# ADVOCACY EXPANDS FAMILY PLANNING ACCESS IN INDIA

## ADVANCE FAMILY PLANNING INDIA REPORT

*May 2020*

Johns Hopkins Bloomberg School of Public Health | Bill & Melinda Gates Institute for Population and Reproductive Health | AFP Advance Family Planning

FRHS India Children by choice, not chance | jhpiego Johns Hopkins University Affiliate | Pathfinder International | PFI Population Foundation of India

# EXECUTIVE SUMMARY

In 2012, India set an ambitious goal to spend 10 billion Indian rupees (INR) – approximately US $2 billion – to ensure free family planning services and commodities for 200 million couples seeking contraceptive services. With this ambitious pledge, policymakers committed to move away from a population control approach towards a rights-based family planning program. Despite national level policies aimed at increasing access to quality family planning, many states struggle to implement these policies due to structural and cultural limitations. In this environment, advocacy is vital to transform policy into practice.[1]

The Advance Family Planning (AFP) India initiative has shown that strategic advocacy can address persistent barriers to policy implementation and realize national commitments at scale. Using a SMART advocacy approach, AFP's partners, in collaboration with the Government of India:

- **DROVE IMPLEMENTATION OF NATIONAL POLICY:** Forty-two districts across six states accelerated the implementation of national family planning policies.
- **IMPROVED QUALITY AND ACCESS:** Overall, advocacy led to the improvement of family planning services at 3,342 health facilities and expanded beyond AFP-supported geographies.
- **CREATED INNOVATIVE SOLUTIONS TO LOCAL CHALLENGES:** With local stakeholders at the fore, state and district advocacy working groups identified their own unique challenges and advanced innovative solutions. Local ownership allowed states and districts to implement national policies or pilot new strategies that met the needs of their localities.
- **BUILT EFFECTIVE PARTNERSHIPS WITH DIVERSE ACTORS:** Advocacy working groups provided a platform for collaboration across sectors on family planning. These diverse partnerships developed a broad base of support and accountability that will sustain the change achieved through advocacy.
- **SECURED FAMILY PLANNING FUNDING:** Advocacy unlocked resources to support the implementation of family planning policies and programs at the state and district level. In total, AFP mobilized 673.3 million INR ($9.8 million) through budget advocacy, including both government and corporate investment.

AFP empowered state and district advocacy working groups driven by local governments and advocates with the SMART advocacy approach. These working groups are agents of change for family planning in India and are well positioned to tackle the challenges that lay ahead. This is a critical moment for government, development partners, and donors to build on AFP's lessons learned, and scale-up advocacy successes in India and beyond.

## WHAT IS SMART?

**The AFP SMART (Specific, Measurable, Attainable, Relevant, Time-bound) approach helps advocates design, implement, and capture the results of an evidence-based, locally-driven advocacy strategy. The SMART advocacy approach helps family planning champions focus their energy and attention on opportunities for action that have the highest potential impact.**

*"Targeted and quality results can be achieved by adopting [the] 'AFP SMART' approach in family welfare programs."*

— Dr. Sitaram Verma, Deputy Family Welfare Officer, Baran District, Department of Health and Family Welfare, Government of Rajasthan, India

[1] "Family Planning 2020 India." Family Planning 2020. https://www.familyplanning2020.org/sites/default/files/Nigeria_FP2020_Commitment_2017.pdf.

# BACKGROUND

## Family Planning in India

In the early 1950s, India introduced the developing world's first centrally-funded national family planning program. Over the last seven decades, India's family planning efforts have gradually shifted from population control to birth spacing and the recognition of family planning as a human right. In 2012, India committed to providing family planning services to an additional 200 million couples by 2020 in its Family Planning 2020 India (FP2020) pledge. India revitalized its FP2020 commitment in 2017 and pledged to increase modern contraceptive usage through initiatives that included:

- **Expanding the range and reach of contraceptive options, especially injectables;**
- **Delivering quality-assured services to the hardest-to-reach areas;**
- **Expanding the role for the private sector in ensuring family planning services;**
- **Enabling young people to access sexual and reproductive health information and services; and**
- **Increasing domestic investment to $3 billion by 2020.**

In order to advance these ambitious family planning pledges and similar commitments made through the Sustainable Development Goals, India enacted several robust and forward-looking policies and initiatives. Despite these efforts, family planning remains out of reach for millions with the modern contraceptive prevalence rate among all women hovering at 54.4 percent in 2019. The unmet need for a modern method of contraception for women who are married/in-union is also holding at 18.9 percent[2]. Contraceptive choice is skewed towards sterilization, and the quality of available family planning services fluctuates. This is fueled by overarching challenges that plague India's health care sector, such as poor infrastructure, shortage of human resources, and limited access to health facilities in hard-to-reach areas. Quality family planning is exacerbated by two main factors:

### INCONSISTENT IMPLEMENTATION OF NATIONAL FAMILY PLANNING POLICIES AT THE STATE AND DISTRICT LEVEL

In India's decentralized health system, policies are established by the national government and districts are responsible for planning and implementation. There are many barriers that stand in the way of local implementation (e.g. lack of information, prioritization, funding). Additionally, a blanket approach to policy implementation has not worked because of the country's size and diversity across geographies. As a result, many districts have not operationalized key family planning policies that were instituted years ago.

