



**An Evaluation of the
Government of India's Initiative
on Contraceptives at the Doorstep
by Accredited Social Health Activists (ASHAs)**



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**An Evaluation of the Government of India's
Initiative on Contraceptives at the Doorstep by
Accredited Social Health Activists (ASHAs)**

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Acronyms

ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
CDMO	Chief district medical officer
CHC	Community health centre
CHW	Community health worker
DNO	District nodal officer
ECP	Emergency contraceptive pill
GOI	Government of India
HLL	Hindustan Latex Limited
IDI	In-depth interviews
IFPS	Innovations in Family Planning Services
ITAP	IFPS Technical Assistance Project
IUCD	Intrauterine contraceptive device
MCHN	Mother and child health and nutrition
MOHFW	Ministry of Health and Family Welfare
MO	Medical officer
OCP	Oral contraceptive pill
PHC	Primary health centre
SC	Sub-centre
SNO	State nodal officer
VHN	Village health and nutrition

EXECUTIVE SUMMARY

The Government of India piloted a new initiative whereby locally recruited accredited social health activists (ASHAs) deliver contraceptive methods directly to the households of their communities (“Contraceptives at the Doorstep”) within a modified supply chain designed to avoid delays in supply. This report details a rapid process evaluation of the new initiative, undertaken by FHI 360 as requested by the Family Planning Division of the Ministry of Health and Family Welfare, with the goal of providing recommendations for its scale-up at the national level.

Objectives

The rapid process evaluation had the following objectives:

- Identify **operational issues** associated with the initiative, including service delivery mechanisms, program monitoring and record keeping at various levels.
- Identify **client-reported perspectives** on access to and utilization of the initiative, particularly barriers.
- Identify **ASHA-reported perspectives** on implementing the initiative and providing family planning in the community, including barriers and facilitating factors.

These objectives were achieved using **quantitative and qualitative data collection** methods across **six geographically representative states**. These six states were selected from the 17 states where the new initiative had been piloted. A cross-sectional survey of **ASHAs (n=92)** who implemented the initiative and of **female beneficiaries (n=458)** and non-beneficiaries who lived in the communities the ASHAs served was undertaken using semi-structured interviews. In-depth interviews were held with **key implementers (n=38)** working at different administrative levels within the initiative. Data were also collected from reporting formats introduced for the initiative to assess the volume of contraceptive method sales under the initiative.

Salient Findings

The findings of the evaluation suggested that the **scheme was acceptable to the community and to ASHAs. Service managers** at various levels were positive about the prospect that the **scheme would be successful over the long term.**

1. Overall, **75 percent of all female beneficiaries interviewed were completely satisfied** with the new scheme, and an additional 20 percent were satisfied to some extent.
2. The **vast majority (86 percent) of the ASHAs** believed that the scheme, including the payments, will be **successful over the long term.**
3. More than **half of the ASHAs (52 percent)** felt that their client load increased because of the pilot scheme.
4. Approximately **50 percent of ASHAs interviewed indicated a positive response** from their communities.
5. Among the ASHAs surveyed, **85 percent said they participated in an orientation** before the scheme started in their catchment areas.

However, there are operational issues that need to be addressed:

6. Because of challenges in **procurement and management of the contraceptive supply chain**, ASHAs could not always meet the contraceptive needs of eligible couples in the community.
7. The **continued presence of left-over free supplies of contraceptives at the community** level created issues related to payment to the ASHAs for scheme supplies. There was also confusion about the scheme among community members.
8. **Similarity between the packaging of free supplies** of family planning products and the packaging of the scheme-based product further reinforced confusion about the scheme and reluctance of clients to pay.
9. **Record keeping and monitoring were often inconsistent** and sometimes non-existent throughout all levels of the supply chain.
10. Exposure of beneficiaries to the scheme's **communication strategies was almost non-existent.**

Recommendations

1. **Manage one stream of supply to eliminate the need for two supply chains** (a free one and a scheme-based one) to decrease confusion, reduce reporting burden and get communities accustomed to purchasing the scheme supply.
2. **Modify the packaging of the scheme-based** products for ease of differentiation from the free supply of family planning products.
3. **Broaden marketing and communication efforts** regarding the scheme to improve community awareness and promote acceptance of new charges.
4. **Develop guidelines on stock requisition** at all levels in the supply chain.
5. **Specify guidelines on withdrawing the free supply** from ASHAs, sub-centres, and primary health centres.
6. **Modify and streamline the reporting formats to incorporate requisition of family planning products.** The reporting of the scheme stock should be incorporated into the health management information system.
7. **Strengthen the role of auxiliary nurse midwives** and then involve them in reporting and supportive supervision.
8. **Improve orientation** on the scheme for implementers at all levels.

VOICES FROM THE FIELD

Female Beneficiaries

“The scheme of making contraception available at home shouldn’t be stopped because it saves money.”

“Government has withdrawn the free supply of these things. I think the things which we buy by paying money have good quality.”

“The new scheme is good as price is not higher. It is cheaper than the market price.”

ASHAs

“There should not be two ways to promote the scheme...either it be made totally free or totally paid...people get confused and then they don’t trust us.”

“Its price is so less than the market price and we were providing the methods near the people at their own village so this scheme will work for a long time.”

“People aren’t accepting this easily. At first they are not interested to pay money so I have to give them free of cost.”

“Free supply scheme has stopped...still we have some old stocks with us...they have not taken it back from us but we are not providing these to people. We’ll return it back to ANM madam.”

“People don’t buy from us...they say you used to sell it for free but now charge...have got greedy...you keep money.”

“This scheme can be improved if medical officer, ANMs will visit to villages and through meetings make women aware of this family planning scheme.”

“If senior officers also come for the meeting, or sometimes go to households with us, people would listen to them.”

“If the old free supply stock will not be withdrawn then this new scheme will not work further. People will demand for that free supply.”

“In the orientation we were told about everything, immunization, delivery of pregnant women, family planning techniques.”

“ASHA should get family planning medicines on right time so that we can give it to the people on time.”

Managers at Various Levels

“Packaging should be given more importance. Now people say that first bring something else, then ask us to pay.”

- Manager (Block Level)

“Community people think that what (family planning products) was available for free earlier they have to pay for it now and that too for government supply.”

- Manager (ASHA Supervisor)

“People say (community) free supply is available in different programmes [like] HIV/AIDs. It is not available in this scheme.”

- Manager (District Level)

“We have provided the free supply along with the scheme supply till we had stocks. Free supply is provided to people who are not taking scheme supply.”

– Manager (District Level)

We have given all the free supply to ASHAs for community distribution.”

- Manager (ASHA Supervisor)

“I stress on packaging, packaging should be better and colorful.”

- Manager (Block Level)

“We fail to supply as much contraceptives to replace the ASHA’s stock whenever it gets over.”

-Manager

HIGHLIGHTS

LEVEL	SUPPLY CHAIN	REPORTING AND MONITORING	ORIENTATION	MARKETING OF THE SCHEME
DISTRICT	<ul style="list-style-type: none"> One-time receipt of scheme supply from manufacturer No information or guidelines on scheme resupply and how to ask for replenishment Unclear on managing free supply 	<ul style="list-style-type: none"> Only collating reports received from blocks and submitting them to states Lack of clarity on components of monitoring No clarity on use of reports and providing feedback/follow-up 	<ul style="list-style-type: none"> Orientation was a part of regular meetings for all levels Orientation primarily supported by scheme guidelines/letter, so many things still remain unclear 	<ul style="list-style-type: none"> Communication materials not available Packaging for both free and scheme-supplied contraceptives similar, leading to questions on price charged for the scheme supply Labeling of price was not prominent on scheme supply
BLOCK PHC/CHC	<ul style="list-style-type: none"> Some districts delay sending stocks until blocks have stock-outs Block officials complain of not receiving the stocks they request Unsure on when would receive scheme resupply Supplied per guidelines to ASHAs, but where are more ASHAs it is a problem 	<ul style="list-style-type: none"> Irregular/inconsistent records maintenance due to non-receipt of reports/formats 		
ASHAS TO COMMUNITY	<ul style="list-style-type: none"> Most ASHAs are not competent in maintaining the records of stocks/supply and distribution ASHAs are traveling to block PHC/PHC to collect stock If stock is available, ASHAs are competent in distributing contraceptives to households 	<ul style="list-style-type: none"> ASHAs are recording sales/distribution in daily diary/pages, but are not posting on format Do not feel the need to adopt a new format Verbal reporting by ASHAs 		

BACKGROUND

Community-based Distribution of Contraceptives

Many developing countries have made extensive efforts to explore alternative delivery systems for family planning services, especially community-based distribution of contraceptives. Many programmes have shown success and acceptability in moving family planning services from physician-based clinical settings closer to the community where demand exists. India's family planning programme has also adopted this strategy, and the Government of India (GOI) uses cadres of frontline community health workers (CHWs) to provide family planning counseling and methods at the community level. These community-based efforts supply non-clinical contraceptives such as condoms, oral contraceptive pills (OCPs) and emergency contraceptive pills (ECPs) to community women as part of free-supply and social marketing schemes. However, since the inception of this programme, issues of availability of the contraceptive supplies and delivery of these methods into the communities have been serious challenges, resulting in limited access to contraceptives. As such, the GOI views poor commodity supply as one of the contributing factors in low rates of use of spacing methods in India: 5 percent for condoms, 3 percent for OCPs, 2 percent for intrauterine contraceptive devices (IUCDs) and less than 1 percent for injectables (IIPS, 2007).

