PROGRESS IN FAMILY PLANNING

RESEARCH BRIEF

Contraceptives to Doorsteps in India: Rapid Evaluation Provides Recommendations for National Scale-up

Objective

To evaluate an initiative by the government of India in which community health workers, who are called accredited social health activists (ASHAs), deliver minimally priced condoms, oral contraceptive pills, and emergency contraceptive pills to households within a modified supply chain. Under the initiative, contraceptive supplies are provided directly from the manufacturer to district-level depots to avoid delays and stock-outs.

Methods

At the request of the Ministry of Health and Family Welfare, FHI 360 facilitated a rapid evaluation of the initiative in six of the 17 states where it was being piloted. A mixed-method approach was used for this evaluation. Semi-structured surveys were conducted with 92 ASHAs and 458 female beneficiaries to explore operational issues as well as barriers and facilitators of implementation. In-depth interviews were held with 17 auxiliary nurse midwives and 21 managers who were supervising implementation of the initiative at different administrative levels. Additional data were collected from four reporting formats that were introduced to track the volume of contraceptive sales under the initiative.

Findings

- The new initiative was acceptable to the community and to ASHAs, who were able to keep the client's small fee to provide them an incentive for promoting family planning. Among the female beneficiaries, 75% were completely satisfied with the initiative. Also, 86% of ASHAs believed the initiative would be successful over the long term.
- Before the initiative, the government was providing a free supply of contraceptives. When the initiative began, free commodities were supposed to have been discontinued at primary health centers and sub-centers, but 26% of ASHAs reported still having free supplies. This created confusion about the initiative and some resistance within the community to pay for supplies.
- Similar packaging for the initiative's supply and the free supply reinforced the community's confusion about the initiative and reluctance to pay under the new approach.
- Although communication materials about the initiative were developed, exposure to the materials was minimal among all participants.
- Record keeping and monitoring were inconsistent at all levels of the supply chain. Although most ASHAs said they were maintaining a register and were tracking the stocks they received and sold, it was unclear whether they were using the formats introduced under the initiative or were using their previous style of registers.
- Because of challenges in procurement and management of the supply chain, ASHAs could not always meet the contraceptive needs of eligible couples in the community.
- Although most ASHAs and managers were oriented to the initiative, the orientation was not always sufficient. In many cases, it focused more on how to counsel clients about specific methods than on how to implement the initiative.

Conclusion

The pilot initiative was highly acceptable to both ASHAs and female beneficiaries, which suggests it is a promising strategy for addressing unmet family planning need and increasing the uptake of birth-spacing methods. However, the evaluation identified several operational challenges for the government of India to address if it scales up the initiative to additional states and districts. The packaging of the initiative's supply of contraceptives could be modified to include the price and to differentiate it from the free supply. Social marketing should be broadened to improve community awareness and acceptance of the new supply charges. Reporting formats used for the new initiative could be simplified and streamlined, and guidelines on stock requisition and removal of free-supply stocks should be developed.

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Background

Many programs in developing countries are exploring alternative ways to deliver family planning services, such as offering them in the community as well as in clinic-based settings. Studies from India, Bangladesh, and several African countries have shown that community health workers (CHWs) can safely and effectively provide a range of contraceptive methods, including injectables, even when the CHWs have low or no literacy.[1-5] CHWs have significantly increased contraceptive use in various populations.[6-7] This has been particularly true for women in underserved communities, whose ability to obtain contraceptive methods can be constrained both geographically and socially.[8]

The government of India's family planning program has adopted this strategy of using CHWs known in India as accredited social health activists (ASHAs). ASHAs are the initial point of contact for all health-related issues at the community level, responsible for safe motherhood initiatives, immunizations, deliveries, and referrals and escorts for women needing health, sanitation, and hygiene services in India.

Under the new initiative, which is being piloted in 233 districts in 17 states, an ASHA's distribution of contraceptives is one step in a modified supply chain.

ASHAs also serve as depot holders for oral rehydration solution and provide non-clinical contraceptive methods like condoms, oral contraceptive pills (OCPs), and emergency contraceptive pills (ECPs) as part of free-supply and social-marketing schemes. Each ASHA is responsible for a catchment population of 1,000 in a village. She is expected to counsel all eligible couples in her area on available contraceptive methods, facilitate screening of women interested in using OCPs, and refer women interested in intrauterine contraceptive devices (IUCDs) to the nearest health facility.