### LOW EXPENDITURE RATES ON FAMILY PLANNING

India has allocated significant resources to family planning, but there are many competing priorities for these resources. Funds are often not allocated or spent in a timely manner. Further, district-level planning and budgeting focuses on supporting recurring costs projected from the previous year's budget and activities, which makes it challenging to incorporate new or innovative activities.

Within this context, strategic engagement with decision-makers–particularly at the district level–is tremendously important for the realization of national policies, including unlocking available resources.

[2] FP2020 2017-2018 Annual Progress Report. Accessed at: **https://www.familyplanning2020.org/sites/default/files/India%202018%20CI%20Handout.pdf**

# AFP's Evidence-Based Advocacy in India

The AFP India initiative launched in 2012. Over time, AFP collaborated with four organizations—the Foundation for Reproductive Health Services India, Jhpiego India, Pathfinder India, and Population Foundation of India—to implement the initiative. The four partners worked across six states and 42 districts to increase the momentum for family planning access at the national, state, and district levels; catalyze better implementation of existing policies at the state and district level; and secure new family planning policies in high impact areas in support of India's FP2020 goals.

Key elements of AFP partners' work in India included:

## SPEARHEADING ADVOCACY ON PRIORITY ISSUES

AFP partners used the AFP SMART approach to:

- Translate policy into action at the subnational level
- Incorporate a rights-based approach to family planning
- Ensure quality of care
- Increase access for adolescents and youth
- Involve the private sector in family planning
- Integrate family planning with other services

## FACILITATING SUSTAINABLE LOCAL ADVOCACY AND ACCOUNTABILITY THROUGH A WORKING GROUP MODEL

At the sub-national level, AFP partners supported a decentralized approach to advocacy that aligns with India's devolved health system. AFP partners facilitated the formation of advocacy working groups or engaged with similar existing bodies—referred to here as district working groups (DWGs) or state working groups (SWGs)—to identify and address local challenges to family planning. The working groups involved a wide range of stakeholders, including key district officials, representatives from the subdistrict level, frontline health workers, and representatives from NGOs. They were usually led by the main decision-maker at that level.

Importantly, AFP partners played a supporting role in the working groups. They provided training on and facilitated the AFP SMART approach to develop and implement strategic advocacy plans, build champions, and (at least initially) ensure that the groups met regularly. They did not provide funding (except to cover the initial meetings), set the agenda, or lead advocacy efforts.


## OUR REACH

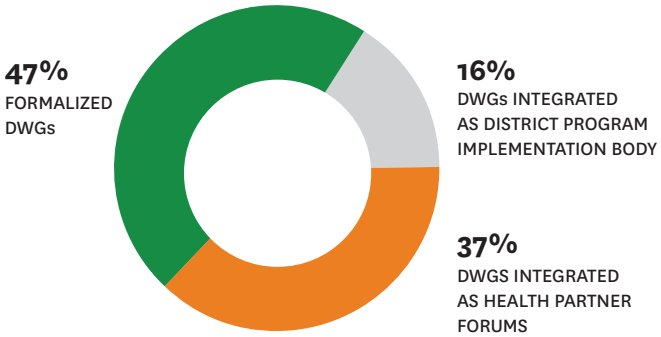
**Jhpiego:** Assam, Jharkhand, Maharashtra, Uttar Pradesh

**Pathfinder:** Rajasthan

**Population Foundation of India:** Bihar, Uttar Pradesh

**Foundation for Reproductive Health Services India:** Bihar, Rajasthan, Uttar Pradesh

**FIGURE 1:** MAJORITY OF WORKING GROUPS FORMALIZED AND/OR INCORPORATED INTO LOCAL GOVERNMENT BODIES




TOTAL DWGS: 42

Reflecting that these bodies are government-led and -owned, AFP-supported advocacy working groups were formalized within the public health system. Of the 42 local advocacy working groups formed in partnership with state governments since 2015, 53 percent were integrated with existing government institutions, such as district program implementation bodies or health partner forums (see Figure 1). DWGs and SWGs have served as an important platform to bring stakeholders and champions together and the SMART approach improved the efficacy of these platforms.

## STRENGTHENING INDIA'S COMMUNITY OF ADVOCATES

With the recognition that many voices on family planning are louder and stronger together, AFP partners played a key role in developing the capacity of non-governmental organizations (NGOs), civil society organizations (CSOs), and government officials on family planning advocacy through training on AFP SMART. To date, AFP partners conducted 93 SMART facilitations that trained more than 130 NGOs and CSOs and 793 government officials to use the SMART approach.

## ENGAGING THE PRIVATE SECTOR AS PARTNERS

AFP partners engaged this largely untapped sector to expand its support for family planning. In collaboration with the government, AFP partners expanded family planning resources through corporate social responsibility (CSR) funding and increased access to quality family planning services through private sector health providers.

## INTEGRATING SMART ADVOCACY WITHIN PARTNER ORGANIZATIONS

AFP's four partners have applied SMART beyond the AFP-supported work, across their programs and geographies in India, and globally through their international affiliates. Integrating advocacy as a mandate within each organization ensures it is applied to all new programs and projects and is adequately resourced.

