White Paper on Family Planning (FP) Counselling

Introduction

Family Planning (FP) counselling plays a vital role in the success of any FP program as it supports clients in choosing a contraceptive method meeting their needs and preferences, managing potential side effects, supporting method continuation and switching, if required.

In 1952 India became the first country in the developing world to have a state-sponsored family planning program, the **National Family Planning Program**. Over the years the Indian Government has made sustained efforts to create a favourable policy environment for family planning in the form of several important policy and programmatic decisions. Family Planning (FP) was made an integral component of the **Reproductive Maternal New-born and Child Health plus Adolescent Health (RMNCH+A) Strategy** that was launched under the **National Rural Health Mission (NRHM)** in 2013. The RMNCH+A framework witnessed the integration of the existing FP Counsellors within the RMNCH+A Counsellors. As part of this strategy, **RMNCH+A/FP Counsellors** were placed at district hospitals, community health centres and in selected primary health centres for increasing awareness and generating demand for RMNCH+A services, including family planning services.

At the London Summit on FP held in 2012, the Government of India made a commitment to enhance counselling services and also increase the number of counsellors. The Government also committed to increasing modern contraceptive use among married women of reproductive age by 2020.[1]

As a result, with the commitment to increase access, choice, and quality of family planning services, greater emphasis was laid on spacing methods and strengthening institutional support and community-based services through ANMs and ASHAs. In 2017, the introduction of three new contraceptive methods - injectable contraceptives, centchroman (weekly pills) and progestin only pills by the Government of India was a step towards a much-needed shift from terminal methods (particularly female sterilization which accounted for two-thirds of contraceptive use in India until 2015-2016)[2] to more modern spacing methods of contraception. Under Mission Parivar Vikas (MPV), the Government of India has identified 146 high fertility districts (with total fertility rate of 3 or above) in Bihar, Uttar Pradesh, Assam, Chhattisgarh, Madhya Pradesh, Rajasthan & Jharkhand, with an aim to ensure availability of contraceptive products to the clients at all levels of the public health system.[3]

These efforts have partly contributed to the decline of maternal mortality rate from 167 (2011-13) to 113 (2016-18) per lakh live births[4] and the Total Fertility Rate (TFR) has decreased to 2.2 in 2015-16, close to replacement level fertility of 2.1 (NFHS 4).[5]

Introduction of new contraceptive methods need to be accompanied with consistent efforts to counsel clients and train service providers as well as having a robust

monitoring/tracking mechanism in place. Effective counselling services ensure that users have better access to accurate information on the basket of contraceptive choices, enabling them to make an informed decision.

This whitepaper aims to analyse the current approaches and practices to FP counselling and the impact that lack of access to counselling can have on clients. The paper brings to attention the reproductive needs of young people, which are different from that of higher parity couples. It also highlights the important role that counselling plays in addressing these varying needs and improving contraceptive behaviour outcomes. In the end it also recommends mechanisms for monitoring quality of counselling.

How Important is Quality FP Counselling?

FP counselling is important to: (i) communicate information on the importance of birth spacing, especially during postpartum and post-abortion period and on the availability of different contraceptives (ii) assess the family planning needs of individuals, (iii) facilitate contraceptive decision making and (iv) establish/inform mechanisms for follow up care.

Different women have different needs for family planning, based on factors like age, marital status, parity, disabilities, and so on. Quality FP counselling ought to consider these diverse needs. Effective training of FP counsellors is critical to improve their assessment of the clients' FP needs. Trainings should emphasize on building counselling skills through practice and feedback, analyzing individual client's circumstances and broader reproductive health (RH) needs in order to help client select a suitable FP method. Appropriate selection through personalized counselling contributes to the successful use of FP methods, which in turn leads to personal well-being as well as programmatic success.

Evidence on Impact of Effective FP Counselling

There have been several studies linking improved outcomes for family planning services like uptake as well as continued use of contraceptives to effective and client-centred FP counselling.

One of the earlier and effective family planning counselling strategies was documented in the mid-1970s under the MATLAB project in Bangladesh where, in religiously conservative villages with poor socioeconomic conditions, educated local women offered doorstep family planning counselling and services. In less than a year, the prevalence of contraceptive use increased from 5% to nearly 20% [6]. A systematic review of randomized controlled trials (RCTs), which compared standard family planning counselling with interventions prioritizing greater client-

provider interactions, found that a combination of intensive counselling and multiple contacts and reminders may be able to play a significant role in improving acceptability, adherence and continuation of contraceptive[7].

Another study showed that a client-centered family planning service program in Jordan called "Consult and Choose" (CC) along with community-based activities to encourage women with unmet need to visit health centres resulted in an increase in the number of new family planning users and in couple-years of protection since the programme started.[8]

The need for greater male engagement in family planning has been extensively documented. If men have accurate information about FP, they may be more likely to support their partner using a contraceptive. In addition, including men could also encourage spousal discussion about FP, leading to a mutual decision on which method to use. A study in Kenya, which involved six focus group discussions with 50 Kenyan men and women showed that a lack of FP knowledge among men contributed to negative views of FP in the community. Men and women perceived that engaging couples in FP counselling via SMS would help overcome barriers to postpartum contraceptive use: by reducing misperceptions about contraceptive harms, providing information about potential side effects, and encouraging communication within couples. Results further showed that the SMS content for an intervention should address FP knowledge gaps and anticipated side effects.