Use of CHWs within community-based family planning has proven to be a high-impact practice both in South Asia and in other developing nations. Research in India and Bangladesh has shown that CHWs can safely and effectively provide a range of contraceptive methods to communities, including injectables (Johri *et al.*, 2005; Georgetown University, 2008; Khan *et al.*, 2004), even in cases where the CHW has low or no literacy. Distribution by CHWs in African programmes has similarly been proven safe and effective (Hoke *et al.*, 2011; Prata *et al.* 2011). Additionally, CHWs can supplement the provision of contraceptive methods through counseling and referrals to clinic-based services (USAID, 2011). In this way, programmes that use CHWs have significantly increased contraceptive use among their target populations (Philips *et al.*, 1999; Stoebenau and

Valente, 2003; Huber *et al.*, 2010). This is particularly true for women in underserved communities, whose ability to obtain contraceptive methods can be constrained both geographically and socially (USAID, 2011).

Across a diverse range of countries, the experience of implementing community-based family planning programmes that use CHWs has demonstrated what features are likely to make a programme more successful. Importantly, CHWs who are recruited from a target population and who share a common language, culture, education, social class or sex with that population are likely to have more success than CHWs who differ greatly from the communities in which they work (Foreit *et al.*, 1992; Lewin *et al.*, 2010). Additionally, expanding the range of methods provided by CHWs tends to increase overall contraceptive use and the number of new contraceptive users. For example, significant increases in contraceptive prevalence were observed after the introduction of the Standard Days Method in Indian community-based programmes and after the introduction of the injectable depot-medroxyprogesterone acetate (DMPA) in rural programmes in Bangladesh and Afghanistan (Johri *et al.*, 2005; Malarcher *et al.*, 2011). Experience has also shown that men can be effectively recruited as CHWs, particularly for their potential in increasing condom distribution (Green *et al.*, 2002).

Finally, the most effective programmes are able to evolve with the changing needs of the communities in which they work. This is particularly true when contraceptive prevalence has increased because of the work of CHWs, after which other types of approaches such as social marketing or a centralised depot approach may be more appropriate (USAID, 2011).

Social Marketing of Contraceptive Initiative by Accredited Social Health Activists (ASHAs)

To improve access to contraceptives at the community level, the GOI decided to utilise the services of accredited social health activists (ASHAs) to improve delivery of contraceptives directly to households and to provide incentives to ASHAs for the effort.

ASHAs are the initial point of contact for all health-related issues at the community level. They are responsible for safe motherhood initiatives, immunizations, deliveries, referrals and escorts for women needing health, sanitation and hygiene services. ASHAs also serve as depot holders for oral rehydration solution and contraceptive methods like condoms, OCPs and ECPs. Each ASHA is responsible for a catchment population of 1,000 in a village, and she is expected to counsel all eligible couples in her area on available contraceptive methods, facilitate screening of women interested in using OCPs by medical officers (MOs) or auxiliary nurse midwives (ANMs), and refer women interested in IUCDs to the nearest health facility.

To facilitate her work, each ASHA maintains a list of couples in her catchment area who are eligible for family planning. The list includes the couples' contraceptive preferences and whether they are currently using a contraceptive method. ASHAs use these lists to target and visit couples to determine their fertility desires, family planning interests, interest in initiating a contraceptive method, and need for resupply.

The Pilot Initiative Supply Chain

Under the new initiative, an ASHA's distribution of family planning commodities to her community is one step in a modified supply chain designed to avoid delays in the supply of commodities and to avoid stock-outs. Initially, commodities from the national manufacturers are sent to state-level depots and then the supplies are distributed down to district-level depots. The new initiative bypasses the state-to-district distribution, where many supply delays take place. At present, condoms, OCPs and ECPs are supplied directly from the national manufacturer to the district-level depots. The guidelines of the GOI suggest that at the district level, the chief district medical officer (CDMO) is responsible for receiving the supplies. However, the states are responsible for developing a mechanism of supply from the district level to primary health centres (PHCs) or sub-centres (SCs) and then to ASHAs (Figure 1).

The ASHA is responsible for traveling to the PHC that serves her community to procure her supply of methods. The ASHA then supplies the contraceptives to couples in her community, charging ₹1 (U.S.\$ 0.02) for a pack of three condoms, ₹1 (U.S.\$ 0.02) for a cycle of OCPs, and ₹2 (U.S.\$ 0.04) for a pack of one ECP, to support her efforts and to encourage her to maintain a constant supply of commodities in her community.

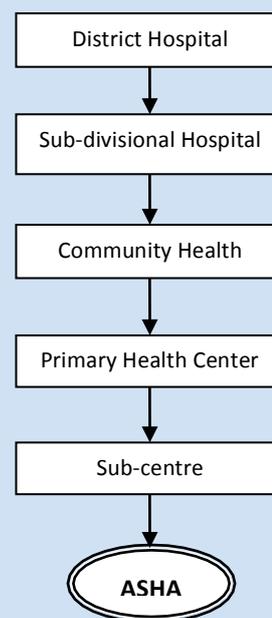


Figure 1. Organisation of Health Facilities from District to Village Level

The new initiative, which began in 2011, is being implemented on a pilot basis in 233 districts in 17 states across the country. Hindustan Latex Limited (HLL) Lifecare Ltd is providing the commodities for direct distribution to the districts and CDMOs. In areas where the new initiative has been introduced, the GOI has discontinued the supply of free condoms, OCPs and ECPs at PHCs and SCs, which are the two lowest levels of health facilities in these rural areas. This step has been taken to encourage uptake and resupply of methods directly with the ASHAs. Free supplies can still be accessed at community health centres (CHCs), sub-divisional hospitals, and district-level hospitals, which are facilities at a higher level than the PHCs. Overall, the initiative is managed at the state level by the state

nodal officer (SNO) and at the district level by the CDMO and the district nodal officer (DNO).

Additional elements of the new initiative include orientation programmes for ASHAs, other health providers, service managers, and district officers; standardised record keeping and stock-reporting mechanisms; communication strategies for couples and communities to renew their familiarity with ASHAs' distribution of contraceptives and to inform them of the new charges and method availability at facilities; and updated packaging for the condoms, OCPs and ECPs to be offered under the initiative.

RATIONALE FOR THE EVALUATION

The Family Planning Division of the Ministry of Health and Family Welfare (MOHFW), GOI, requested FHI 360 to facilitate a rapid process evaluation of the new initiative, with a main focus on service delivery, the supply chain, communication materials, program monitoring and the record-keeping system. The evaluation included provider and beneficiary perspectives on the initiative in terms of its strength and sustainability. The effectiveness and impact of the new initiative on overall contraceptive uptake in the pilot communities was not an element of the evaluation. The process results of the evaluation will be utilised by the GOI to strengthen the initiative and to inform national scale-up.

Objectives

The overall goal of this rapid process evaluation was to assess the new initiative of community-based distribution of contraceptives by ASHAs and to provide recommendations for its scale-up at the national level.

The process evaluation had the following specific objectives:

- Identify operational issues associated with the initiative, including service delivery mechanisms, programme monitoring and record keeping at various levels.
- Identify client-reported perspectives on access to and utilization of the initiative, particularly barriers.
- Identify ASHA-reported perspectives on implementing the initiative and providing family planning in the community, including barriers and facilitating factors.

Key Research Questions

- What are the operational barriers in maintaining the supply chain at various levels?
- Have the key players in the initiative — DNOs, MOs, ANMs and ASHAs — been fully oriented to the new initiative?
- What are the key challenges of conducting required monthly meetings, record keeping and supply tracking, and what recommendations can be made to improve these mechanisms?
- What are the key supportive factors, operational barriers and cultural barriers for ASHAs to carry out the new initiative and successfully offer contraceptives within their own community?
- What are the perceptions of community women about the initiative, the feasibility of buying methods directly in their communities, and the availability of the contraceptives, and what are the opinions of community women on buying contraceptives at a subsidized cost against freely available methods?

STUDY DESIGN

The rapid process evaluation used quantitative and qualitative methods of data collection. A cross-sectional survey was undertaken with ASHAs implementing the initiative and with female beneficiaries and non-beneficiaries living in the communities the ASHAs served. In-depth interviews (IDIs) were held with key implementers, including officers and officials working at different administrative levels within the initiative. Finally, data were collected from reporting formats introduced to assess the volume of sales of condoms, OCPs and ECPs under the initiative.