*"AFP SMART is a good strategy to make our work easier... The best approach of the SMART tool was how we could identify the decision-maker and the way we can influence them. [The] DWG is important because it gives the platform where different types of leaders can share their ideas and experience and that can help [us] to do better work for communities."*

— Dr. Kailash Soni, Additional Chief Medical Health Officer, Family Welfare District, Sawaimadhopur, Department of Medical Health and Family Welfare, Government of Rajasthan, India

# ADVOCACY DELIVERS RESULTS

With the support of AFP partners, 42 districts across six states accelerated the implementation of family planning policies. In total, family planning services improved at 3,342 health facilities, which has led to increased access and improved quality. Notably, in some cases the government has already replicated these wins beyond AFP-supported geographies. There are opportunities to further scale up these wins, which has the potential to change the family planning landscape in India.

BY THE NUMBERS

**324** advocacy wins focusing on contraceptive information, services, and supplies, achieved together with government partners from 2014 to 2019, including:

**261** policy wins and **63** budget wins

**1,118** family planning counseling corners established in health facilities

**3,342** health facilities with new or improved family planning services

**$9.8 million** in funding mobilized for family planning through budget advocacy

**118.6 million** women of reproductive age potentially impacted by AFP-supported efforts in **42** districts across **6** states

The AFP India initiative achieved success by accelerating policy and programmatic change, creating innovative solutions to local challenges, building effective partnerships with a diverse set of partners, and securing family planning funding.

## Drive Implementation of National Policy

### OPERATIONALIZE FIXED DAY SERVICES TO IMPROVE QUALITY OF STERILIZATION

Female sterilization is the most widely prevalent method of modern contraception in India with 75 percent[3] of all contraceptive users utilizing the method. However, unmet need for limiting methods (including female sterilization) remains persistently high. A national policy on fixed day services (FDS)—the provision of a service on a designated day, every week, throughout the year—was introduced in 2008 as a mechanism to provide consistent, quality sterilization services for women. States have been slow to implement the policy, with many districts continuing to provide sterilizations through a "camp" approach, which compromises quality and restricts availability to October through March. In response, India's Supreme Court issued a directive in 2016 to discontinue these camps within three years, but many states did not implement FDS.

With AFP partner support, DWGs advocated with Bihar, Jharkhand, Rajasthan, and Uttar Pradesh to implement the national FDS directive. As a result, 135 facilities were improved to provide FDS. Many facilities offered the FDS sterilization for the first time and helped break the seasonal access to sterilization. Sterilization became more available and utilized as the quality of female sterilization services in public health facilities improved across these four states.

[3] International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS

## Advocacy Impact

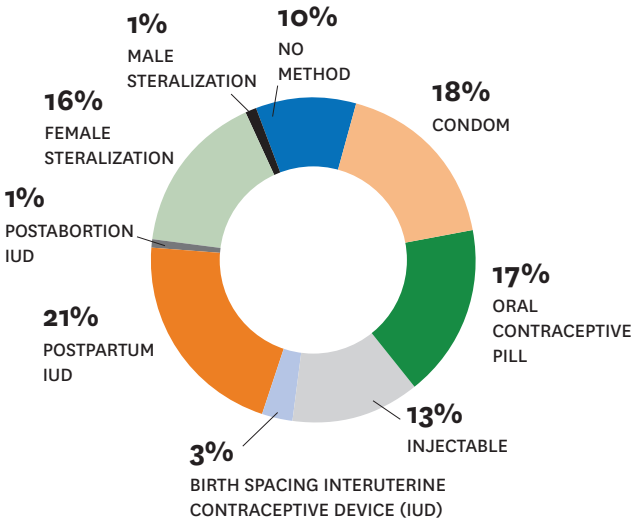
In 2017, following DWG advocacy from an AFP partner, four districts in Uttar Pradesh initiated a pilot in four facilities to test an appointment-based system to schedule sterilization procedures on fixed days. This enhancement allowed facilities to streamline procedures and maximize resources. Results showed that facilities managed and conducted fixed day services better than before and more clients availed services when pre-scheduled. This system allowed clients to get proper counseling, enabled facilities to be better prepared, and aided in breaking the seasonality cycle with consistent quality services throughout the year. In 2019, Uttar Pradesh government scaled up this new approach to fixed days across all districts and allocated an additional budget of 456,000 INR ($6,600) to support this effort.

### IMPROVE INFORMED CHOICE THROUGH FAMILY PLANNING COUNSELING CORNERS

Family planning counseling plays an important role in shaping contraceptive behavior. However, availability of counseling is limited by health care providers' lack of time and training and the absence of confidential meeting spaces. In response, the national government issued a policy in 2013 that mandated dedicated family planning counseling corners at public health facilities. The policy was not rolled out nationally due to limited personnel, infrastructure, and funding.

DWG advocacy supported districts in operationalizing the national policy through the establishment of 1,118 new counseling corners which led to increased uptake of contraception and improved method mix. Figure 2 shows the broad range of contraceptives selected by clients during counseling in Rajasthan. The wide range of contraceptives clients selected after receiving family planning counseling demonstrates users' interest in methods beyond sterilization.

