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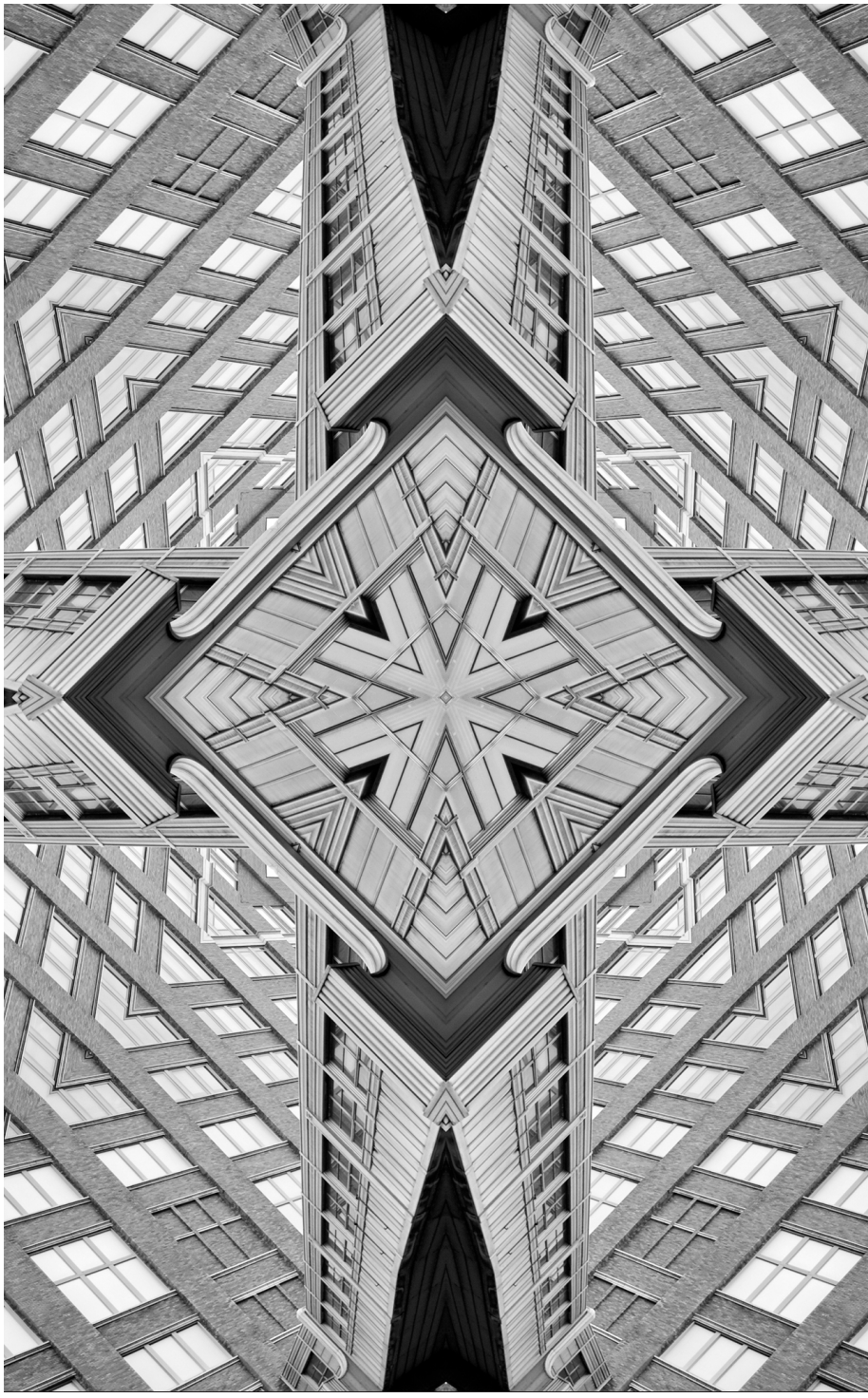

Localisation: A Model Strategy for Family Planning and Maternal and Newborn Healthcare in India

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Abstract

Adapting health interventions to the social, economic, political, ecological, and cultural contexts of local communities increases trust and acceptability for policies and programmes. Locally led initiatives entrust local stakeholders with providing insights into grassroots-level realities and community-sensitive approaches. Global and country-wide evidence also highlights that granting authority and accountability to local stakeholders improves the performance of health indicators and builds acceptability for sensitive issues related to family planning (FP) and maternal and newborn health (MNH). This brief examines the potential of local solutions and the role of localisation in improving FP and MNH outcomes in India.

