PROGRESS IN FAMILY PLANNING

RESEARCH BRIEF

Delivering Family Planning Information and Services through a Microfinance Program: Lessons from Uttar Pradesh, India

Objective

To assess whether the provision of information on family planning (FP) and referrals to local service providers is associated with a meaningful increase in FP use among members of a non-governmental microfinance program in rural Uttar Pradesh, India.

Methods

FHI 360/PROGRESS in collaboration with the Network of Entrepreneurship and Economic Development (NEED) and the Institute for Reproductive Health (IRH) trained and supported 35 Village Health Guides (VHGs) to deliver basic FP information to members of self-help/joint-liability groups (SHG/JLG) and others in 70 villages of Sitapur District, Uttar Pradesh. The VHGs received one week of training in 2011, along with job aids and a guide to compiling a village-specific referral directory for services. Over the next 9 months, the VHGs led discussions on FP as part of the regular SHG/JLG meetings held in public places, made home visits to discuss these topics one-on-one when requested, and made referrals to local FP service providers. IRH and NEED district coordinators provided monthly supervision and technical assistance.

A cohort of 800 women who were members of the SHG/JLGs was formed and interviewed before the intervention and again about 15 months later to document changes in awareness of FP methods, actual FP use, any reductions in unmet need, and degree of acceptability of the intervention. The project also assessed the feasibility of the intervention, estimated the cost of scaling up the intervention within NEED's program, and developed guidance for replication of this approach in similar contexts.

Findings

- Within the cohort, FP use for all methods increased significantly from 40% at baseline to 69% at endline, with a majority of new users reporting using rhythm/periodic abstinence.
- During the intervention, the unmet need for FP declined sharply from 42% to 12%.
- At endline, the main reasons cited by those not using FP were currently breastfeeding and no menses (29%), wants to get pregnant (25%), and currently pregnant (21%). These women are potential future users of FP services.
- The SHG/JLG members in the cohort reported attending 7 out of 12 group sessions; 83% talked to the VHG about the potential benefits of FP use during a home visit and found the information important (89%) and easy to understand (90%).
- The 35 VHGs held 965 group sessions in 70 villages and made 15,939 home visits to discuss FP over 7 months, providing repeated exposure and easy access to information.

Conclusion

Adding FP information to existing health information activities of a microfinance organization increased uptake of modern FP methods and reduced unmet need dramatically among the cohort observed. Semi-literate health workers successfully delivered the FP information after one week of training and with on-going support. Building upon an existing cadre of health workers within NEED who already were seen as trusted information sources by the members of the SHG/JLGs was a key part of the intervention. In areas with high unmet need for FP services in particular, interventions linking FP to other development programs may provide an important complement to existing mass communication approaches to raise awareness of the potential benefits to couples and families associated with FP use.

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A trained Village Health Guide leads a discussion on family planning.

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N·E·E·D नीड Putting Poor People First (PPPF)

Institute for Reproductive Health Georgetown University

Background

Globally, many women have an unmet need for family planning (FP). Approximately 1 in every 5 married women worldwide wants to avoid pregnancy but is not using an effective means of FP. In Uttar Pradesh, the largest state in India with 200 million people, modern contraceptive prevalence among married women increased from 21% in 1998-99 to 29% in 2005-2006. Despite these gains, unmet need for FP remains high at 21% indicating that about 1 in 5 currently married women in Uttar Pradesh could benefit from accessing FP services.[1]

A further challenge to expanding contraceptive prevalence is a discontinuation rate of 36% within the first year of use among FP users in Uttar Pradesh.[1] This adds to the burden of unmet need if women do not switch to an alternative effective method of FP. Efforts to improve the quality of FP information available to those with unmet need as well as reinforcing decisions to use FP among new acceptors has the potential to maintain gains in FP acceptance and reduce unmet need.

Microfinance programs have responded to the needs of women by granting loans either exclusively to women or by giving preference to women borrowers. These women are most commonly in their reproductive years. However, morbidity and mortality associated with child-bearing and early childhood diseases can place a significant drain on household resources. At the population level, the use of FP services has been associated with reduced maternal morbidity and mortality and reduced infant and child mortality.[2] In addition, population-level fertility declines are associated with increased earnings by women and higher rates of paid labor-force participation. At the household level, children of women who access FP services are healthier and better educated than children from households without access to FP services.[3] Unanticipated health expenses have been cited by clients and creditors as a cause for loan defaults.[4] This suggests that improving access to FP services among clients of microfinance programs could be a useful complement to the opportunity for improving financial status that microfinance programs offer their clients.