FIGURE 2: CLIENTS SELECT A BROAD RANGE OF METHODS AFTER CONTRACEPTIVE COUNSELING




DATA SOURCE: COUNSELING REGISTERS FROM 52 COUNSELING CORNERS ACROSS 6 DISTRICTS IN RAJASTHAN. TOTAL CLIENTS COUNSELED (N) = 36,085

*"The DPIB meetings are very useful as we are able to discuss the problems we face at the implementation level ... In one of the meetings, we discussed how the quality of counseling was poor in our health facilities. Post discussion, we successfully established a counseling corner in some primary health centers/community health centers of Banswara district which provides privacy to the client being counseled. We have provided materials to the counselors, and we encourage them to use that while counseling clients."*

— Dr Pankaj, Additional Chief Medical and Health Officer, Sawai Madhopur District, Government of Rajasthan, India

### OPTIMIZE THE IMPACT OF FRONTLINE HEALTH WORKERS

Frontline health workers, such as accredited social health activists (ASHAs), form the closest link between rural clients and local health facilities. In recognition of the value of this cadre in providing family counseling, supplementing human resource gaps, and improving access to quality family planning, the Government of India introduced the "Ensuring Spacing at Birth" (ESB) scheme in 2012. Under ESB, ASHAs in 18 states are paid to counsel newly-married couples to wait at least two years after marriage to have their first child, and new parents to wait at least three years after the birth of their first child to have another.

In 2015, Maharashtra state first introduced ESB in nine high-priority districts, which excluded Pune. Pune's DWG identified this as a missed opportunity due to the state's higher than average unmet need for birth spacing. Following DWG advocacy, the state announced it would introduce ESB in all 34 districts. The expansion of the initiative to 55,000 eligible couples is projected to avert 93 child deaths, 13,000 unintended pregnancies, 6,100 abortions, and as a result of advocacy saved the state $574,286.[4]

**Advocacy Impact**

In early 2019, following advocacy by AFP partners, the Rajasthan state government issued a directive to establish private and confidential family planning counseling corners in all public health facilities across the state. Following the directive, an additional 1,974 family planning counseling corners (beyond the original 1,118 family planning counseling corners) were established between February and October 2019.

## Improve Access and Quality

### EXPAND CONTRACEPTIVE CHOICE THROUGH NEW AND EXISTING METHODS

One key focus of all DWG advocacy is to expand method mix by shifting from sterilization to other long acting methods such as IUDs and expanding choice with more methods like injectable contraceptives. DWGs knew facilities needed support beyond a simple directive to operationalize these services. DWG members played an active role in supplementing state support and advocated for multiple issues for each individual method – from training service providers to ensuring supply and infrastructure were in place. Table 1 shows increased availability and uptake of family planning services across all six states.

**TABLE 1: HEALTH FACILITIES WITH NEW OR IMPROVED CONTRACEPTIVE SERVICES**

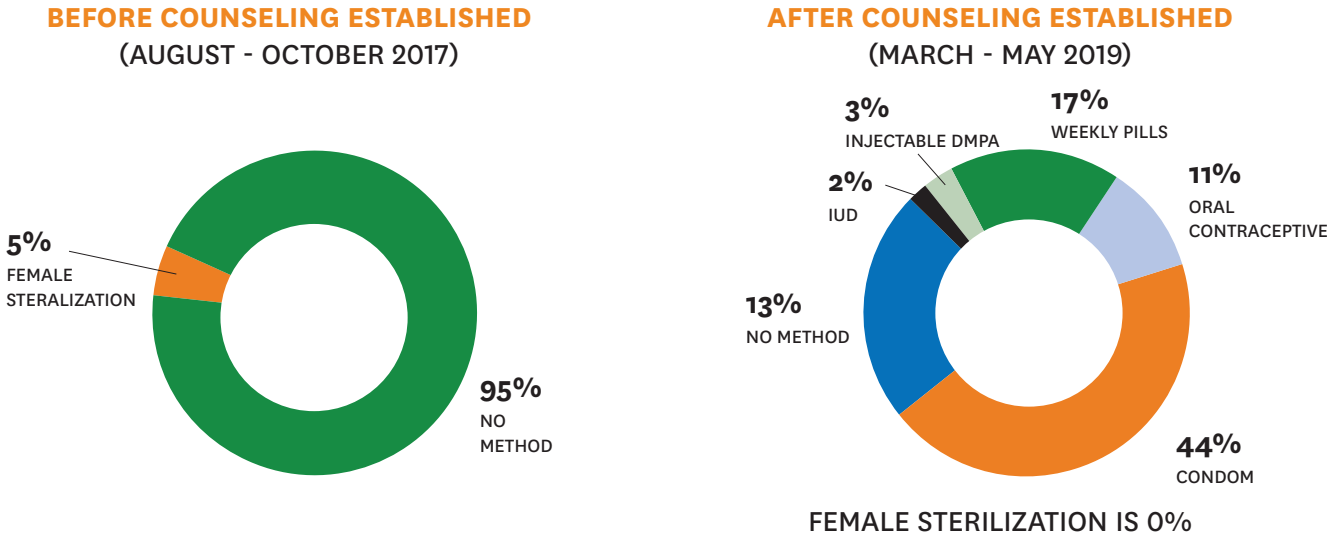
| | |
|---|---|
| Interval IUD | 416 |
| Post partum IUD | 149 |
| Post abortion family planning | 36 |
| Intramuscular DMPA | 1381 |
| Non-scalpel vasectomy | 16 |
| **TOTAL FACILITIES** | **1998** |

**Advocacy Impact**

In 2017, four districts in Uttar Pradesh (Bahraich, Basti, Gonda, and Sant Kabirnagar) offered only post abortion sterilization as a contraceptive method at all comprehensive abortion care facilities. After DWG advocacy, providers were sensitized and trained to provide all methods. As a result, post abortion clients' dramatically changed their intention to use family planning. Before DWG advocacy, only five percent of clients planned to use family planning and only one method (female sterilization) was considered. After the sensitization and training, 77 percent of clients used family planning and were interested in at least five different types of contraception.