This evaluation was reviewed and approved by FHI 360's Protection of Human Subjects Committee and by the institutional review board of the Centre for Media Studies in New Delhi.

Study Sites

The Family Planning Division of the GOI selected six geographically representative states and districts (Figure 2) that were part of the pilot initiative to participate in this rapid evaluation: Assam (Jorhat), Bihar (Gaya), Madhya Pradesh (Mandla), Gujarat (Banaskantha), Odisha (Anugul), and Jammu and Kashmir (Udhampur).

One PHC was selected from each of the districts to participate in the evaluation, for a total of six PHCs included in the study. The criteria for selecting the PHC were 1) the PHC had been running the initiative for at least three months and 2) the PHC had a minimum of 25 ASHAs associated with it. On average, one PHC serves a population of 30,000 individuals (20,000 in the case of difficult terrain) or more, as per guidelines of the MOHFW. With one ASHA serving a population of 1,000, it was estimated that the majority of PHCs within a district would have a minimum of 25 ASHAs.

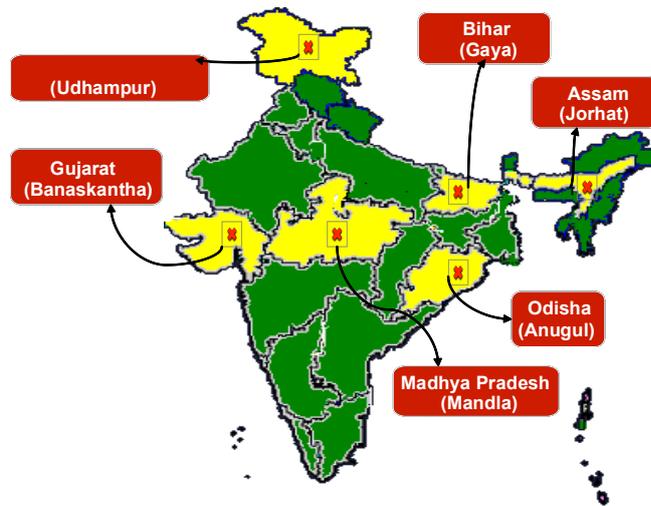


Figure 2. Map of India with Evaluation States and Districts Highlighted

FHI 360 and the research agency Ipsos selected the PHCs in consultation with the DNOs in charge of the initiative for the selected districts. During the selection process, Bihar and Odisha were found to have slightly different health system structures than the other evaluation states. They each had one large block PHC serving a population of 200,000, and then one level down health SCs serving 5,000-7,000 individuals. To reach the comparable population size served by PHCs in the other states, three health SCs that were running the initiative in Gaya District, Bihar, were selected for the evaluation. Three SCs running the initiative in Anugul District, Odisha, were also selected. In each district, the number of ASHAs working in the combined health SC areas totaled more than 25, meeting the study's selection criteria.

Study Methods

The study methods, including the targeted populations and sample size, are described below. Table 1 summarises the actual number of study participants for each of the study groups in each of the six study sites.

A. Semi-structured interviews with ASHAs

Semi-structured interviews were planned with 15 ASHAs selected systematically from each PHC, for a total of 90 ASHAs. A list of the ASHAs working in each selected PHC was obtained from the PHC supervisor, MO, or block program manager when the team reached the centre. The list was arranged in alphabetical order, and 15 ASHAs were selected using systematic random sampling. The semi-structured interview tool included both close-ended and open-ended questions to capture ASHAs' views of the initiative. Specifically, the tool covered orientation to the initiative, family planning provision, stock maintenance and procurement, record keeping and reporting, communication materials, and supervision. The tool also included details on the barriers and facilitating factors related to these components.

B. Semi-structured interviews with female beneficiaries and non-beneficiaries

Women residing in the catchment areas of the interviewed ASHAs were targeted for semi-structured interviews. In order to be eligible to participate in the survey, women had to be married, between 15 to 49 years of age, and living with their spouse, and neither spouse could be sterilised. Both beneficiaries and non-beneficiaries were interviewed. A beneficiary was defined as an individual who had purchased condoms, OCPs or ECPs from the ASHA at least once during the period from February 2012 to April 2012. The planned sample size was five beneficiaries and five non-beneficiaries for each selected ASHA, resulting in 75 beneficiaries and 75 non-beneficiaries for each PHC and a total sample of 450 beneficiaries and 450 non-beneficiaries.

A listing exercise was conducted to create a master list of all women who were eligible to participate in the study from the catchment area of each ASHA. Depending upon the eligibility criteria, five beneficiaries and five non-beneficiaries were selected using a systematic random sampling technique in the catchment area. Attempts were made to select women from unique households, and no two women were selected from the same household.

The survey instrument for both the beneficiaries and the non-beneficiaries asked about current family planning use, source of family planning method, general interactions with the ASHA, knowledge of the initiative, participation in the initiative, and attitudes and experiences towards the initiative.

C. In-depth interviews

IDIs were conducted with ANMs and managers. For each PHC, up to two ANMs were asked to participate in an IDI, for a maximum of 18 participants. A list of ANMs who worked with the selected 15 ASHAs was obtained from the PHC supervisor, MO, or block programme manager when the study team reached the district. Two ANMs were selected from the list in the descending order of the number of ASHAs selected. Interviews with ANMs focused on knowledge of and orientation to the initiative, roles and responsibilities, supervision and management, stocks and procurement, challenges experienced, and suggestions for improvement.

Other individuals who participated in IDIs were managers and key implementers of the scheme, including officers and officials working at different administrative levels within the initiative. IDIs were held with 1) SNOs, 2) DNOs, 3) block programme managers, 4) CDMOs, 5) ASHA supervisors, and 6) joint directors/deputy directors of health. These individuals were selected purposely. Four interviews per district/state were planned, for a total of 24 IDIs. These interviews covered topics similar to those covered with the ANMs but had an overall emphasis on the commodity supply chain.

D. Service statistics

Data were also collected from reporting formats introduced for the initiative to assess the volumes of sales of condoms, OCPs and ECPs under the initiative. Service statistics were collected from the registers of the MO in-charges (CHC, block PHC, block office) for individual ASHAs' distribution of contraceptives, using Format C. (For more description of Format C and other formats introduced, see section on Reporting and Monitoring Formats).

Half of the study districts could provide Format C data. The remaining three were able to provide only Format B data, which showed data aggregated across all ASHAs for a block.

E. Data collection

Ipsos was contracted to collect the data under the supervision and direction of FHI 360 and the Family Planning Division of the GOI. Data collection took place during May 2012 in all six study districts. The sample targeted was 90 ASHAs, 450 female beneficiaries, 450 female non-beneficiaries, 18 ANMs/MOs and 24 managers. However, overall, a total of 92 ASHAs, 458 female beneficiaries and 427 female non-beneficiaries were interviewed across the study sites, along with a total of 17 ANM/MOs and 21 managers (Table 1). The high rate of sterilization in the Mandla made it difficult to meet the sampling criteria for non-beneficiaries, so the required sample size was not reached.

Table 1. Achieved Sample Size by Study State

STATE	DISTRICT	ASHAs	ANM/MOs	MANAGERS	BENEFI- CIARIES	NON BENEFI- CIARIES
Odisha	Anugul	16	3	4	75	75
Gujarat	Banasthkam	15	3	4	74	77
Bihar	Gaya	15	3	4	80	80
Assam	Jorhat	15	3	3	75	75
Madhya Pradesh	Mandla	15	3	3	80	39
Jammu & Kashmir	Udhampur	16	2	3	74	81
TOTAL		92	17	21	458	427

The informed consent statement was read to all study participants who agreed to participate in the evaluation. To ensure confidentiality, all of the participants were assigned identification numbers. The identification numbers were used on the quantitative questionnaires, audiotapes, notes pages and transcripts. All audiotapes were destroyed at the completion of data analysis.

The study team was also instructed to respect confidentiality by not discussing the responses of particular interviewees with anyone in the community or health care facilities. Ipsos transcribed, translated and entered the data, with FHI 360 conducting analysis using Stata for quantitative analysis and Atlas/ti for qualitative analysis. All analyses were descriptive and may not be transferable to similar contexts.

FINDINGS

There were many important components of the scheme that needed to be implemented in order for the scheme to be successful. Here we describe results related to the experience beneficiaries had with the scheme, the impact of the scheme and operational issues in terms of formats, the supply chain, payment, removal of the free supply, social marketing and orientation of the scheme. The data from non-beneficiaries are not been presented in this report.

Beneficiary Experience Under the New Scheme

In the six study states, 458 female beneficiaries were surveyed about their participation and experiences with the new scheme. These women had an average of 2.0 living children, and most were interested in avoiding or delaying pregnancy. Aside from receiving family planning methods from ASHAs, many of the women had regular contact with ASHAs for additional health services (Table 2).