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Setting the Context

Goal 3.1 of the Sustainable Development Goals (SDGs) aims to reduce the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births and neonatal mortality rate (NMR) to below 12 per 1,000 live births. Despite progress achieved in the last two decades, India still has a long way to go to achieve the global targets, with latest statistics reflecting an MMR of 97 (2018-20) and an NMR of 20 (2018-20).[1,2]

To ensure an accelerated pace of growth, there is a need to adopt a life-cycle approach to women's health. Evidence from existing literature[3] suggests that, more than access, the quality of services, especially postnatal care, needs to be prioritised in order to improve maternal and newborn health services in the country. Additionally, the need for human resources in this space needs to be addressed; India currently has 1.7 nurses per 1,000 people, compared to the World Health Organization's (WHO) norm of three nurses per 1,000 people. The low nurse-patient ratio results in increased workload, long working hours, multiple shifts, and other factors that contribute to poor treatment quality.[4]

According to the National Family Health Survey-5 (NFHS-5), 50 percent of households in India do not generally seek healthcare from the public sector. The most commonly reported reason for not using government health facilities at the national level is the poor quality of care. Nearly one-third (31 percent) of women report concerns that no female health provider is available, and 39 percent report that no provider is available at all.[5]

About 40-45 percent of maternal deaths in India occur in the first 24 hours after delivery.[6] For both the mother and the infant, prompt postnatal care is important to treat complications that could arise from delivery. It is also necessary to provide the mother with important information on caring for herself and her newborn. According to NFHS-5,[7] 61 percent of mothers had a postnatal check within two days after giving birth, whereas 16 percent did not receive any. Mothers were most likely to receive a postnatal check within two days of delivery in Goa (95 percent) and the least likely in Nagaland (48 percent).

Another important factor intrinsically linked with the quality of maternal health is ensuring that the family planning needs of women are met. The unmet need for family planning methods is highest in Meghalaya (27 percent) and lowest in Andhra Pradesh (5 percent). Studies have found a direct correlation between

increased contraceptive prevalence rate and reduced maternal mortality[8] and the complications of pregnancy and childbirth. India has witnessed increased uptake of modern contraceptives, which stands at 56.5 percent today (NFHS-5), compared to other low- and middle-income countries (LMICs) such as Uganda where the proportion is at 28 percent.[9] There is, however, considerable unmet need in certain regions; indeed, there is a significant variation in the use of modern contraceptive methods across districts in India, ranging from a notable 81 percent, to 11 percent at the other end.[10]

FP 2030

Highlighting its commitment to ensuring equitable access to family planning (FP) services, India in September 2022 became a signatory to the global 'FP 2030' Partnership, which aims to empower women and girls by investing in rights-based family planning. Framed during the London Family Planning Summit in 2012, FP 2030 is a platform that seeks to be inclusive, effective, and resilient.

A 2019 study has recommended regional contextualisation of not just policies in the space of FP and Maternal and Newborn Health (MNH) but also financing schemes (including vouchers and incentives) in order to bring about change.[11] Regional contextualisation will require an understanding of these issues at the local level. While many of these issues may be common across regions, the reasons for their prevalence vary. In this context, it is essential to understand local issues and involve local stakeholders in the decision-making process.

Against the backdrop of FP 2030 and the SDGs, international organisations have endorsed locally led solutions to address social problems for long-term change. For example, the United States Agency for International Development (USAID) recommends that local leadership and ownership are essential for fostering sustainable results across development and humanitarian assistance work.[12] In India, the government, private organisations, and civil society organisations are engaged in recognising subnational contexts for achieving health outcomes.[13,14]

'Localisation' is defined as the "pathway towards achieving self-sufficiency, where local resources are leveraged to strengthen and empower local stakeholders to produce, deliver and govern health services."[15] Localisation can be encouraged by international and national stakeholders. For an international donor, for example, localisation would involve country-specific organisations with decision-making powers. At the district level, organisations would be empowered to engage community stakeholders.