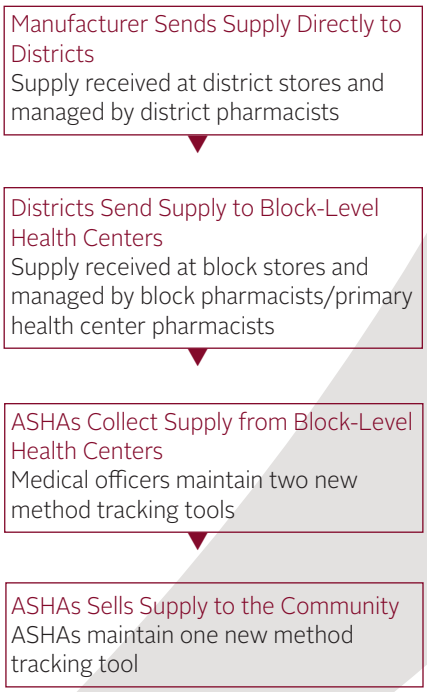
Under this CHW strategy, however, access to contraceptives has been limited because of inconsistencies in the availability of contraceptive supplies. The government views poor supply of commodities as a contributing factor to low rates of use for birth-spacing methods in India, which are 5% for condoms, 3% for OCPs, 2% for IUCDs, and less than 1% for injectables.[9]

A New Initiative

To improve access to contraceptives at the community level, the government of India began an initiative in 2011 for ASHAs to deliver contraceptives directly to households and to receive small incentives for their effort. Under the new initiative, which is being piloted in 233 districts in 17 states, an ASHA's distribution of contraceptives is one step in a modified supply chain designed to avoid stock-outs and delays of contraceptive commodities.

Traditionally, commodities from the national manufacturer are sent to state-level depots and the supplies are then distributed to district-level depots. However, the new initiative bypasses the state-to-district distribution step, where many delays take place. Condoms, OCPs, and ECPs are supplied directly from the national manufacturer to district-level depots, where they are then distributed at the block level (see Figure 1).

Figure 1. Modified Supply Chain under the New Initiative



Each ASHA is responsible for traveling to the block or primary health center (PHC) that serves her community to obtain her supply of contraceptives. The ASHA then provides the contraceptives to couples in her community, charging 1 rupee (U.S. $0.02) for a pack of three condoms, 1 rupee for a cycle of OCPs, and 2 rupees for one pack of ECPs. The charges are incentives for the ASHAs to promote family planning and to maintain a constant supply of methods in their communities. In areas where the new initiative was introduced, the government was advised to discontinue its supply of free contraceptives at PHCs and sub-centers (SCs).

New reporting formats were issued to standardize record-keeping and stock-reporting; communications materials were developed for display in the community; and the packaging for condoms, OCPs, and ECPs was updated to display the new prices; and a corresponding stamp was developed to help brand the initiative. The Ministry of Health and Family Welfare (MOHFW) also distributed a letter that included guidelines for introducing the initiative, and officials at the district level were responsible for orienting ASHAs and others involved in implementing the initiative.