Table 2. Characteristics of Female Beneficiaries and Recent Services Received from the ASHA

CHARACTERISTICS	FEMALE BENEFICIARIES (n=458)
	%
Would like no more children	61
Would like to delay pregnancy 2 years or more	33
In the past three months, received help from AHSAs for	
Family planning	100
Immunizations	76
Oral rehydration solution	47
Help with delivery	27
Nutrition	21
Malaria	18
Antenatal care	17

During the three months leading up to the survey, beneficiaries and their husbands were primarily receiving OCPs and condoms from the ASHAs (Table 3). The mean number of months the beneficiaries had been using their methods was 14.6, indicating that most beneficiaries did not initiate their methods under the scheme. However, 15 percent and 12 percent of beneficiaries reported using their methods for three and four months, respectively, suggesting that about a quarter of the women potentially initiated their method under the scheme.

Most beneficiaries were receiving their methods at home. When the need arose for resupply, 53 percent reported that the ASHA remembered that the couple needed to resupply, and 43 percent said she or her husband contacted the ASHA to request additional packs of methods. Only 6 percent of the beneficiaries had any difficulty contacting the ASHA. Most beneficiaries thought “It is a good scheme as materials are provided at home.”

Table 3. Method Use and Supply Under the Scheme, Reported by Beneficiaries

METHOD USE AND SUPPLY	FEMALE BENEFICIARIES
	(n=458)
	%
Methods received from ASHA in past three months	
OCPs	59
Condoms	54
ECPs	5
Time using method	
Mean (months)	14.6
Best way to describe how beneficiary gets method	
ASHA brings the method to the beneficiary's home	85
Beneficiary meets the ASHA away from the home	10
To resupply the method	
ASHA remembers it is time to resupply	53
Beneficiary or husband contacts the ASHA	43
Ever had problems locating the ASHA	6

Impact of the Scheme

Although the assessment was not designed to measure the impact of the pilot scheme on contraceptive uptake or unmet need in the study areas, the assessment did ask the beneficiaries and the ASHAs about their perceptions and satisfaction with the scheme. Overall, 75 percent of all female beneficiaries interviewed were completely satisfied with the new scheme, and an additional 20 percent were somewhat satisfied. Satisfaction did vary between study areas, although dissatisfaction with the scheme was never higher than 12 percent, which was reported in Assam. In Gujarat and Bihar, beneficiaries reported 95 percent and 89 percent complete satisfaction, respectively.

“The scheme of making contraception available at home shouldn’t be stopped because it saves money.”

- Female Beneficiary

“Government has withdrawn the free supply of these things. I think the things which we buy by paying money have good quality.”

- Female Beneficiary

“The new scheme is good as price is not higher. It is cheaper than the market price.”

- Female Beneficiary

Interpretation of these data should take into account that the women who were completely dissatisfied with the scheme could have chosen to obtain their methods elsewhere, making them ineligible for this beneficiary assessment.

When ASHAs were asked if they felt the scheme increased, decreased or left the same the number of women obtaining methods from them, 20 percent noted a negative impact on their client numbers. Half (52 percent) felt their client numbers increased, and 26 percent

felt the number of acceptors remained the same. The vast majority (86 percent) believed that the scheme — including the payments — would be successful over the long term. They attributed this success to the methods costing less than those for sale in the markets or shops, and to couples receiving the methods without traveling to the markets or shops (which often are quite a distance from the beneficiaries' homes).

“Its price is so less than the market price, and we were providing the methods near the people at their own village, so this scheme will work for a long time.”

-ASHA

Many ASHAs felt that TV and radio advertising about family planning had increased and, in turn, had increased community interest in using family planning. They believed this has led community members to seek information and methods from the ASHAs. Moreover, despite the complaints about the supply no longer being free, several ASHAs noted that once the scheme has been operating longer, they think women and men will become accustomed to the payments.

“Time will be taken, then they shall understand, and scheme shall be successful.”

-ASHA

Payment for Methods Under the New Scheme

Under the detailed guidelines issued by the GOI for the scheme, ASHAs would charge ₹1 for a pack of three condoms, ₹1 for a cycle of OCPs and ₹2 for a pack of one ECP. These methods were previously offered for free, but the new charges were designed to be incentives for the ASHAs, to support their efforts and to encourage them to maintain a constant supply of methods in their communities.

During the assessment, ASHAs were asked, “In general, what type of reaction did you receive from the community when you started to charge for methods?” Figure 3 shows that

50 percent of the ASHAs indicated a positive response from their communities. However, the responses were extremely varied across the six study areas. Overall, results from the surveys and interviews indicated that in many areas, the ASHAs were facing challenges to implementing the new charges.

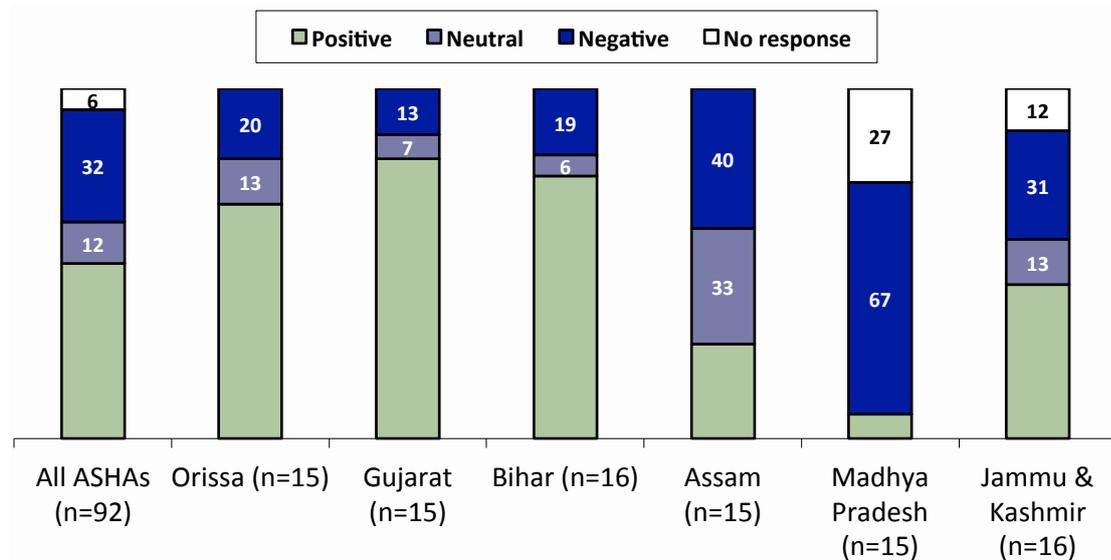


Figure 3. Community's Reaction to Introduction of Charges for Methods, Reported by ASHAs

Results from the surveys and interviews also indicated that in many areas, beneficiaries were still obtaining their methods for free. Among the beneficiaries interviewed for this assessment, 50 percent of condom users, 25 percent of OCP users and 52 percent of ECP users said that the last time they obtained their method from an ASHA, it was free. Reports from the ASHAs and managers corroborated this, with many noting that they were providing the scheme supply for free because of community resistance to the new charges. Certain sections of communities were unwilling to pay for GOI stocks, citing that the contraceptives used to be free and that they should continue to be free because all other products from the GOI are free.

“Community people think that what (family planning product) was available for free earlier they have to pay for it now and that too for government supply.”

- Manager (ASHA Supervisor)

“People say (community) free supply is available in different programme [like] HIV-AIDS. It is not available in this scheme.”

- Manager (District Level)

In many states, because of the community’s refusal to pay, the ASHAs were giving the scheme supplies for free.

“People aren’t accepting this easily. At first they are not interested to pay money so I have to give them free of cost.”

- ASHA

Some beneficiaries were not paying for methods because some ASHAs still had free supply stocks, as did some lower-level SCs and PHCs that should have had their free stocks removed at the introduction of the scheme. On the day of the assessment survey, the ASHAs were asked to show what methods they had with them (Table 4). Overall, 18 percent of ASHAs had free-supply condoms, 17 percent had free-supply OCPs and 13 percent had free-supply ECPs. Most of the free supply of methods was seen in Assam and Odisha, yet they were found in all states. About 21 percent to 46 percent of ASHAs did not have one of the methods with them the day of the interview. This may have been attributed to stock-outs.

Table 4. Types of Stock ASHAs Had on the Day of Interview

TYPE OF STOCK	ASHA
	(n=92)
	%
CONDOM SUPPLY	
Free supply	18
Scheme supply	36
ASHA had no condoms with her	29
OCP SUPPLY	
Free supply	17
Scheme supply	46
ASHA had no OCPs with her	21
EC SUPPLY	
Free supply	13
Scheme supply	17
ASHA had no ECPs with her	46
ASHA REFUSED TO SHOW SUPPLY	24

The presence of free-supply stocks in many communities contributed to the confusion and resistance to paying for scheme supplies.

“If the old free-supply stock will not be withdrawn then this new scheme will not work further. People will demand for that free supply.”