The social nature of microfinance meetings can support behavior change. Since microfinance groups meet regularly, trust in group leaders builds, and messages can be integrated and reinforced over time. Research has shown that women who are able to meet regularly and discuss their FP experiences are more likely to continue using a method than those without a similar network.[5] Given the reach of microfinance in the lives of women who are motivated to improve their socio-economic standing and the unmet need for modern contraception, microfinance programs provide a safe and secure environment to reach women with FP information.

Prior studies of the impact on contraceptive use of adding FP messages or linkages to services to microcredit programs have shown mixed results. Studies from Indonesia and Bangladesh[5, 6, 7] suggest a positive impact on contraceptive use, while other programs in Ethiopia, Bolivia, and Bangladesh[8, 9, 10] have shown little to no measurable effect. The unsuccessful reports from Bolivia and Ethiopia thought the problem was due to a mismatch between the methods offered through the agent and the methods that are most popular with the users in the country.

The primary objective of this study was to assess whether the provision of FP messages was associated with a meaningful increase in FP use among members of a non-governmental microfinance program in rural Uttar Pradesh. The messages focused on the potential benefits of FP use, the various options for realizing fertility intentions, and how to discuss FP options with a partner.

Specific objectives of the study were to:

1) Measure the net increase in FP use among self-help groups* or joint liability groups† (SHG/JLG) members whose Village Health Guides (VHGs) and support persons receive training in delivering FP information and linking to services.

2) Measure unmet need for FP services among SHG/JLG members prior to and subsequent to the VHG delivered information campaign.

Secondary objectives of the study were to:

3) Test the feasibility of training VHGs serving SHG/JLGs to deliver FP information and provide linkages to FP services as a regular part of their interaction with clients.

4) Estimate the costs of scaling up the intervention within the implementing partner and provide budgetary guidance for replication of this approach in similar contexts.

Study Design

This was a pretest-posttest cohort design study of women 18 to 35 years old who are voluntary members of SHG/JLG supported by the study implementing partner, Network of Entrepreneurship & Economic Development (NEED), and who attend bi-weekly information meetings with a NEED employed VHG. These VHGs were trained by the Institute for Reproductive Health (IRH) to deliver a series of information sessions highlighting the potential benefits of FP use, how to decide on appropriate method, and how to discuss FP with the women's partner. The training materials were developed and field tested by FHI 360 and IRH.

The information sessions were designed to be delivered over a period of 9 months; each month had a designated theme such as the benefits of FP or details on a particular FP method available in India. The VHGs were provided with a pictorial flip-book with simple graphics for each theme, a job aid with key messages for each theme summarized, a CHETNA apron‡ to assist in discussion of reproductive anatomy and how fertilization occurs or how a

* A self-help group (SHG) is a village-based financial intermediary usually composed of between 10-15 local women. It is a registered or unregistered group of micro-entrepreneurs having homogenous social and economic backgrounds. They voluntarily come together to save regular small sums of money, mutually agreeing to contribute to a common fund and to meet their emergency needs on the basis of mutual help. The group members use collective wisdom and peer pressure to ensure proper end-use of credit and timely repayment. This system eliminates the need for collateral and is closely related to that of solidarity lending, widely used by micro-finance institutions.

† A joint liability group (JLG) is an informal group of 4-10 individuals, about 80% women, coming together for the purposes of availing bank loans either singly or through the group mechanism against a mutual guarantee. Each member accepts the responsibility for repayment of every loan provided to remaining members. Activities of JLGs include a diverse profile of livelihoods and micro-enterprises.

‡ The Centre for Health, Education Training and Nutrition Awareness (CHETNA) is a non-governmental organization based in Gujarat, India. Among its many projects, it produces aprons that have graphics of the reproductive health system and related health issues.

Information Sessions – Key Themes

The VHGs ended each meeting with clients by stressing three key themes:

1. FP can benefit the couple and family.
2. Different couples have different FP goals.
3. There are options for each FP goal.

This approach was designed to reinforce the idea that FP use should be a conscious decision by couples.