[4] Weinberger M, Berdellima A, Stephens R, Hayes G, Munroe E.Impact2v5:An innovative tool for estimating the impact of reproductive health programmes—methodologypaper.London:MarieStopesInternational,2018.

**FIGURE 3: POST ABORTION FAMILY PLANNING IMPROVED CLIENTS' USE OF A WIDER RANGE OF METHODS IN FOUR DISTRICTS OF UTTAR PRADESH**




## INCREASE CLIENT FEEDBACK MECHANISMS TO IMPROVE QUALITY AND ACCOUNTABILITY

Quality of care emerged as a central organizing principle for family program managers and policymakers in India, with clients' experiences at the center of their focus. To improve social accountability and the inclusion of clients' perspectives on quality of care, a client feedback mechanism was introduced for the first time at 108 facilities for key family planning methods – DMPA-IM, IUD, and sterilization. DWG efforts also helped establish quality improvement circles, an accountability mechanism, in 44 sites across two states.

## INCREASE FAMILY PLANNING AVAILABILITY THROUGH PUBLIC-PRIVATE PARTNERSHIPS

While 69 percent of clients seek family planning methods at India's public sector facilities, these health centers suffer chronic shortages in trained surgeons, paramedics, equipment, and supplies.[5] Clinical Outreach Teams (COTs)—privately-run, fully-equipped mobile outreach teams—were designed to fill the gap by providing a range of high-quality family planning services in public facilities where health care coverage is poor. Yet, under national guidelines, private sector providers using the COT approach were reimbursed less than their actual costs for services, which was a disincentive for using the model.

## Advocacy Impact

**The DWGs in Uttar Pradesh's Basti, Behraich, Gonda and Santkabirnagar districts oriented key district level officials on conducting exit interviews for clients receiving permanent or spacing methods and supported the establishment of a review mechanism. Following advocacy by the DWG with the state, the strategy was piloted in one facility in each of the four districts. Over a period of four months, clients provided feedback on the services they received: 29 percent identified the need for better care by health workers and 17 percent identified shorter waiting times as key areas to increase the quality of sterilization services. Notably, nearly 80 percent identified waiting at least one hour between the time of admission and surgery as an important area for improvement. These findings were used by the facilities to improve services and by DWGs to guide future advocacy.**

[5] International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS.

As a result of AFP advocacy, the National Health Mission (NHM) issued a policy amendment that recognized private COTs as a distinct service delivery method. In 2017, the NHM public-private partnership policy, officially expanded the model nationwide, and increased the reimbursement rate for COT providers in high-focus states. In Bihar, Jharkhand, Rajasthan, and Uttar Pradesh, governments approved an additional 105.4 million INR ($1.6 million) to provide family planning services via this model in FY 2018-19.

This favorable policy environment and revised reimbursement paved the way for the expansion of private sector participation in family planning and unlocked access in hard to reach areas. After Rajasthan and Bihar adopted the COT model in 2018, 16 additional providers and an AFP partner initiated additional COT services in these two states. These additional services covered 262 facilities across 33 districts and served more than 83,000 clients (most of who live in extreme poverty or had been previously unable to access family planning services) from January to December of 2018. Modeling shows that these new providers averted nearly 50,000 unintended pregnancies, 41 maternal deaths, and 258 child deaths in 2018 alone.[6]

# Create Innovative Solutions to Local Challenges

## INNOVATE TO ADDRESS ACCESSIBILITY BARRIERS AT HEALTH CENTERS

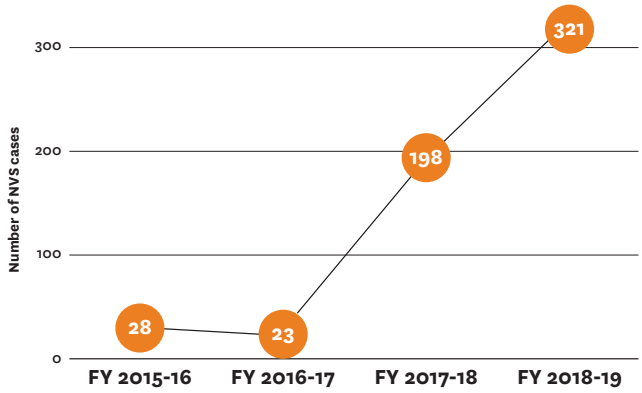
Locally-informed and -led advocacy provides the platform to hone in on the unique barriers to access in a context and then apply innovative approaches to tackling these issues. As state officials saw the success of AFP-driven policy change at the district level, many of them chose to replicate and scale up those changes statewide.