Fig. 1. Types of Localisation

India is currently at the **advanced stage of localisation, heading towards the final integration stage** through capacity building of country institutions and consultants by 2030

	No localisation	Limited Localisation	Partial localisation	Advanced localisation	Locally led
	No systematic engagement	**Notable engagements with irregular cadences with local people**	**Systematic engagement and regular cadences with local people**	**Collaborative decision-making processes**	**Local stakeholders leading the interventions**
International or National				• National training institutes for ANMs and midwives • The 15th Finance Commission is channelling funds to local bodies • FP-LMIS, an ABDM initiative gives instant access to stock information from national to ASHA level and the autonomy to directly place orders	

India is currently at the **advanced stage of localisation, heading towards the final integration stage** through capacity building of country institutions and consultants by 2030					
	No localisation	**Limited Localisation**	**Partial localisation**	**Advanced localisation**	**Locally led**
State				• State training institutes for ANMs and midwives • Inputs taken from DHAPs to prepare State PIPs	
Local				• Strengthening Health workers at local health facilities • Produce equipment locally Accessibility through local channels • Local donors (L-NGOs recipient of funds)	

Source: Saferworld's spectrum of Localisation[16]

The global lens on localisation

The relevance of localisation was underlined, during the COVID-19 pandemic, by the significant degree of vaccine hesitancy in LMICs. While public distrust and hesitancy towards vaccines was a global issue,[17] the case of LMICs was a more significant challenge. India, despite having one of the largest vaccine campaigns in the world, had met with difficulties particularly in the earlier rounds of the vaccination rollout.[18] Community-focused studies have highlighted how localisation of vaccine campaigns and having local champions is essential to increase the uptake of health services to combat an epidemiological concern of this magnitude.[19]

Participation of local stakeholders, including through linguistic familiarity, is known to improve healthcare service utilisation.[20] The quality of the services delivered and responsiveness from both the user and provider is found to be better when local stakeholders participate.

Localisation is effective even in other aspects of health, such as maternal health and family planning. Community-mobilisation efforts are known to have a direct impact on maternal and newborn health (MNH) indicators such as MMR and NMR, as working directly with local communities to improve community support for Ante Natal Care (ANC)/Post Natal Care (PNC) gives the community the power and responsibility that drives behavioural changes.[21] This was observed in a study undertaken in the Kabula locality in Bungoma County, Kenya, between January 2016 and April 2019, where resource persons from the community provided healthcare services at community facilities and health dispensaries.[22] This helped improve the indicators in maternal and child health about child immunisation, ANC attendance, and facility utilisation rate. From 2015 to 2018, there was a fivefold increase in ANC attendance, which was higher than the projections anticipated in annual work plans. The facility deliveries also increased from 61 percent in 2015 to 87 percent in 2018.

In Uganda, a Costed Implementation Plan (CIP)—a roadmap designed to support the government in achieving its family planning goals—was developed in 2014.[23] To meet its objectives of reducing the unmet need for family planning and increasing the modern contraceptive prevalence rate (mCPR) amongst women, one of the strategies adopted was the use of decentralised structures to offer service delivery to citizens. The mCPR increased from 23.5 percent in 2015 to 30.4 percent in 2020. Community-based distribution through Village Health Teams played a role in increasing access to DMPA contraceptives.[24] It was also realised that the nation was heavily dependent on donor funding, which was unsustainable. District leaders were encouraged to advocate for increased funding for FP at the national level. Further initiatives were taken to prioritise FP budgeting at the subnational and district levels, thus providing funding solutions at a local level.

