a client to adopt a method that they might not otherwise choose[18].

- The system also appears to be placing an increased focus on spacing methods with non-MPV states such as Karnataka bringing in incentives for Antara, which are currently being provided in MPV states. Given that the value of incentives for Antara is being seen, this could be scaled up to other states as well.

WORKFORCE FOR PROVISION OF FP SERVICES

- Respondents of this study reported a shortfall in the workforce, specifically of surgeons and ANMs. While

the dearth of surgeons impacts availability of sterilization services in FP, the lack of ANMs can impact the opportunities of clients to have in-depth discussions around FP, an essential component of informed choice for clients. There is therefore a **need for the system to assess and address the workforce gaps** to minimize its effect on choice-based services.

- One of the ways of addressing the workforce gaps is through involving the private sector. The strategy of **Clinical Outreach Teams (COT)** has been operational wherein states / districts are encouraged to engage with private accredited providers and NGOs to provide services to the last mile through mobile teams while utilizing public health infrastructure. Given that this mechanism exists, it can be strengthened to not only address the availability and accessibility of sterilization services but also of other reversible methods including Injectable and IUCD services.

TRAINING MECHANISMS AND CURRICULUMS

- Findings indicate that refresher trainings, that are to be conducted based on a needs-assessment, may not be as frequently conducted as desired. This highlights the need for instituting a **system that regularly identifies the needs of training for providers** (facility and community stakeholders). Moreover, trainings should be conducted on-site to the extent possible to minimize impact on workforce and ensure convenience to them (and therefore motivation). In Rajasthan, **e-training modules** are being given to ANMs for them to access the training at their own pace. This is followed by in-person meetings to assess absorption of training. Practices such as this can increase efficiency of trainings and provide additional flexibility to stakeholders.

- **Trainings are also opportunities for reinforcing the importance of ensuring choice-based services**. While counselling is a part of training curriculums, there needs to be a greater emphasis in these on how facility and community stakeholders can guide clients to make their own choices and decisions.

ADAPTATIONS OF INFORMATION AND COMMUNICATION ACTIVITIES AND CONTENT

- The study findings reveal that while IEC material for FP may be intended to facilitate informed choice, it may not be easily comprehensible for all people specifically for those who are unable to read or have limited reading abilities. Moreover, stakeholders reported a need for having IEC material that is adapted in the local vernacular language of the people. The practice of the state / district sending material along with instructions for use / display at the facility and community levels, appears to be common. While this may ease the implementation process, it needs to also include **elements of flexibility for facility and community stakeholders to adapt the content such that it is easily understood by the community for example, by making the material in the local language**. There are also indications of an increase in the **use of audio clips**, as done in Rajasthan for providing clients with information on Injectable contraceptives. Developing audio-visual forms of IEC for methods can solve for challenges in accessing information among audiences who are unable to read or have limited reading abilities and can also lead to increased engagement with content.

- In Karnataka, there are other innovative practices being deployed to increase community awareness on FP. This includes leveraging influencers (or active members) in communities for spreading information on FP to other members in the community. **Leveraging social networks is a simple and effective way to spread information in the community** and is a practice that is potentially feasible to scale-up[19].

- The increasingly holistic focus of the FP program on community engagement provides an opportunity for the

FP program to **include aspects of client rights within ongoing activities**. Platforms such as home-delivery of contraceptives (HDC) visits, Immunization days, Village Health and Nutrition Days (VHNDs), 'saas bahu sammelans' etc. are all opportunities for communicating with clients on FP and for sensitizing the community on why and how women making their own decisions can contribute to better health and well-being. This would complement the government's increased focus on women empowerment, and provide women with the knowledge about exercising their rights and choices in FP. This in turn would also make the health system more responsive towards provision of choice-based services.

Conclusion

This study provides unique perspectives from the field on implementation of the FP program. The strength of the study lies in the documented evidence on the intent with which the FP program is implemented in states, the good practices that have potential for replication in other areas as well as some of the challenges that impede choice-based service provision. Interventions and approaches that are based on the insights from this research study can contribute towards strengthening the provision of choice-based FP services in India and making choice a reality for all people.