In May 2017, Rajasthan became the second state in India to introduce DMPA-IM, launching the method in 98 public health facilities in Bhilwara district and expanding to 33 other districts in July 2017. DWGs identified the critical need to support women to continue using the method after the first injection and piloted a web-based monitoring system for community health workers in Bhilwara district. More than 7,000 women received DMPA-IM and demonstrated high continuation rates. Since the system launched, 78 percent of users returned for the second injection and 56 percent returned for a third injection. The following year, the Rajasthan government expanded web-based monitoring to all 34 districts in the state.

## EXPANDED USE OF VASECTOMY

Male use of family planning remains a challenge in India, and the number of men opting for non-scalpel vasectomy (NSV) has remained low. Some DWGs identified this as a key issue and used the AFP SMART model to find creative solutions. In Rajasthan's Baran district, advocacy led to a multi-pronged strategy to increase use of NSV. Using its family planning budget, the district held an NSV awareness campaign including community-level sensitization meetings, the engagement of clients who had previously undergone NSV to share their experiences, and the development of NSV champions (medical officers and frontline workers) to motivate clients through informed choice. The district also strengthened the quality of service provision and ensured FDS for NSV at public facilities. Over the last three years, NSV uptake increased ten-fold in Baran, from 28 NSV cases in 2015-16 to 321 in 2018-19 (see Figure 4).

**FIGURE 4: NUMBER OF NSV CASES IN BARAN DISTRICT INCREASES 10-FOLD AFTER COMMUNITY AWARENESS CAMPAIGN BEGAN IN 2016**




DWGs have also worked directly with private sector companies to leverage their support. For instance, Uttar Pradesh's Firozabad district is an industrial district, where 95 percent of workers are men; most are daily wage workers. The DWG identified wage loss as a major barrier to men choosing NSV. They engaged with representatives of the Industrial Association, who agreed to establish a

[6] Weinberger, Michelle B, Kenzo Fry, Tania Boler, and Kristen Hopkins. "Estimating the Contribution of a Service Delivery Organization to the National Modern Contraceptive Prevalence Rate: Marie Stopes Internationals Impact 2 Model." BMC Public Health 13, no. Suppl 2 (2013). https://doi.org/10.1186/1471-2458-13-s2-s5.

policy that provides three days paid leave for workers taking up the sterilization service, making this the first district in country to establish such a policy. The estimated cost of the implementation of this policy to the Association was 4 million INR ($56,000), and the National Health Mission allocated a further 4.3 million INR ($60,000) for dissemination of information on the policy and promotion of demand generation in the area. Firozabad district recorded uptake of 32 NSV services in the first year, of which 56 percent were industrial workers.

### FACILITATE YOUNG PEOPLE'S ACCESS TO INFORMATION AND SERVICES

Half of India's population of 1.3 billion is below the age of 25,[7] yet young people's access to family planning services remains low due to socio-cultural beliefs and the stigma attached to sexual and reproductive health and rights (SRHR). In January 2014, India launched its National Adolescent Health Strategy to increase the access of 10 to 19-year-olds to SRHR information and services, mandating the establishment of adolescent-friendly health services in public health facilities. However, when offered at all, these services were often limited or not easily accessible to young people. Further, the focus age group of the strategy excluded young people aged 19 to 24.

To address this gap, an AFP partner engaged with the Uttar Pradesh government to extend SRHR services beyond public health facilities and closer to young people in colleges. As a result, the State Innovations in Family Planning Services Project Agency approved a proposal to establish youth centers in 40 colleges across Uttar Pradesh, which included a budget of 14.8 million INR ($207,500) and an operational plan for all 18 divisions in the state. Forty centers—designed to reach young people (married and unmarried) aged 16 to 23—are now open. Approximately 80,000 students will benefit from these services.

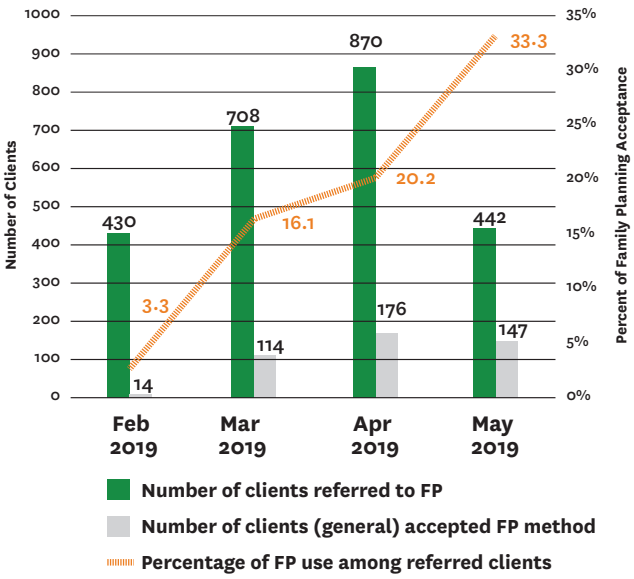
## Leverage Opportunities to Bring Diverse Partners to the Table

### INTEGRATE FAMILY PLANNING IN HEALTH SERVICES AND BEYOND

The far-reaching impact of family planning on gender equality, women's empowerment, maternal and child health, and economic growth makes a strong case for collaboration with government sectors beyond health. DWGs provide a platform for the active participation of health and other government departments on family planning. Key multi-sectoral wins include:

- Integration of family planning services into HIV and maternal, newborn, and child health programs. In Maharashtra, counseling on IUDs and DMPA-IM was included in immunization and antenatal care (ANC) days and at integrated counseling and testing centers for HIV at 12 facilities in Ahmednagar and Pune districts. Many HIV clients accepted family planning methods – e.g. of the 5,880 clients counseled on family planning at these 12 facilities between February and May 2019, 2,450 (41 percent) were referred for family planning services. Of these, 18 percent accepted family planning on the same day, as illustrated in Figure 5.