-ASHA

ASHAs reported this not only for the free stock still being offered in locations where it should have been stopped (such as CHCs, SCs and PHCs), but also for the higher-level facilities where it was still being offered legitimately. In communities located close to the CHC/block PHC, men and women would choose to visit the facility for a free supply instead of purchasing a supply from the ASHA.

“There should not be two ways to promote the scheme...either it be made totally free or totally paid...people get confused and then they don’t trust us.”

-ASHA

Many ASHAs and managers noted limited guidance on how to remove the free-supply stocks (see section on Removal of Free-Supply Stocks). Many ASHAs already had the free supply when the initiative began. In many instances, it had been given to them by PHC and SC officials, as they did not have guidance on the existing free supply.

“We have provided the free supply along with the scheme supply till we had stocks. Free supply is provided to people who are not taking scheme supply.”

– Manager (District Level)

We have given all the free supply to ASHAs for community distribution.”

- Manager (ASHA Supervisor)

Among the beneficiaries who did pay for their most recent supply of methods, the median cost reportedly paid matched the GOI guidelines. A very small number of beneficiaries did note paying slightly more for their scheme methods than the allotted GOI price. These instances were spread out among the six states and did not appear to show a trend of overpayment in any area.

In Bihar, the introduction of the charges under the new scheme had a positive effect on the perceptions of the scheme. Many ASHAs noted that the community sees the scheme supply as better quality than the free supply because they now have to pay for it.

“The new scheme methods must be better than the old scheme methods such as OCP, EC, condoms. Before they were supplied free, but now they are charging ₹1 or ₹2.”

-Female beneficiary

Removal of Free-Supply Stocks

Under the new scheme, the supply of free condoms, OCPs and ECPs should have been discontinued among the ASHAs and the two lowest-level facilities (the PHCs and SCs) to encourage uptake and resupply of methods directly with the ASHAs. Free supplies could still be accessed at CHCs, sub-divisional hospitals and district-level hospitals. However, the evaluation found ASHAs still carrying free-supply methods (Table 4). When asked directly, 26 percent of ASHAs reported having some free-supply stocks with them, although 10 percent said they were not distributing the free stocks, as it would confuse the community. One out of four ASHAs said free-supply methods were still being given at the SCs and PHCs in their areas.

“Free supply scheme has stopped. Remaining stock at SC and PHC, but we are not being provided with those methods...still we have some old stocks with us...they have not taken returned from us but we are not providing these to people. We'll return it back to ANM madam.”

-ASHA

Many managers expressed confusion over how the free commodities should have been handled once free distribution was discontinued among the ASHAs, SCs and PHCs. The scheme guidelines did not indicate if the free supplies should have been distributed until stocks were completed, as 25 percent of ASHAs reportedly did, or if the free stocks should have been pulled out of the communities, as mentioned by the ASHA above. Additionally, it was unclear what should have been done with the stocks, or where they should have been sent, once they were taken out of the SCs and PHCs.

Social Marketing for the Scheme

A. Communication

Under the GOI guidelines issued for the scheme, states were responsible for developing and displaying communication materials at PHCs and SCs. Additionally, under the Innovations in Family Planning Services (IFPS) project and the IFPS Technical Assistance Project (ITAP), a behavioral change communication campaign was developed for use at the community level (ITAP, 2012). ITAP's approach included leaflets and flipbooks for ASHAs to use with community women and men; the development of poster and wall paintings for key community locations, along with tin plates for rickshaws and flex banners for group meetings like village health and nutrition (VHN) days; and the design of posters and leaflets to be distributed within health facilities. The campaign also received its own tag line, "*ASHA se mango*" (Ask/demand from the ASHA).

Through the interviews and surveys with ASHAs, managers and community women, the assessment found that many of these materials were not present in the six study communities. Among the beneficiaries, 20 percent had seen posters or banners, 27 percent had seen wall writings, 5 percent had received leaflets or other printed materials and only 8 percent were familiar with the tag line. ASHAs also reported the absence of the materials, as 62 percent said they did not receive any materials to help them inform their communities and 58 percent did not see any posters, banners or wall writings in their areas. Several ASHAs mentioned seeing promotional materials for family planning methods or other schemes, but these were not specific to the new initiative. Anecdotally, members of the assessment team also did not see any materials during their time in the facilities and communities where the evaluation was being conducted.

Many ASHAs complained that this lack of marketing left their communities uninformed about the changes and caused community members to question the legitimacy of the new charges for the methods. Some of the ASHAs were accused of devising the new charges on their own, instead of implementing a new GOI policy.

“People don’t buy from us...they say you used to sell it for free but now charge...have got greedy...you keep money.”

-ASHA

Aside from wanting a more visible communication campaign to help inform their communities about the new scheme, many ASHAs requested that ANMs, MOs and other higher-level officials visit their communities to endorse the scheme and to emphasise it is an initiative of the GOI.

“This scheme can be improved if medical officer, ANMs will visit to villages and through meetings make women aware of this family planning scheme.”

-ASHA

“If senior officers also come for the meeting, or sometimes go to households with us, people would listen to them.”

-ASHA

B. Packaging of scheme supply

Under the new scheme, packs of condoms, OCPs and ECPs included the Rs 1 or Rs 2 price printed on the package along with the following stamp:

“Government of India supply”

“For home delivery by ASHA”

“₹ 1/- for a pack of 3 condoms”

“₹1/- for a cycle of OCPs”

“₹ 2/- for a pack of one ECP”

Of the ASHAs interviewed, 60 percent could spontaneously note that the scheme supply has the price marked on the package and 23 percent described the stamp on the package stating home delivery by the ASHA. Yet, 16 percent said there was no difference between the packaging for the scheme supply and the packaging for the free supply. Another 14 percent either did not know or reported other changes that were not correct. Some of this unfamiliarity can be attributed to free-supply stocks still being with ASHAs, as discussed in the previous section, but at the time of the assessment, all ASHAs should have been distributing scheme-supply stocks for a minimum of three months.

Several of the managers interviewed for the assessment complained about the revised packaging under the scheme. They felt the labeling of the price did not stand out enough and that, aside from the stamps, the design and appearance of the packages had not changed. This led to confusion between the scheme-supply stocks and the free-supply stocks, and contributed to the communities' resistance to the scheme and paying the ASHAs for the methods.

“Packaging is given more importance. Now people say that first bring something else then ask us to pay.”

- Manager (Block Level)

“I stress on packaging, packaging should be better and colourful.”

- Manager (Block Level)

Reporting and Monitoring Formats

The GOI introduced four new reporting forms, or formats, for the scheme. They are outlined in Table 5. In addition to maintaining Format A, ASHAs were expected to maintain an ASHA register that records the contraceptive stocks they receive and sell.

During the assessment, problems were seen with each format type and the ASHA register. Among the ASHAs interviewed, 64 percent said they were maintaining a register of whom they sell methods to and 82 percent were tracking stocks received and sold. However, it was unclear whether the ASHAs were using the formats introduced under the scheme or were using their previous style of registers. Many ASHAs were reportedly borrowing existing lists of eligible couples from the Anganwadi center and the local ANMs, instead of generating their own. Other ASHAs admitted to not targeting their contraceptive sales to listed eligible couples.

Table 5. Description of Each Reporting Format

FORMAT TYPE	INDIVIDUAL RESPONSIBLE	INFORMATION RECORDED	FORMAT SUBMITTED TO
A	ASHA	List of all eligible couples in an ASHA's village, noting their fertility intentions, current contraceptive use, and method using	SCs and PHCs
B	MO in-charge (at block level)	Monthly record of aggregate stocks received and distributed by MOs	Districts, which collect all formats and send to states
C	MO in-charge (at block level)	Monthly record of stocks received and distributed by each ASHA within block of MO's supervision	For MO's own use; in the future could be added to health management information system
D	SNO	Quarterly report of aggregate stocks received and distributed across all districts under the scheme	National level

Nearly a quarter of the ASHAs admitted that they do not maintain any stock records at all, primarily in Bihar, Odisha and Madhya Pradesh. 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. Many ASHAs were interested in maintaining records, but they just needed more guidance and oversight. For example, 24 percent of ASHAs said no one had checked their stock registers in the past three months.

Completion of Formats B and C are tied together, with Format B relying on the detailed information collected through Format C. As just noted, ASHAs were not necessarily tracking their sales in Format A, leaving little reliable information for the completion of Format C. In some instances, data for Format C were collected through verbal reports, which could have introduced errors through recall problems. Confusion on reporting time frames and on when records should have been started were also reported.

These problems with Format C became systematised when data were transferred to Format B, sent to the district level, and then forwarded to the state level for compilation into Format D. Additionally, at the block, district and state levels, confusion occurred on whether free-supply stocks (which were still legitimately being distributed in the block- and state-level facilities) should be accounted for in the new formats.

As part of the assessment, data from Format C were to be collected for the three months leading up to the assessment (approximately February to April 2012) to comment on volume of sales. In each study site, inconsistent data and missing forms were observed (Table 6). Half of the areas could not provide the ASHA-wise data, but only the aggregate stocks received and sold. Additionally, the stock numbers recorded were not consistent from month to month, and misunderstandings about the purpose of the different columns of the formats occurred.