FP method works, and a solar lamp to provide light in dimly lit settings as needed. In addition to these communication aids, each VHG was asked to maintain a referral directory for each of the two villages she supported. This directory included a list of FP providers, methods available, location, cost of service, and hours of availability. This allowed the VHG to discuss service delivery options with SHG/JLG members seeking to access FP services. In addition, local health workers known as ASHAs were invited to attend the information sessions to answer questions or follow-up with service provision among those attendees requesting services. In this way, the activities of the VHGs complemented the existing programs of the government rather than replaced them.

The study used a non-experimental pre-test-posttest design (with no control group) for the following reasons: 1) training only a subset of the VHGs to deliver FP messages would create equity concerns within the implementing partner (NEED), and 2) asking the VHG to turn-on/off the FP messaging between an intervention and a control group would be expected to lead to contamination as some information would likely spill-over into control groups served by trained VHGs. The main advantage of including a control group would be to protect against external threats to validity such as some other intervention that changes the demand for FP within the villages served by the VHGs. Considering the short timeline for the study, the data that about 40% of the women are not being exposed to media, and the general somnolent state of the FP program in rural UP, the need to protect against this threat with a control group was felt to be minimal and offset by the potential benefit of reaching more women with unmet need for FP services with information and services that can help protect them from unintended pregnancies.

Data Collection and Analysis

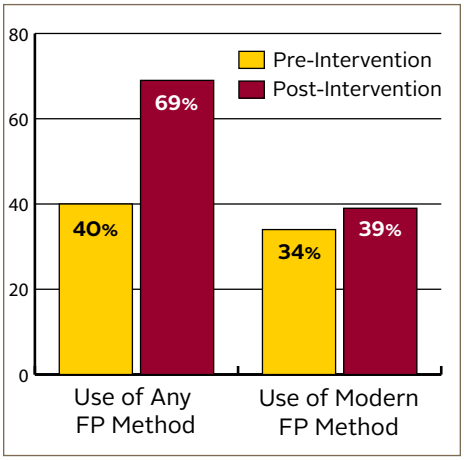
A baseline interview with 800 SHG/JLG members 18 to 35 years old took place 3 months prior to the introduction of the information sessions (June to July 2011). Thematic areas within the baseline interview included: demographics, reproductive history and fertility desires, family planning use, future family planning intentions, and household characteristics. In addition to the interviews with SHG/JLG members, the VHGs submitted monthly reports on their activities noting sessions conducted, questions raised, home visits made, and any referrals to FP services. The district coordinators and IRH also submitted monthly reports on their supportive supervision and refresher sessions, which they held with VHGs to review key messages for each monthly topic and clarify technical points. Because approximately one-half of VHGs were illiterate, the monthly refresher sessions by the district coordinators were an important complement to the job aids provided to the VHGs during training and provided an opportunity to rehearse message delivery prior to the SHG/JLG meetings.

Of the 800 women recruited at baseline, 676 were interviewed at endline 3.5 months after completion of the last information session (Oct. to Nov. 2012). (The un-interviewed 124 returned to maternal village, left the area, or were unwilling to participate). Forty-eight endline interviews were excluded from analysis due to inconsistent reporting of FP method use or inability to match on identifying variables. This yields an analytic cohort of 628 women with both baseline and endline data.

Net Increase in Family Planning Use

Figure 1 shows a dramatic increase from 40% to 69% of women reporting any FP use from baseline to endline ($p<.001$) – a 29 percentage point increase. Restricting the analysis to use of modern FP methods only still results in a statistically significant ($p<.001$) increase in FP use, but the change is a more modest 5 percentage points (34% to 39%). The difference here is due to the fact that about 45% of the 192 new FP users reported they used periodic abstinence/rhythm as their current FP method of choice, which is not considered a modern method in this calculation. Focusing on modern method use protects against the risk of women reporting rhythm/periodic abstinence at endline being counted as a new user when in fact they have not changed behavior but have learned a term

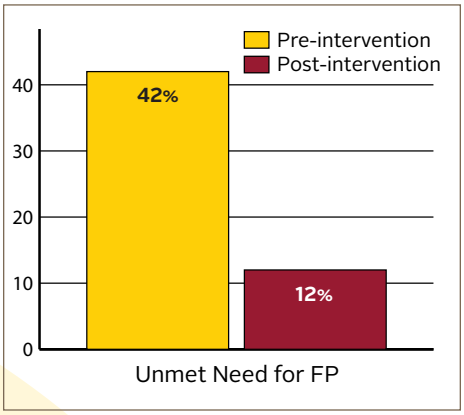
Figure 1: Change in Percentage of Women in Cohort Reporting FP Use



associated with what they were practicing all along. Within modern methods, female sterilization is the dominant method of choice followed by condoms, which is consistent with FP use across all of India.