**FIGURE 5:** A THIRD OF HIV CLIENTS USED FAMILY PLANNING SERVICES AFTER RECEIVING CONTRACEPTIVE COUNSELING




[7] United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, custom data acquired via website.

- Allocation of 242 million INR ($3.4 million) by the State Health Society of Bihar in February 2019 for a network of self-help groups to reach communities with family planning information and referrals for services.

- Promotion of family planning messages with a focus on male engagement by leveraging free television airtime and newspaper ads through the information and broadcast department in Agra district, Uttar Pradesh. The promotions had an estimated value of 660,000 INR ($9,600).

- Provision of training by the Food and Public Distribution Department for its 90 ration shopkeepers (called kotedars), who distribute food and goods as part of the government's subsidized food program. In Sitapur, Uttar Pradesh, this training included key family planning messages, particularly on male engagement. The effort successfully led to uptake of NSV. Of the 42 NSVs reported in Sitapur in 2018-19, 22 were mobilized by the trained kotedars.

> ***"The collective forces of government agencies and corporates can be [channeled] for the greater common good, including ensuring reproductive rights of women."***
>
> — **Mr. Naveen Jain, Ex. Secretary & Mission Director, National Health Mission, Department of Health and Family Welfare, Government of Rajasthan, India**

# Secure Family Planning Funding

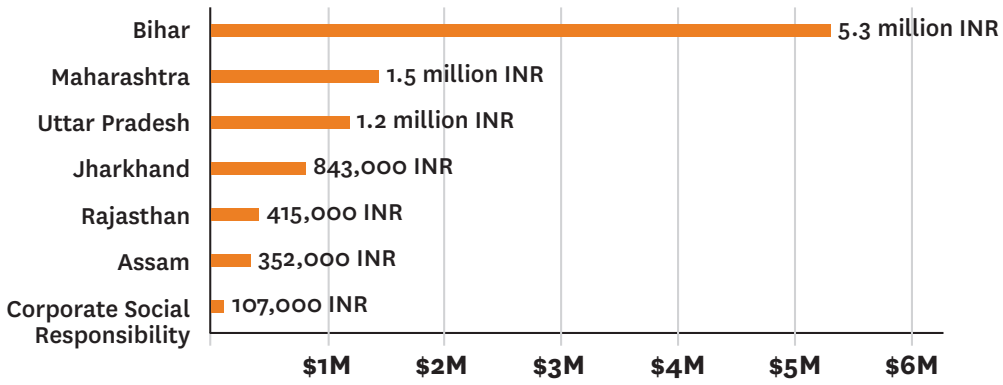
## INCREASED DOMESTIC RESOURCES FOR POLICY IMPLEMENTATION

While India has shown global leadership in making ambitious funding pledges to family planning, it has not been enough to support the fulfillment of its FP2020 goals. Social sector spending, particularly on health, remains low, and national programs (such as the Reproductive and Child Health component of the National Health Mission) recently cut funding for family planning.[8] Lack of dedicated funding continues to be one of the key obstacles to the implementation of family planning policies at the local level.

Notably, the focus of advocacy in India was not on mobilizing funding but on expenditure. Thus, the translation of policies into practice and innovations by the DWGs led to increased domestic funds, which ranged from smaller allocations (e.g. $7,900 to address the needs of 11 health facilities in Uttar Pradesh to establish fixed day services) to much larger investments (e.g. $1.6 million for COTs in Bihar, Jharkhand, Rajasthan, and Uttar Pradesh). In total, 673.3 million INR ($9.77 million) in domestic resources was leveraged over the last five years (see Figure 6).

**FIGURE 6: FUNDING MOBILIZED FOR FAMILY PLANNING, 2012-2019**

**TOTAL 673.3 MILLION INR ($9.77 MILLION)**




[8] Accountability Initiative-Interim Budget 2019 Key Social Sector Allocations https://accountabilityindia.in/wp-content/uploads/2019/03/stats-1.pdf

## EXPANDED PRIVATE SECTOR INVESTMENT THROUGH CORPORATE SOCIAL RESPONSIBILITY

India has recognized the need to scale up the role of the private sector. The Companies Act of 2013 instituted CSR as a legal mandate. Corporations are required to donate 2 percent of their net profit to charity, which provided an opportunity for AFP partners to engage private companies in committing resources to family planning through CSR. As a result, seven corporations and foundations invested in improving access to quality family planning counseling and services.

- Ambuja Cement Limited incorporated family planning into its CSR program and allocated 38,800 INR ($581) over three years to deliver family planning techniques and training to 23 staff, thereby reaching 11,500 people.

- Mylan Pharmaceuticals Ltd. donated 4.6 million INR ($68,000) worth of DMPA-IM kits and 200,000 INR ($3,000) for the training of service providers in Rajasthan.