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Annexures

ANNEXURE 1: HEALTH SYSTEM FRAMEWORK VARIABLES

HS COMPONENTS	VARIABLES EXPLORED
Institutional mechanisms	Planning, monitoring, reviewing and reporting processes
Service delivery	Strategies guiding availability and accessibility of services; factors influencing service delivery (provider beliefs and experiences, and community norms)
Commodities	Availability and management processes of commodities, including method of indenting and stock keeping
Information and communication	Activities conducted for spreading information on FP and for communicating with clients; relevance and comprehensibility of IEC content
Health workforce	HR availability for FP; their skill sets and training mechanisms
Infrastructure	Facilities for provision of FP services
Financing	Budgeting processes and incentive structures for FP

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ANNEXURE 2: LEARNINGS FROM GOOD PRACTICES REPORTED ACROSS STATES WITH POTENTIAL FOR REPLICATION IN OTHER AREAS

The good practices listed below have been documented through the valuable insights provided by the study participants during the qualitative interviews. The study acknowledges that there may be numerous local practices beyond its scope to capture, and some of the identified practices may be common across states.

STATE	PRACTICES / INNOVATIONS	LEARNINGS
Jharkhand	Post-partum family planning – providing condoms to clients at facilities in attractive bags. **"When there is delivery and they are not taking PPIUCD, we give them contraceptives (condoms and pills)...sir suggested that we give this to them in a beautiful jari purse so that they also feel that they got something when they went to the hospital...This will have contraceptives and some messaging around family planning."**	Packaging contraceptives in an attractive way adds value to the commodities and can influence intention to use the methods; the 'nayi pehel' kits provided to newly married couples can be adapted for provision at facilities to clients as part of post-partum family planning.
Jharkhand	Involving private sector surgeons to increase availability and accessibility of sterilization services. **"Laparoscopic is not from the Government side. We have a concept of outreach in MPV districts, so we hire private laparoscopic surgeons who perform the procedure in our custody and get paid for each case."**	Given that there already exists an engagement with the private sector for sterilization services, this can be strengthened to also increase availability and accessibility of reversible methods such as IUCDs and Injectable contraceptives.
Karnataka	Ensuring continued adoption of contraceptives among clients who may be travelling by giving extra stock of oral pills. **"We are giving these tablets (contraceptive pills) but in between suppose if they are going out of station, we have to include next month's tablets and give them to her. We adjust and give extra pills to those who are going out of the station. We give oral pills and Chhaya pills but as per protocol, we have to give one packet to one beneficiary."**	Providing extra stock of contraceptives to clients was set out as a practice under the guidelines for FP service provision during and post-COVID; taking cue from this and driving the guideline down to the implementation level is important as providing extra stock particularly to those who are likely to travel or migrate can reduce chances of drop-outs.
Karnataka	Reinforcing availability of all contraceptive methods in IEC material. **"In everything (IEC) we say that these are all the methods available with the govt. It is done in such a way that every poster will have one line that speaks about all the methods."**	While there may be IEC material that is specific to a method, it is important to keep reinforcing the availability of a basket of contraceptive methods that the client can choose from.

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STATE	PRACTICES / INNOVATIONS	LEARNINGS
Karnataka	Spreading information on FP methods and free service availability through word-of-mouth. **"We select one active person from each household... so, out of 10 families, whoever is active and attends meetings regularly, we select them and we talk to them about family planning methods and tell them to guide others and their relatives and neighbours; we tell them to make use of these facilities and that the government is providing them for free.."**	Leveraging influencers (active members) in communities and spreading information on FP services through them is a way of generating demand for services; leveraging social networks is a simple and effective way to create awareness in the community and is a practice that is potentially feasible to scale-up.
Madhya Pradesh	Leveraging male multi-purpose workers (MPWs) to encourage uptake of male sterilization services. **"Male MPWs go to the field and their primary role is to counsel males for NSVs. X district has had a good number of NSVs in the past with as many as 91 NSVs in a year done at xx Hospital."**	Active engagement by male MPWs can lead to increased male engagement and higher motivation among men to take responsibilities for FP and reproductive health; the institutionalization of Health and Wellness Centres (HWCs) and under them the inclusion of male MPWs, is an opportunity to involve this cadre in FP service provision.
Madhya Pradesh	Dispelling myths surrounding male sterilization by providing personal examples. **"If I talk about myself, I have gone through the process of NSV to give example to the other ladies that it is useful. And when I tell them that I did it for myself then it will be more effective for them as well."** **"One of my colleague's husbands has done NSV, and it has become like an example. Whenever we go on a visit, we give her husband's example to explain, there is nothing like that - questions of sexual ability get addressed."**	Using personal stories, examples and experiences can be effective in dispelling myths surrounding contraceptive methods, particularly for male sterilization as this is reported to be surrounded by many misconceptions. Reinforcing the use of this strategy during trainings can help community health workers navigate the challenges they face in discussing male sterilization with clients.
Madhya Pradesh	Linking cultural practices with taking oral pills to act as reminders for clients. **"When I give ANMs training I tell them that women in the village have their fasts on Monday and can take Chhaya after eating something the next day. This way they can remember when to take the pill, since it must be taken weekly."**	Using cues that are part of the clients' regular routine and linking them with taking the pill, can act as reminders; such local cultural practices / rituals can be identified and adapted as cues by community stakeholders when providing instructions to clients on complying with the regimen of taking oral pills or coming for the Injectable-IM doses etc.