Figure 2 shows the reduction in unmet need from baseline to endline. Notably, at baseline the percent of women with an unmet need for FP in this cohort was 42%, double the 21% unmet need for all of Uttar Pradesh. At endline, the unmet need in the cohort fell all the way to 12%, to almost half of statewide figure.

Figure 2: Change in Percentage of Women in Cohort Indicating Unmet Need for FP Services



Feasibility of Intervention

The feasibility of the intervention is assessed along three dimensions: accessible, acceptable, and relevance. In terms of the accessibility of the information campaign, on average, SHG/JLG cohort members report attending 7 out of 12 group sessions and 82% reported talking to the VHG about benefits of FP during home visits. VHGs reported delivering 965 group sessions in 70 villages over a 7-month period and reaching on average 9 SHG/JLG members

and 7 non-members during a group session. In addition they report making 15,939 home visits to discuss FP over the 7-month period.

In terms of acceptability, 89% of cohort members reported the FP information was important and 90% reported it was easy to understand. The VHGs reported it was hard to reach newly married women through the group talks, but they were successful in reaching them through home visits. They also noted the importance of the refresher sessions in making them comfortable and confident to conduct the group meeting in the villages.

Finally, with respect to relevance, almost half (49%) of cohort members indicated that the information from the VHG made them think about starting or changing their FP use. Of the non-users at baseline, 65% were interested in using FP after receiving information from the VHG. Overall 75% were interested in discussing FP use with VHG; more than half (55%) asked the VHG about how to access FP services, and 43% reported actually receiving help from the VHG to access services. The VHGs reported receiving 501 requests for referrals to FP services across the 70 villages in the 7-month period. The development of the referral directory was noted as an important activity to introduce the VHGs to service providers and helped them respond to the requests for referrals from SHG/JLG members as well as from other villagers.

Estimated Cost of Scaling-Up/ Replication

In order to continue providing the existing service and also expand the intervention to an additional 35 VHGs within NEED it is estimated that an additional $14,200 would be required for the next year. The details of this estimate are described below:

Activity/Resource	Estimated Cost
Training of Another 35 VHGs and 2 District Coordinators	
Residential 5-day Workshop	9,300
Printed Job Aids, Flipbooks, etc.	2,000
Chetna Aprons/Solar Lamps	1,600
Subtotal	$12,900
On-going Operational Support	
Supervision & Refresher Sessions (per annum)	$1,300
Total	**$14,200**

For other organizations interested in replicating/adapting this approach copies of the training manuals, job aids, and flip charts are available in English and Hindi for download at http://www.fhi360.org/projects/progress-india-partnership-microfinance-organization. In terms of planning a budget to support this approach, an organization needs to assess the number of field workers to be trained, any transport and per diems required during the training, the venue for the training, associated meeting package fees, and the cost of materials to be provided during the training. Post-training, the program needs to think about any additional resources required to support the intervention such as additional supportive supervision visits and refresher sessions (especially if field workers are semi-literate or new to FP).

Conclusions and Recommendations

The results from this study have shown that adding an FP information campaign to a microfinance program is feasible and can be successful. The intervention resulted in a dramatic increase in FP use and reduced unmet need for FP services. This response indicates that the SHG/JLG members are receptive to the idea of fertility regulation and willing to act upon the simple messages delivered by the VHGs. By taking advantage of the existing SHG/JLG structure, the intervention was able to reach people who are motivated to make positive changes in their lives and to reinforce basic messages about how FP use can impact lives and families. The semi-literate VHGs were able to deliver these simple messages and make referrals to the existing service providers. Through the referrals, this intervention complemented investments made in service delivery programs.

Going forward, some questions do arise. How can this approach be used to help the users of periodic abstinence/rhythm transition to more effective modern FP methods? Because the VHGs are now seen as a trusted source for FP information and assistance in accessing FP service providers, they may be able to invite FP service providers to specifically discuss method effectiveness and relative pros and cons of different methods to the group talks or to household visits among those ready to consider switching to a more effective modern method. Such interpersonal communication will serve as an important complement to future mass media campaigns and any outreach efforts taking place at the village level.

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