These problems prevented any meaningful conclusions from being made on volume of sales in this assessment. However, they do highlight the lack of clear guidance and oversight on format completion.

Table 6. Observations on Formats B and C as Collected for the Assessment

STATE	TIME BLOCK BEGAN TRACKING	FORMAT TYPE RECEIVED	OBSERVATIONS
Odisha	Dec 2011	Format B	No track of original stock received in Aug 2011
Gujarat	No data	Format C	Limited data on stock sold
Bihar	Jan 2012	Format C	No data on stock sold
Assam	Sep 2011	Formats B & C	Format C data not shown separately by month, but in aggregate for all months since Sep 2011; no data on ECP stock sold
Madhya Pradesh	Jan/Feb 2012	Format B	No data on stock sold
Jammu & Kashmir	No data	Format B	No data on stock sold

Supply Chain

The new supply chain guidelines issued by the GOI instructed that the state level be bypassed in the distribution of the commodities. The manufacturer HLL now sends the scheme-supply condoms, OCPs and ECPs to district-level depots (Figure 4). Once at the district level, under the direction of the CDMO and the DNO, the methods are supplied to the CHC/block PHC. The ASHAs are responsible for traveling to the CHC/block PHC to pick up their supply of methods.

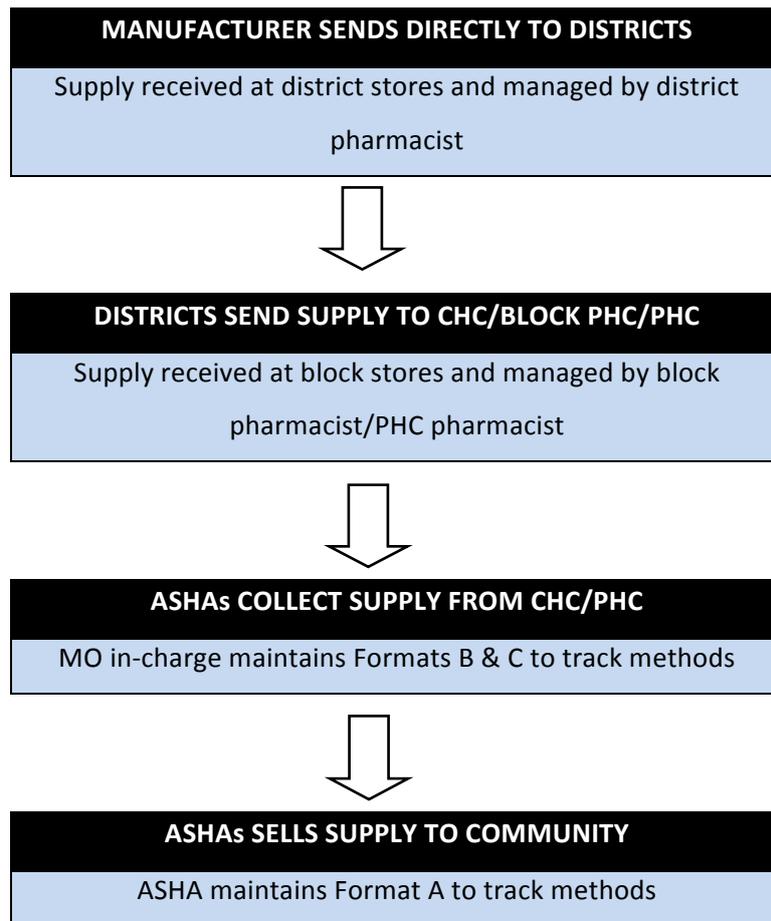


Figure 4. Steps in the Supply Chain Under the Scheme

A. Supply from manufacturer to district level

Many officials at the state level were confused about the changes in the commodity chain and where the supply was originating from, citing both the GOI and HLL. At the district level, most managers reported that only one shipment had been received from HLL. A few noted that they received their first shipment of scheme stocks separately by method. The receipt of only a single shipment is of note, as most areas included in the assessment had already distributed all the stocks they received and had no more scheme-supply stocks. As such, many district managers complained that the initial shipment was insufficient for their area's commodity needs and that the shipment was not timed properly to coincide with the start of the scheme. Some areas received their stocks months before the scheme started and others had the scheme start without receipt of the scheme stocks.

Moreover, district officials were given no guidance on how to procure additional shipments of scheme stock, and state officials mirrored their confusion. The scheme guidelines did not specify if the district or the state should initiate the procurement and whether that procurement should be sent to HLL or to the GOI at the national level. At the time of the assessment, many states had already submitted Format Ds that showed they were out of stock, yet they received no additional stock.

B. Supply from district level to CHC/block PHC

The assessment found that the district was taking responsibility for transporting the scheme stocks to the block level, including paying for the vehicle and other transportation costs. To save money on these costs, some districts delayed sending stock replenishments until the blocks reported finishing their supply of multiple methods. Block-level officials were responsible for sending requisitions for stock replenishments to the district, but no specific and regular timeframe had been established under the scheme for this requisition process. As a result, some blocks were waiting until all scheme stocks were depleted before sending a requisition. Furthermore, many blocks complained that they were being given stocks based on the number of ASHAs and eligible couples in their areas. Frequently, these allotted stocks were not enough to meet the community demand.

“We fail to supply as much contraceptives to replace the ASHA’s stock whenever it gets over.”

-Manager

C. Supply from CHC/block PHC to ASHAs

ASHAs were fulfilling their new responsibility of traveling to the CHC/block PHC to collect their scheme stocks. Among the ASHAs surveyed, 57 percent said they picked up their stock from the CHC/block PHC and another 34 percent picked up their methods at the PHC. At some time since the scheme began, 20 percent of ASHAs admitted that ANMs or other couriers had brought the methods directly to them, going against the scheme guidelines. A

third of the ASHAs were collecting their supply of methods every two months, and another quarter got them once a month; 23 percent had only received a single supply.

Overall, the ASHAs were unsure how many condoms, OCPs and ECPs they should have on hand. The GOI guidelines stipulate that early supplies should be based on the number of eligible couples in an ASHA's area and that subsequently, supplies should be given based on her actual sales. This being said, most ASHAs complained about not being supplied on time with enough methods, and ANMs echoed this complaint.

“ASHA should get family planning medicines on right time so that we can give it to the people on time.”

-ASHA

“The main challenge is ASHAs do not get stock on time.”

-ANM

D. Supply from ASHAs to their community

In an earlier section, Table 4 showed that 21 to 46 percent of ASHAs did not have one of the methods with them the day of the interview. Some of this may be attributable to stocks not being available for the ASHAs at the block level. In the survey, 36 percent of the ASHAs reported not receiving what they had requested. From the beneficiaries' side, 16 percent commented that in the past three months, the ASHA did not have the method they wanted. However, only 1 percent of all beneficiaries said the ASHA was always out of the method. About 9 percent of beneficiaries said the ASHA is only sometimes out of the method. Among those who said the ASHA did not have the method they wanted, most either bought the method from a different location (8 percent of all beneficiaries) or waited until the ASHA got more of their method (6 percent of all beneficiaries).

Orientation to the Scheme

In August 2011, the MOHFW, GOI, distributed a letter that included guidelines for introducing the scheme and outlining the points of the scheme. It also included guidance on roles and responsibilities, key officers, monitoring, and reporting formats. SNOs were designated responsible for the conduct of the scheme, including introducing all pilot districts to the new scheme. CDMOs and DNOs, operating at the district level, were given the task of orienting MOs, ANMs and particularly ASHAs to their new responsibilities.

Overall, the results from the survey and IDIs revealed that although most of the managers and ASHAs received orientation about the scheme, the quality of the orientation may not have been sufficient to prepare them to implement all aspects of the scheme. In the evaluation, managers at the district and block levels reported that their orientation to the scheme was primarily through reading and discussing the GOI letter and guidelines during routine management meetings.

Nearly all managers reported that the details of the scheme were read out during the orientation. Among the ASHAs surveyed, 85 percent said they participated in an orientation before the scheme started in their catchment areas. MOs were the most likely to have led these ASHA orientations, followed by block program managers, ANM managers or supervisors, and lady health visitors or female health workers (Table 7).

The orientation was typically part of the ASHAs' regular monthly meetings or sector meetings, held at the block level where MOs and managers explained the new guidelines and discussed method counseling, the eligible-couples register, stock maintenance, and implementation of the scheme, including new scheme incentives (Table 7).

Table 7. ASHA Orientation to the Scheme

DETAILS OF ORIENTATION	ASHA
	(n=78)
	%
Orientation was led by	
MO	41
Block program manager	15
ANM manager or supervisor	14
Lady health visitor or female health worker	11
ANM	5
Deputy CDMO or district program manager	5
Topics discussed during orientation	
Counseling on condoms	59
Counseling on OCPs	58
Preparing the eligible-couples register	53
Maintaining the eligible-couples register	38
Counseling on ECPs	31
Maintaining stocks of methods	23
How to implement the scheme	22
Scheme incentives	21

Many ASHAs recalled that the orientation discussions focused more on specific method counseling than on the primary elements of the scheme. For example, fewer than one-fourth reported that they had received training on essential components such as stock maintenance and how to implement the scheme incentives.