The Government of India is building on localisation strategies, as evident from the process of preparing the State Program Implementation Plan (PIP) budget within the ambit of Community Action for Health (CAH) under the National Health Mission (NHM).[25] It involves strengthening committees such as Village Health Sanitation and Nutrition Committees (VHNCs), *Rogi Kalyan Samiti*, and Primary Medical Centres (PMCs) at the block, district, and state levels.

Another important example of the government's efforts in localisation can be noted from the Bihar Rural Livelihoods Promotion Society (BRLPS), an autonomous body under the Department of Rural Development spearheading the World Bank-aided Bihar Rural Livelihoods Project (BRLP), also known as JEEViKA.[26] The programme aims to achieve social and economic empowerment of the rural poor through improved livelihood opportunities of both self-employed and those in wage employment. Further, community-level enquiries are made to assess the availability, range, and quality of health services, and the responses are used to develop reports that reflect the status of health services at the village and facility levels.

Public dialogue is organised for advocacy with health providers and managers to highlight gaps, find solutions, and plan for issues. The Advisory Group on Community Action (AGCA) developed by the Ministry of Health and Family Welfare (MoHFW) provides technical support to the MoHFW and state governments to strengthen and scale up implementation of the CAH component. It includes facilitating state-level visioning and planning exercises, including the development of state NHM Programme Implementation Plans (PIPs). A bottom-up approach is followed in a PIP,[27] with inputs taken from implementing authorities to form Block Health Plans which are aggregated and consolidated to form District Health Action Plans (DHAPs). These DHAPs are further consolidated to prepare a state PIP. This is a prime example of including local stakeholders to align the health budget plans with local needs.

The recommendations of the 15th Finance Commission also focus on the need for local body engagement in primary healthcare.[28] The Finance Commission is the constitutional body that allocates resources between the central and state governments. As per its recommendations, a health grant of INR 70,051 crore (US$9.4 billion) will be directly allocated to local bodies to build a strong primary healthcare system. Government policies for health in India indicate

a concerted effort towards greater involvement of local stakeholders in developing strategies for health.

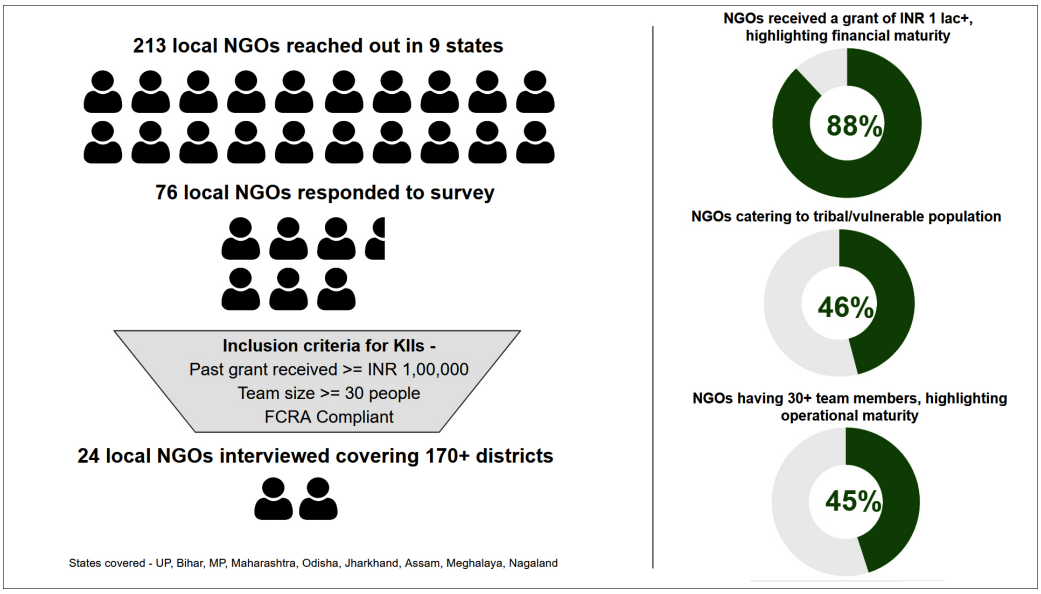
Another example of engaging local stakeholders is the Advance Family Planning India initiative,[29] which includes an advocacy initiative implemented by four organisations (i.e., Foundation for Reproductive Health Services India, Jhpiego, Pathfinder, and Population Foundation of India) in partnership with the Government of India. Structural and cultural limitations lead to many states struggling to implement national-level policies aimed at increasing access to quality family planning. To address this, they used strategic advocacy methods wherein working groups (consisting of key district officials, representatives at the sub-district level, frontline health workers, and representatives from NGOs) were formed at the district and state levels to identify and address local challenges to family planning. The advocacy led to an improvement in quality and access to family planning services at 3,342 health facilities and expanded beyond AFP-supported geographies. This highlights the insights held by grassroots stakeholders and how their inputs can result in positive policy change.