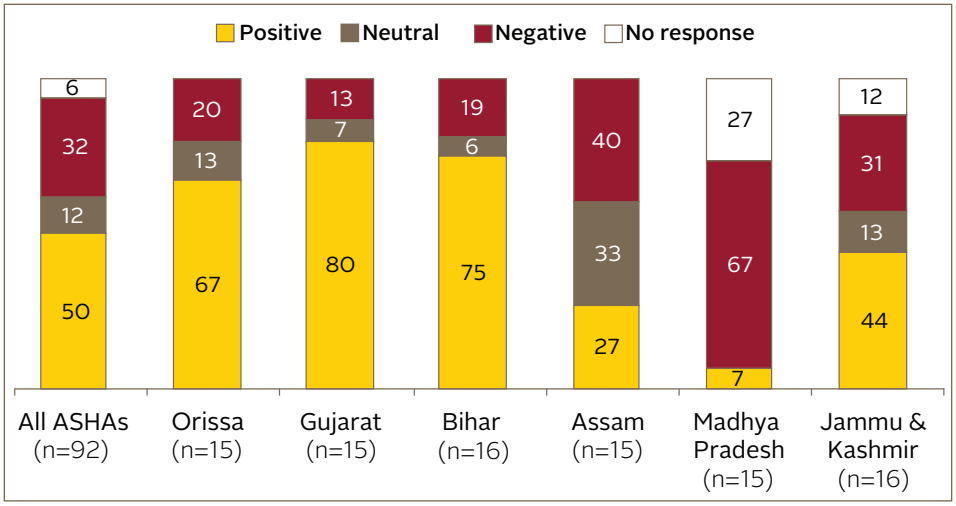
Study Design and Methods

At the request of the Family Planning Division of the MOHFW, FHI 360 through its PROGRESS project facilitated a rapid evaluation of the initiative to help the government strengthen the initiative and to inform national scale-up. The research company Ipsos was contracted to collect the data in May 2012 under the supervision and direction of FHI 360 and the MOHFW.

The evaluation was conducted in six of the 17 states (one district per state) where the initiative was being piloted: Assam, Bihar, Madhya Pradesh, Gujarat, Orissa, and Jammu/Kashmir. One PHC from each district was included in the study. All six PHCs had been running the initiative for at least three months and had a minimum of 25 ASHAs per PHC.

Semi-structured surveys were conducted with 92 ASHAs and with 458 female beneficiaries in the catchment area of the ASHAs. In-depth interviews were held with 17 auxiliary nurse midwives (ANMs) and 21 managers who were supervising the implementation of the initiative. The questions focused on operational issues, barriers, knowledge and attitudes about the initiative, experiences under the initiative, and the commodity supply chain. Data were also collected from the new reporting formats to track the volume of contraceptive sales.

Figure 2: Community Response to the Introduction of Charges for Methods, as Reported by ASHAs*



Acceptability

The female beneficiaries who were surveyed had a mean of 2.0 living children, and most were interested in avoiding or delaying the next pregnancy. The beneficiaries had been using their methods for a mean of 14.6 months, indicating that many of them had begun using their methods of contraception before the initiative began. About a quarter, however, had potentially initiated their method under the initiative.

Overall, 75% of the female beneficiaries were completely satisfied with the new initiative, and an additional 20% were somewhat satisfied. When the need arose for resupply, 53% reported that the ASHA remembered that the couple needed to resupply, and 43% said she or her husband contacted the ASHA to request additional supplies. Only 6% had any difficultly contacting the ASHA.

About half (52%) of the ASHAs thought that the initiative had increased their number of contraceptive acceptors, 20% thought it had decreased their number of acceptors, and 26% felt it had not affected their client numbers. The majority of ASHAs (86%) believed that the initiative would be successful in the long-term because the methods cost less than those for sale in shops and because couples did not have to travel to shops to get their methods anymore.

New Charges

Although 50% of ASHAs reported that they received a positive response from the community when they started charging for methods, the responses varied greatly across the six study sites (Figure 2). Surveys and interviews also showed some community resistance to the new charges, making implementation of the initiative difficult when some clients refused to pay.

The supply of free condoms, OCPs, and ECPs should have been discontinued to encourage uptake and resupply of methods with the ASHAs. However, 26% of ASHAs reported still having some free-supply stocks, and about 25% said free-supply methods were still being provided at the PHCs and SCs in their areas. Because of some community members' refusal to pay, ASHAs in many states were giving the initiative-based supplies for free. Among beneficiaries, 50% of condom users, 25% of OCP users, and 52% of ECP users reported not paying for their last method.

Communication Materials

The assessment found that many of the communication materials developed for the initiative were not present in the six study communities. Among the beneficiaries, only 20% had seen posters or banners, 27% had seen wall writings, 5% had received leaflets or other printed materials, and 8% were familiar with the initiative's tag line. Also, 62% of the ASHAs said they did not receive any materials to help them inform their communities.

Regarding the new packaging of commodities, 60% of the ASHAs noted that the packaging had the price marked on it, and 23% described the tag-line stamp. Yet, 16% said there was no difference between the packaging for the initiative's supply and the free supply. Another 14% either did not know the difference or reported differences that were not correct. Several of the managers complained about the revised packaging. They felt the price did not stand out enough and that, aside from the stamp, the design and appearance of the packaging were the same as the packaging for the free supply, which led to confusion, further contributing to the community's resistance to pay ASHAs.