“In the orientation we were told about everything, immunization, delivery of pregnant women, family planning techniques.”

- ASHA

Among the ASHAs who did not report taking part in a formal orientation (n=14), all but one noted that their roles and responsibilities under the scheme were explained verbally to them in a meeting (n=8) or informal discussion (n=5). Additionally, the IDIs with ANMs revealed that most of the ANMs were not part of the orientation process.

DISCUSSION

The evaluation findings suggest that, overall, the scheme of community-based distribution of contraceptives by ASHAs is acceptable to the community as well as to ASHAs. The operational issues examined through the evaluation included various service delivery aspects like orientation on the scheme, the supply chain, monitoring, reporting, marketing of the scheme, and client-reported and ASHA-reported barriers to access and implementation, respectively. The service managers monitoring the scheme at various levels in the state and district administration were positive and opined that the scheme would be successful over the long term. However, the evaluation exposed a number of operational challenges for the MOHFW to consider for scaling up this pilot scheme across India.

The main barrier cited over and over again in the evaluation was supply issues accompanied by stock-outs. Earlier studies have shown that ensuring the soundness of the supply chain for family planning commodities that CHWs distribute is a particularly important feature of successful programmes (Hasselberg *et al.* 2010; Hoke *et al.*, 2010). The existence of the free supply of family planning commodities at PHCs and SCs created confusion among the community regarding the pilot scheme. This is mostly due to the fact that the managers were unclear on how to manage the existing free supplies at the PHCs and SCs. Stock-outs of the scheme supply of family planning commodities were noted during the evaluation. However, if stock is available, ASHAs are competent and comfortable in distributing contraceptives at the community level.

Monitoring and reporting is another area that needs to be strengthened. The ASHAs were mainly supervised by the ANMs, who were not oriented on the scheme. This may have contributed to the lack of understanding about roles and responsibilities. The evaluation planned to collect service statistics to assess the volume of sales of condoms, OCPs and ECPs through the initiative. These data were supposed to be collected block-wise for the quarter from February to April 2012 using Format C. However, the data could not be collected

because of the irregularities and inconsistencies in record maintenance in most of the study sites.

Marketing of the pilot scheme was very weak, and the evaluation team could not spot any communication materials on the scheme within the community or in the facilities.

Consequently, the community had various queries on the price charged by ASHAs and had mistrust in ASHAs. Also, the evaluation found that the orientation discussions did not emphasise specific elements of the scheme, thus leading to gaps seen in maintaining records, registers and formats.

If the MOHFW wants to scale up the pilot scheme to other states and districts, it will need to address the above barriers in the service delivery of the scheme. Overall, however, the pilot scheme of community-based distribution is a promising strategy by the GOI to address the unmet family planning need and to increase the uptake of spacing methods of contraception in India.

RECOMMENDATIONS

1. Manage one stream of supply to eliminate the need for two supply chains (free and scheme) and to decrease confusion, reduce reporting burden and get communities accustomed to purchasing the scheme supply.

The existing free supply and the scheme supply are creating confusion at all levels according to the process evaluation. Having one stream of supply of family planning commodities (not a free supply as well as a scheme supply) will enhance the supply chain and reduce reporting burden. If the scheme supply of family planning commodities is selected as the single stream, then communities will become accustomed to purchasing family planning commodities at the nominal price.

2. Modify the packaging of the scheme supply of family planning commodities to differentiate it from the packaging of the free supply.

The reported confusion among beneficiaries about the difference in the scheme-supply stocks and the free-supply stocks resulted in resistance to paying for what, at the moment, essentially looks the same as the free supply. Packaging that allows the scheme supply to be clearly differentiated from the free supply — including a clearly visible price — will reduce confusion about the scheme-supply methods and reduce resistance to paying for them at the community level. This should help to reduce the incidence of ASHAs giving out scheme-supply methods for free because of refusals to pay. Differentiated packaging with a highly visible price will also help to improve community awareness and acceptance of the scheme, as well as to enhance perceptions of quality, as reported by some beneficiaries.

To further reduce resistance to paying for the scheme supply, the currently inconspicuous ₹1 stamp should be replaced by a highly visible image of a ₹1 coin, similar to the image in Figure 5. Additionally, packaging with the conspicuous price should be made highly visible on the scheme communication materials such as posters, leaflets and banners. As a result, both current and potential beneficiaries will be able to link the scheme supply with the scheme itself.



Figure 5. Example of Recommended Scheme Packaging with Highly Visible ₹1 Price

3. Broaden marketing and communication efforts on the scheme to improve community awareness and acceptance of new charges.

Communication efforts should include ANMs, MOs and other officials visiting areas where there is resistance, to endorse the program and to emphasise to the community that this is a GOI initiative. Additionally, radio spots can be used to broaden marketing about the scheme.

Many ASHAs complained that the lack of marketing left their communities uninformed about the changes and caused community members to question the legitimacy of the new charges for the methods. Many ASHAs were accused of devising the new charges on their own, instead of implementing a new GOI policy.

Furthermore, in order to improve awareness of scheme packaging, images of modified packaging with the highly visible price should be depicted in all communication materials, such as posters and banners used to promote awareness of the scheme.

4. Specify guidelines on how to requisition stock at different levels in the supply chain, especially at the district level.

Guidelines gave the states the opportunity to establish supply-chain mechanisms that worked within their systems. The district and blocks received very little guidance on how and when to procure methods, leading to confusion and stock-outs of methods. Bypassing the state government for scheme supply is not improving the situation. Instead, it is leading to more confusion when the one-time supply is used up at the district level. Therefore, involving the state government initially for disbursing and maintaining stock records is essential to more ownership at the state level. It is also essential for accountability for reporting to the GOI at the state level.

5. Specify guidelines on how to retrieve the free supply of family planning commodities from ASHAs, SCs and PHCs.

The confusion created at the community level by the existing free-supply stock of condoms, OCPs and ECPs was a major barrier to service delivery in the pilot scheme. Future scale-up efforts by the GOI should consider modifying the guidelines not only to include directions on withdrawing the free supply at PHCs and SCs but also to mention how to handle existing stocks of free supply. It can be a centrally directed collection process to ensure that all free supply is removed from the PHCs and SCs and taken back to the CHC level.

6. Modify and streamline the reporting formats to incorporate requisition of family planning products.

The results of the evaluation highlight the discrepancies in reporting formats (Format C and Format B). Thus, reporting formats need to be simplified and streamlined with the requisition of family planning products at various levels. A recording format for the ANMs should be included to better monitor the scheme. The reporting of the scheme stock should be incorporated into the health management information system. Appendix A proposes an alternative reporting pattern.

7. Strengthen the role of ANMs.

The results of the evaluation highlight that ANMs were not part of the orientation to the scheme in some states. Based on the problems with reporting found during the evaluation,

it is best to involve ANMs during orientation of the scheme and then in helping in operation, supervision and reporting. Specific directions should be given on the role of ANMs in supportive supervision, monitoring and quality assurance.

8. Strengthen orientation on the scheme for all implementers so that they fully understand the steps needed to requisition methods, complete formats correctly, manage the free supply, market the scheme and supervise lower-level staff.

The rapid process evaluation revealed a lack of guidelines or lack of familiarity with guidelines on all systematic levels, from how to deal with free stock to how stock should be replenished. Improved orientation based on clear standardised guidelines, specifically for ASHAs, will increase the efficiency and effectiveness of scheme delivery at all levels. This could include more formal, more in-depth and perhaps more frequent orientation sessions.

Many ASHAs stated that the orientation discussions focused more on specific method counseling than on the primary elements of the scheme. The lack of literacy among some ASHAs and the consequent incorrect or verbal reporting on this level need to be addressed. Otherwise, oversights and mistakes at this lowest level, for example within completion of Format C, will propagate up the supply chain.

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APPENDIX A: Proposed Reporting System for Scheme Supply

Village Level

- There will be no format for ASHAs.
- ASHA will procure her supply from block CHC/PHC.
- ANM will keep the updated list of eligible couples for each ASHA catchment area.
- ASHA will keep the names of eligible couples in her daily copy/diary.
- Each ASHA copy/diary will have two main pages: 1) names of eligible couples by their type of contraceptive and 2) type of contraceptive stock received by the ASHA.
- ANM will orient ASHA on where to note the name of a user by contraceptive and how to update the stock at each sale.
- At each sale, ASHA will note the name and type of contraceptive supplied on the page of eligible couples. She will also record the contraceptive sold and the balance in the stock.
- ASHA will add new users, if found, and update the ANM's register of eligible couples.
- ASHA should have a minimum required stock (to be decided by the GOI) of contraceptive methods every month.
- ASHA will submit her monthly sales/distribution figures at mother and child health and nutrition (MCHN)/VHN day once a month.
- ANM will organise MCHN/VHN day each month in each village. ASHA will assist the ANM in her work.
- ANM will collect information on sales/distribution of contraceptives either at MCHN/VHN day or ASHA's monthly meeting at PHC.
- ANM will check ASHA's copy/diary, assist each ASHA in updating her figures, such as on type of contraceptives distributed for eligible couples, names of eligible couples and contraceptive stock matching (e.g., received versus balance).
- ANM will collect all the information for the month and prepare Format A.
- ANM will submit Format A to block PHC (Bihar), PHC (other states) or as applicable.