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ANNEXURE 2: LEARNINGS FROM GOOD PRACTICES REPORTED ACROSS STATES WITH POTENTIAL FOR REPLICATION IN OTHER AREAS

STATE	PRACTICES / INNOVATIONS	LEARNINGS
Madhya Pradesh	Monitoring through conducting interviews with FP clients for taking feedback on service provision. **"Once or twice a year, the BMO on block level interviews 10 ladies (FP clients)...on that basis we will come to know actually how much work we are doing (in FP) and what is it's effect. For instance, Nayi pehel kit has started, we give FP material and pamphlets to newlywed couples. We purchase vanity boxes, put the bangles, bindi, make-up items, hankey, other small items with a pack of condoms, etc. Beneficiaries received it in a positive manner, but we are not getting any reports on it. We get information on no. of kits distributed but we were not getting feedback from couples as we have not done a survey on it."**	Direct inputs from clients on perceived quality of service provision is a way of providing feedback to the system on what is going well and where the challenges lie, thus, paving way for improved service provision; block level authorities can include these annual / biannual feedback visits to the community in their planning for the year and the feedback received can become a part of the agenda for program review meetings.
Odisha	Monitoring through back-check processes. **"(We monitor) randomly; there is no other way out to monitor. When clients come to us, we will cross-check with them, we will do cross questioning or whenever we are going there, we will check physically. False figures cannot be put in because the client phone number is recorded. So, when we go on outside visits, we randomly go and ask."**	Direct inputs from clients on perceived quality of service provision is a way of providing feedback to the system on what is going well and where the challenges lie, thus, paving way for improved service provision; these back-check processes can be institutionalized and regularized.
Odisha	Redistribution of stock through monitoring using FP-LMIS. **"We divert this stock to other areas. So that it doesn't go to waste. We know the over stock materials in the portal at that time we distribute it in other sub centers so that it doesn't go waste. Automatically the portal will show where additional stocks are available."**	Using FP-LMIS in tracking where there is additional stock and redistributing it to other sub-centres is a way of ensuring both uninterrupted availability and reduce wastage of commodities; strengthening the use of these tracking features in FP-LMIS across each level of the health system can lead to more effective management of commodities.
Rajasthan	Leveraging technology for training ANMs. **"We have an E-module in the training in which all ANMs are given pen drives they have to listen to it. After this, they're called for a meeting where we orient them and take their feedback. ANMs are field functionaries and we can't tamper with them for five days; so we take advantage of these methods."**	Developing e-training modules followed by in-person meetings to assess absorption of training can increase efficiency of trainings and provide flexibility to stakeholders in terms of accessing training material at their own pace.

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ANNEXURE 2: LEARNINGS FROM GOOD PRACTICES REPORTED ACROSS STATES WITH POTENTIAL FOR REPLICATION IN OTHER AREAS

STATE	PRACTICES / INNOVATIONS	LEARNINGS
Rajasthan	Leveraging technology to provide information to clients on Injectable contraceptives. "Technology plays an important role. We have sent pre-recorded audio of Antara to facilities till the sub-centre level. We help her (the client) listen to the recording, so that she understands the complications. She can listen to it and carry it forward so that shows active involvement. Then there is no issue in convincing."	Developing audio-visual forms of IEC for methods can solve for challenges among audiences with limited reading abilities in accessing information and can also lead to increased engagement with content.

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