- Transport Corporation of India added family planning into their CSR policy as a component of family health care in 2017.

- Jindal Stainless Ltd. Invested 947,000 INR ($14,000) as a CSR allocation for family planning counseling in Hisar, Haryana.

- Spark Minda committed 1.1 million INR ($17,000) per year until 2020 to sensitize 3,000 women and men in the rural areas of four states on family planning, reproductive health, and menstrual hygiene.

In total, companies committed 7 million INR ($106,000) to family planning through CSR, directly or indirectly providing access to family planning counseling and commodities. The inclusion of family planning at the policy level in these companies will mean continued funding for years to come.

## Advocacy Impact

In the lead up to the 2017 Family Planning Summit in London, an AFP partner engaged with several Indian corporations and encouraged them to make CSR commitments to FP2020. Spark Minda, a leading manufacturer of automobile components agreed to incorporate family planning into its CSR efforts for the first time and time to provide family planning sensitization workshops for 1,000 community members in four states. The company's expanded FP2020 commitment to reach 3,000 people recognizes that family planning is a significant contributor to women's empowerment and socio-economic development. The attention received following Spark Minda's global announcement at the London Summit may inspire other Indian corporations to adopt family planning into their CSR programs.

# LOOKING AHEAD: SHIFTING THE LANDSCAPE THROUGH ADVOCACY

## Priority Advocacy Issues

Despite the success highlighted in this report, India has yet to realize its Family Planning 2020 (FP2020) and Sustainable Development Goals 2030 (SDG 2030) goals. Advocacy will be critical for catalyzing further progress to:

- **MAINTAIN THE MOMENTUM FOR FAMILY PLANNING AT THE NATIONAL LEVEL:** The government is increasingly focused on a variety of development issues and has launched many new programs. Strong advocacy is required to ensure that family planning remains on the agenda amid different priorities and to support the implementation of new family planning policies and programs.

- **TRANSLATE POLICY INTO ACTION:** Until subnational units implement the country's policies and strategies, India will not achieve its goals or objectives at any level. India's varied geographies, socio-cultural beliefs, and health system issues are critical factors that challenge policy implementation.

- **SHIFT THE NARRATIVE:** Despite the evolution of the country's policies to reflect a rights-based approach to family planning, the legacy of population control still lingers today. Advocacy is required to ensure that rights-based family planning remains the organizing framework for family planning.

- **ENSURE QUALITY OF CARE:** Advocacy achieved important, incremental improvements to quality of care. Consistent advocacy is needed to ensure that every person's right to quality health services is fulfilled.

- **INCREASE ACCESS FOR ADOLESCENTS AND YOUTH:** To meet India's commitments to the FP2020 and SDG 2030, specific strategies targeted at increasing family planning access for adolescents and youth are needed. SMART advocacy supports targeted policy implementation to remove barriers that prevent young people from accessing family planning.

- **INVOLVE THE PRIVATE SECTOR IN FAMILY PLANNING:** The potential for private sector impact on family planning is largely untapped. Advocacy to unlock resources through CSR is a priority, as is engagement with the government to incentivize private provision of quality, affordable services in marginalized areas.

- **INTEGRATE FAMILY PLANNING WITH OTHER SERVICES:** Integration with other health and social services can expand coverage and address the gaps in service delivery. For instance, advocacy to integrate family planning counseling services with antenatal care and immunization days can reach more clients with critical information, commodities, and services.

# Recommendations for Scaling-Up Advocacy in India and Beyond

## GOVERNMENT

1. Continue to prioritize family planning within health and development, with a focus on the realization of India's FP2020 and SDG 2030 commitments.
2. Maximize the impact of Advance Family Planning-supported advances by:
    - Scale up funding and policy changes achieved by advocacy working groups across geographies.
    - Incorporate the use of AFP SMART in all convergence mechanisms—those working on family planning as well as those working on other health issues—to maximize impact and sustainability of this important government strategy.
3. Involve a variety of government departments regularly in finding solutions for persistent barriers to family planning access and quality.
4. Identify new partnerships, especially with the private sector, that can help the public sector better meet the current demand for quality family planning services.
5. Prioritize strategies that increase access and quality of youth-focused family planning services.

## DEVELOPMENT PARTNERS

1. Develop the institutional capacity to engage in strategic, evidence-based advocacy within all health and development projects and programs, including family planning, wherever possible.
2. Increase advocacy impact by strengthening collaboration with like-minded organizations and community groups.
3. Increase dialogue between donors and state/district governments to enable a mutual understanding of priorities and possibilities.

## DONORS

1. Dedicate funds to build and sustain the capacity of grantees to engage in advocacy within family planning projects and in other health and development areas.
2. Support subnational advocacy on policy implementation as a critical next step for the translation of policy into action.
3. Encourage donors and the private sector to increase advocacy investments.

### ABOUT US

Advance Family Planning is an initiative of the Bill & Melinda Gates Institute for Population and Reproductive Health within the Department of Population, Family and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health. It is supported by the Bill & Melinda Gates Foundation, The David and Lucile Packard Foundation, and the William and Flora Hewlett Foundation. The AFP initiative was implemented by four organizations working in partnership with the Government of India: Foundation for Reproductive Health Services – India, Jhpiego, Pathfinder, and Population Foundation of India.

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