Scoping local organisations in FP and MNH in India

Sattva Consulting, of which the authors of this brief are part, conducted a study in 2022-23 to understand the current landscape of local organisations working in the domain of FP and MNH. The study was undertaken over a period of three months and involved a survey of 76 organisations[a] across nine states and key informant interviews of 24 organisations that met the inclusion criteria.

a Organisations interviewed for each state: Uttar Pradesh 24, Bihar 20, Madhya Pradesh 5, Maharashtra 9, Jharkhand 5, Odisha 3, Assam 5, Meghalaya 3 and Nagaland 2.

Fig 2: Data Collection by Sattva



The interviews highlighted the following challenges:

- Lack of healthcare facilities, unavailability of human resources for healthcare (gynaecologists, surgeons, female doctors), and lack of expertise among healthcare providers leave big gaps in the healthcare services. An organisation in Bihar highlighted situations where people prepared themselves for surgeries but returned home without being operated on because the surgeons were absent. There is a lack of medical instruments, along with the absence of Nutrition Rehabilitation Centers (NRCs). Another systemic issue is the shortage of human resources, primarily frontline health workers (FLWs) like Accredited Social Health Activist (ASHAs) and Auxiliary Nurse Midwife (ANMs). Existing FLWs are overburdened, and therefore, resist being trained, leading to a lack of skills and knowledge, further resulting in poor service provision. FLWs were also shown to have skewed preferences for addressing cases with higher incentives, causing low-incentive cases to be neglected, which is similar to recent findings from nation-wide analyses.[30]

- More recent studies[31] have found limited discussion and awareness about maternal health, which reflected in the quality and uptake of services. An organisation in Bihar described an incident where a blood test camp showed that 100 percent of the population were anaemic. However, there was no support from the community for treatment. Local non-government stakeholders in Meghalaya stated that there is a lack of awareness about FP and MNH-related issues. Nurses are not aware of the protocols of labour rooms and methods of FP and are thus unable to transfer knowledge to patients.

- Lack of trust in government healthcare facilities leads people to choose private alternatives to healthcare, resulting in high out-of-pocket expenditure (OOPE). As noted in a 2023 study among the tribal communities in Odisha, lack of trust in maternal health services is often attributed to a lack of cultural context to bridge the gaps in accessibility and affordability issues.[32] Local stakeholders can play an important role in the trust-building process.

- Financial constraints: Government allocation for healthcare is higher than utilisation, and therefore, streamlining mechanisms to monitor the utilisation of funds to meet community needs is imperative. This is especially grave for the North-Eastern states, where the existing deficits in human resources for health (HRH) are exacerbated by limited available training to the employed staff.

The research highlighted that the interventions undertaken by local organisations in collaboration with government officials have the potential to drive change and improve outcomes at local levels. The NGOs in Bihar and Meghalaya have adopted innovative local solutions to address the problems of unavailability and inaccessibility of drugs and services in remote areas. They used drone services to deliver generic medicines to remote areas. In communities where vaccine hesitancy was noted, efforts were made to reach out to the communities and build trust.

In family planning, the proven on-ground interventions are inclusive of vulnerable communities and aimed at end-user behaviour change by focusing on outcomes. These strategies have been used for promoting safe delivery, pre- and post-natal care, HIV/AIDS care, and awareness of contraception methods. The use of a localised approach was observed wherein organisations leveraged

community strength by nominating women as 'FP Champions', who then engaged with the public health system and understood the needs of pregnant women to provide them with the required information.