Orientation and Reporting

Although most ASHAs and managers reported being oriented, many recalled that it focused more on counseling on methods than on the elements of the initiative. Fewer than 25% reported receiving training on essential components such as stock maintenance and how to implement the initiative's incentives. Managers at the district and block levels reported that their orientation was primarily through reading and discussing the government guidelines during routine management meetings. ANMs were not part of the orientation to the initiative in some states.

During the assessment, problems were seen with each reporting format. Among the ASHAs interviewed, 64% said they were maintaining a register of whom they sell to, and 82% said were tracking stocks received and sold. However, it was unclear whether the ASHAs were using the formats introduced under the initiative or were using their previous style of registers.

Nearly 25% of the ASHAs admitted that they do not maintain any stock records at all. Managers attributed these problems to low levels of literacy among ASHAs and to an overall lack of understanding on how to complete and use the forms. Because ASHAs were not necessarily tracking their sales in the local reporting format, errors and missing data remained when the data were transferred to district-level and state-level formats. Also, some data were being collected verbally, with recall contributing to errors. Confusion on time frames and on whether free-supply stocks should be accounted for in the formats was also reported. Collectively, the problems at all levels prevented any meaningful conclusions from being made on volume of contraceptive sales.

Supply Chain

Many officials at the state level were confused about the changes in the supply chain. At the district level, most managers reported that only one shipment of commodities had been received from the

manufacturer. Many blocks complained that they were being given stocks based on the number of ASHAs and eligible couples in their areas but that these allotted stocks were not enough to meet the community's demand. Moreover, district officials were given no guidance on how to procure additional shipments of stock, and state officials mirrored their confusion.

Many ASHAs were unsure how many condoms, OCPs, and ECPs they should have on hand. On the day of their interviews, at least one-fifth of ASHAs did not have specific methods with them. Most of the ASHAs complained about not being supplied on time with enough methods, and ANMs echoed this complaint. Some of this may be attributable to stock-outs at the block level. Similarly, 16% of beneficiaries reported that in the past three months, their ASHA did not have the method they wanted:

Recommendations for National Scale-Up

Nearly nine out of 10 ASHAs thought that the initiative would be successful in the long term, and more than seven out of 10 female beneficiaries were completely satisfied with the initiative. While these are promising results, the evaluation identified operational challenges for the MOHFW to address if they scale up the initiative to other areas and made the following recommendations to inform the next steps.

- The existence of the free supply in addition to the initiative's supply is creating confusion at all levels. By using the new initiative supply as the single supply stream, communities will likely become accustomed to purchasing family planning commodities at the nominal price.
- The initiative's supply could be clearly differentiated from the free supply by modifying its packaging to include a highly visible image of a 1-rupee coin. This could reduce confusion and resistance to paying for the methods, reduce the number of ASHAs who give the initiative-based supply for free, and improve community awareness and acceptance of the initiative.
- The confusion created at the community level by the existing free-supply stock was a major barrier to service delivery in the pilot initiative. Modified guidelines should include directions on withdrawing and handling the free supply at PHCs and SCs.
- Communication efforts should be broadened to improve community awareness and acceptance of the new charges. New packaging for the initiative's supply of contraceptives should be visible on all communication materials. ANMs, medical officers, and other officials could also visit areas of high resistance to endorse the initiative.
- Bypassing the state government in the supply chain does not seem to be working well, as it leads to confusion when the supply is used up at the district level. Involving the state government in disbursing and maintaining stock records will be essential for increasing ownership and accountability at the state level.
- The new reporting formats need to be simplified and streamlined. A recording format for the ANMs should be included to better monitor the initiative, and they should be involved in the operation. Also, the reports on the initiative's supply stocks should be incorporated into the health management information system.
- Orientation on the initiative should be strengthened for all implementers so that they fully understand the steps needed to requisition methods, complete formats correctly, manage the free supply, market the initiative, and supervise lower-level staff.

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This work was made possible by the generous support of the American people through the U.S. Agency for International Development (USAID). The contents are the responsibility of FHI 360 and do not necessarily reflect the views of USAID or the United States Government. Financial assistance was provided by USAID under the terms of Cooperative Agreement GPO-A-00-08-00001-00, the Program Research for Strengthening Services (PROGRESS) Program. FHI 360 acknowledges the support of the Ministry of Health and Family Welfare, Family Planning Division, Government of India.

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