PHC Level

- PHC supervisor or data entry operator will collect Format A from each ANM under the PHC.
- ANM will inform about the replenishment figures that need to be provided to ASHAs.
- ANM will collect and distribute to ASHA (develop and plan their system and keep record).
- At PHC level, Format B will be filled by collating the information from all the ANMs, such as number of eligible couples provided with contraceptives by type, stock distributed and balance with each ANM (for ASHAs).
- After noting the details about the utilization of contraceptives under each ANM (health SC) area, stocks will be replenished to each ASHA.
- Format B will be submitted to CHC/block PHC.

Block PHC/CHC Level

- PHC supervisor will collect all Format Bs from PHCs and prepare a consolidated Format B by adding information from all PHCs.
- Block PHC in Bihar will prepare own Format B.
- Consolidated Format B will be submitted to district.
- Stock requisition will be prepared and sent to district for resupply.
- Efforts should be made to collect one-month advance supply.

District Level

- District ASHA coordinator or equivalent should be the point person at district level under DNO.
- District ASHA coordinator or equivalent will collate all the consolidated Format Bs from each block.
- District ASHA coordinator or equivalent will prepare a Format C and send to state.
- District ASHA coordinator or equivalent will also prepare a requisition for supply for each block based on PHC requisition formats.
- District ASHA coordinator or equivalent will ensure timely supply to blocks.

APPENDIX B: Formats Used in Scheme Reporting



SOCIAL MARKETING AND HOME DELIVERY OF CONTRACEPTIVES BY ASHAS AT DOORSTEP OF BENEFICIARIES

FORMAT – A (To be filled-in by ANM at Health Sub Centre Level)

DISTRICT: _____ BLOCK: _____ HEALTH SUB-CENTRE: _____
 MONTH: _____ DATE OF SUBMISSION: _____

GENERAL INFORMATION:		Each month update these figures	
Total Number of ASHAS under HSC	=	Total Number of Eligible Couples (Last month)	=
Number of ASHAS submitted Reports in a current month	=	New Addition in ELCO Register	=
Number of Villages under HSC	=	Any Deletion in ELCO Register	=
Population Covered	=	New Total of Eligible Couples under HSC	=

Community Based Distribution Status:	NUMBER OF ELIGIBLE COUPLES PROVIDED WITH CONDOMS	=
	NUMBER OF ELIGIBLE COUPLES PROVIDED WITH OCPs	=
	NUMBER OF ELIGIBLE COUPLES PROVIDED WITH ECPs	=

Stock Status	Opening Balance at the start of month	Distributed in current month	Balance	Minimum Stock Required under Scheme	Supply Requirement for ASHAS
1	2	3	4	5	6 = (5 - 4)
CONDOMS (packs)				78 packs	
OCPs (Cycles/strips)				10 cycles/strips	
ECPs (Pieces/packs)				10 pieces / packs	

REMARKS/COMMENTS:

Signature of ANM: _____ Name of ANM and Sub-centre= _____

SOCIAL MARKETING AND HOME DELIVERY OF CONTRACEPTIVES BY ASHAS AT DOORSTEP OF BENEFICIARIES

FORMAT – B

(To be filled-in by PHC Supervisor or equivalent at PHC level) [INFORMATION FOR ALL SUBCENTRES TO BE ADDED, USE FORMAT-A TO FILL UP THIS FORMAT]

DISTRICT: _____ BLOCK: _____ PHC: _____
 MONTH: _____ DATE OF SUBMISSION: _____

GENERAL INFORMATION:		Each month update these figures
Total Number of HSCs under PHC	=	Total Number of Eligible Couples under PHC (Last month) =
Number of HSCs submitted Reports in a current month	=	New Addition in ELCO Register =
Number of ASHAs under PHC Area	=	Any Deletion in ELCO Register =
Number of Villages under PHC Area	=	New Total of Eligible Couples under PHC =
Population Covered =		

Community based Distribution Status:	Number of Eligible Couples provided with Condoms	=
Sum of all HSCs Reports	Number of Eligible Couples provided with OCPs	=
	Number of Eligible Couples provided with ECPs	=

Stock Status <i>Sum of all HSCs</i>	Opening Balance at the start of month	Distributed in current month	Balance	Minimum Stock Required under Scheme	Total Supply Requirement for all ASHAs under PHC
1	2	3	4	5	6
CONDOMS(Packs)				78 packs	
OCPs (Cycles/strips)				10 cycles/strips	
ECPs (Cycles/strips)				10 pieces / packs	

SIGNATURE OF PHC SUPERVISOR = _____ NAME: _____

REMARKS/COMMENTS:

SOCIAL MARKETING AND HOME DELIVERY OF CONTRACEPTIVES BY ASHAs AT DOORSTEP OF BENEFICIARIES

FORMAT – B [CONSOLIDATED] (To be filled-in at Block PHC/CHC level)

DISTRICT: _____ BLOCK: _____ BLOCK PHC/CHC: _____
 MONTH: _____ DATE OF SUBMISSION: _____

GENERAL INFORMATION:		Each month update these figures	
Total Number of HSCs under PHC	=	Total Number of Eligible Couples under Block PHC (Last month)	=
Number of PHCs submitted Reports in a current month	=	New Addition in ELCO Register	=
Number of ASHAs under PHC	=	Any Deletion in ELCO Register	=
Number of Villages under PHC	=	New Total of Eligible Couples under Block PHC	=
Population Covered	=		

Community Based Distribution Status:	Number of Eligible Couples provided with Condoms	=
Sum of all PHC Reports	Number of Eligible Couples provided with OCPs	=
	Number of Eligible Couples provided with ECPs	=

Stock Status	Opening Balance at the start of month	Distributed in current month	Balance	Minimum Stock Required under Scheme	Total Supply Requirement for all ASHAs under PHC
Sum of all PHCs	2	3	4	5	6
CONDOMS (Packs)				78 packs	
OCPs (Cycles/strips)				10 cycles/strips	
ECPs (Cycles/strips)				10 pieces / packs	

Signature of PHC Supervisor: _____
 Name of PHC Supervisor = _____

REMARKS/COMMENTS:

**SOCIAL MARKETING AND HOME DELIVERY OF CONTRACEPTIVES BY ASHAS AT DOORSTEP OF BENEFICIARIES
FORMAT – C (TO BE FILLED-IN AT DISTRICT LEVEL)**

DISTRICT: _____ MONTH: _____ DATE OF SUBMISSION: _____

GENERAL INFORMATION:	
Total Number of Blocks under District	=
Number of Blocks submitted Reports in a current month	=
Number of ASHAs in the District	=
Number of Villages in the District	=
Population Covered	=
Total Number of Eligible Couples in District (Last month)	=
New Addition in ELCO Register	=
Any Deletion in ELCO Register	=
New Total of Eligible Couples in District	=

Distribution Status:	
Number of Eligible Couples provided with Condoms	=
Number of Eligible Couples provided with OCPs	=
Number of Eligible Couples provided with ECPs	=

Stock Status <i>Sum of all Block PHCs</i>	Opening Balance at the start of month	Distributed in current month	Balance	Minimum Stock Required under Scheme	Total Supply Requirement for all ASHAs under PHC
1	2	3	4	5	6
CONDOMS(Packs)				78 packs	
OCPs (Cycles/strips)				10 cycles/strips	
ECPs (Cycles/strips)				10 pieces / packs	

REMARKS/COMMENTS:

Signature of District ASHA Supervisor: _____
Name of District ASHA Supervisor= _____

PROPOSED PAGES FOR ASHA COPY/DIARY - TABLES

Month:

Name of ASHA =

S. No.	Name of Eligible Couple	Age (years)	Condom (Packs)	OCPs (Cycles/Strips)	ECPs (Pieces/Packs)	Date of Distribution
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

STOCK KEEPING DETAILS OF ASHA

Month:

Name of ASHA =

Date of Submission	Stock Status	1	Condom	OCPs	ECPs	Remarks/Comments
	Date of Receipt	1				
	Opening Balance <i>(At the start of month)</i>	2				
	Distributed in the current month	3				
	Balance	4				
	Minimum Stock Required under Scheme	5				
	SUPPLY REQUIREMENT FOR NEXT MONTH	6 = (5 - 4)				