The key product and process innovations adopted by the NGOs are summarised in Table 1.

Table 1: Process and Product Innovations

Process Innovations	Product Innovations
Including religious leaders for sexual and reproductive health awareness.	Child-friendly comics were used to spread awareness and information on menstruation.(Bihar)
Leveraging interactive community participation methods like theatre for knowledge dissemination and end-user behaviour change. Skits on issues like SRH encouraged conversation and helped change mindsets. (UP)	Drone services were used to deliver medicines and basic tests in remote areas to cover a larger and more difficult-to-reach population. (Meghalaya)
Adopting the community model, which involves the formation of task-force groups to deal with issues of domestic/gender violence. These groups were given authority and held accountable for their actions. This created a sustainable model and a good exit strategy for the organisation to focus on other affected areas.	An app was created that integrated data from different sources to form a repository of health records. Health apps work in silos, and AMRIT app provides an integration platform for these registries to streamline digital health architecture for the state government. This could help health systems to track the continuity of care for a patient. (Assam)
Undertaking innovative methods to prioritise vulnerable cases: - Use of vulnerability mapping criteria: A 10-point criteria was used within MNH to identify the most vulnerable cases and high-risk pregnancies. Accordingly, interventions were prioritised. - Bangle marker system: Four bangles of different colours were used to categorise pregnant women according to the number of ANC checkups they had taken. Identification of the number of ANC check-ups and high-risk pregnancies became easier and controllable. (UP)	Mobile medical units were established to make MNH services accessible for high-risk pregnancies. (Assam)

In the migrant community, it was observed that, during pregnancy, the women became vulnerable when their husbands left for work, as the women had to care for themselves as well as manage household chores. These women were taught to write letters to their husbands where they could express their expectations and feelings during the pregnancy. It received a good response, as husbands became more involved and responsible in their roles. (UP)	Use of community radios covering an area of 18-20 kilometres for better transmission of information on education and health aimed at behaviour change. (Bihar)

Source: Authors' own based on primary research conducted by Sattva

With time and increased interaction with local communities, these organisations have successfully identified local solutions to address people's problems. This can be leveraged to understand community needs and make interventions in alignment with those.

Recommendations and Conclusion

Localisation is a pivotal strategy to address the diverse issues at a magnitude that can bring sustainable and lasting changes in a country as massive and diverse as India. Many local organisations are adopting path-breaking routes to make FP-MNH services more accessible and relevant to target populations. These process and product innovations should be scaled through meaningful collaborations and partnerships between government and non-government stakeholders. Such collaborations have already resulted in improved rates of contraceptive use, child immunisation, and the ANC 'India Local Initiatives Program'[33] where NGOs were involved in extending government services by generating demand, building local capacity, and improving access to services.

Primary research has noted that the following opportunities can be leveraged for noting the impact on FP-MNH health services utilisation across multiple states in India:

- Direct access of services to the community
- Greater community ownership of FP-MNH indicators at the local level
- Contextualised solutions that mirror the socio-economic and cultural landscape and in turn contribute to better acceptability
- Engagement with government stakeholders at sub-national levels
- Opportunities for international donors to make sustainable investments due to increased community acceptance

Funding is also an essential part of the conversation. According to current literature and corroborated by the findings of the authors of this brief, there is a skewed preference for the geography and development sectors regarding funding from any source.[34] Where local non-government organisations[35] are willing to bootstrap the innovations, the imperatives laid down by national policies need expanded mandates to accommodate investments from the private sector.

Recommendations and Conclusion

Capacity-building efforts at the service delivery as well as the administrative levels are pivotal, especially with regard to HRH. The delivery of health services was affected by the mismanagement of resources at the institutional level (primary, tertiary, and community levels), urging the government to streamline and strengthen HRH. Utilising local resources and building the capacity of available frontline healthcare workers will go a long way in empowering the grassroots, tying into the national strategy to achieve SDGs through localised efforts.

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