Another study identified numerous factors relevant to young people's access to family planning services. The findings suggest that young people value confidentiality, ***supportive provider interaction***, specialized provider training, and the removal of logistical barriers. Further, it highlights the importance young people place on receiving comprehensive, client-centred family planning counselling[9].

In the Indian state of Bihar, the Prachar project emphasized generating demand for family planning services and aimed to increase contraceptive use for delaying and spacing births through communication interventions. The program underscored the role that counselling plays in bringing about behaviour change and promoting contraceptive uptake even in a challenging state like Bihar with high unmet need and fertility levels. It introduced young people and their families to basic information about caring for their own health and the economic advantages of delaying and spacing births. The project highlighted the fact that demand for contraception exists, and many people want to control their reproductive lives by spacing and limiting their births. As a result of the intervention, demand for contraception increased from 25% at baseline to 40% at follow-up in intervention areas, but remained virtually unchanged in comparison areas[10].

Need to Strengthen FP Counselling

Global Evidence

Despite the globally recognized role of counselling in the success of FP programmes, several studies conducted worldwide have repeatedly shown that the quality of FP counselling services continues

to struggle due to inadequacies in the providers' skills. Counselling training traditionally focuses on addressing the needs of new clients. In their effort to provide information, many providers end up giving clients too much information and often miss out on crucial information on side-effects. The communication is usually one-way. There is an urgent need to close gaps in counselling training, by addressing the needs of returning clients in addition to new clients; and by bringing the client perspective to trigger client-centered thinking and counselling[11].

A recent study by the World Health Organization (WHO) in 36 countries showed that two-thirds of sexually active women who wanted to delay or limit their pregnancy stopped using contraception due to health concerns, fear of side effects and underestimation of the likelihood of contraception[12]. This resulted in one in four pregnancies being unintended, thereby increasing maternal and new-born health risks, which can have a lasting impact on education and employment opportunities for women and children, pushing them further into poverty[13]. In the absence of adequate counselling, quality FP services, and availability of a basket of contraceptive choices, the cycle will continue.

Globally, 74 million women living in low and middle-income countries have unintended pregnancies annually, leading to 25 million unsafe abortions every year[14]. A study published in the Lancet estimated that 15.6 million abortions took place in India in 2015 [14]. Studies have shown that 85% of women who stopped using contraception became pregnant during the first year[15]. Another study conducted in the Philippines, found that only 3% of women wanting to delay or limit childbearing received contraceptive counselling during their last visit for any reason to a health facility[14]. All the above issues could be substantially addressed through provision of effective FP counselling services.

The Indian Context

India is a young country today with a high proportion (about 30 per cent) of young persons – adolescents (10-19 years) and youths (15-24 years), who are in the reproductive age group or will soon be.[16] In order to ensure that this demographic dividend is favourable to the socioeconomic development of the nation, it is imperative to address their sexual and reproductive health needs and inform their choices.

Another important factor influencing India's family planning discourse is the high unmet need for contraception among women of reproductive age, which is at 13%[17]. There is also a disconnect between a woman's desired fertility and her access to quality family planning services (NFHS4). Furthermore, the Indian FP scenario continues to be influenced by socio-cultural factors such as high incidence of early marriage, high rate of early pregnancies, sex selection and son preference. The fourth National Family Health Survey (2015-16) states that over half of the married women, between 15-19 years of age, had begun childbearing. However, only 18% female non-users have had a health worker talk to them about family planning. Furthermore, only 47% current users have ever been told about the side effects of the contraceptive method they are using. Another cause of concern is the decline in modern contraceptive prevalence rate (mCPR) from 48. 5% in 2005-06 (NFHS-3) to 47.8% in 2015-16 (NFHS-4) which indicates an unmet need for family planning in the country.

All of this point in one and only one direction – the need for quality FP counselling. In addition to providing a wide range of quality contraceptive methods for spacing, it is important to give clear and adequate medically accurate and relevant information including the benefits and risks, so that women and men can choose the method they want to adopt. There is evidence that increasing the basket of choice increases access to FP[18] but it has to be accompanied by proper counselling.

The existing guidelines on family planning by the Ministry of Health and Family Welfare, Government of India (MoHFW) have limited reference to counselling, although training modules do include sessions on counselling. Some of the other bottlenecks that adversely impact FP counselling include: limited availability of skilled human resources, inadequate supportive supervision of front-line service providers, low quality of training and skill building, lack of focus on improving quality of services and insufficient information, education and communication on key family planning practices.

While method-specific operational guidelines **(annexure 1)** do mention counselling but most of them are designed for medical and nursing professionals, and not for counsellors. Moreover, quality FP counselling services for spacing methods need significant strengthening in the country. Quality Assurance Committees (QACs) responsible for monitoring quality of services in most states and districts are not functional and the existing RMNCH+A Counsellors handbook (2012)[19] needs to be updated with comprehensive counselling guidelines which include the three new contraceptives recently introduced in the public health system.

The landmark verdict in the Devika Biswas versus Union of India case in 2016 made a number of recommendations to ensure diligent functioning of the Quality Assurance Committees at the State and district levels[20]. The judgment took cognizance of "The Robbed of Choice and Dignity" report of the multiorganizational fact-finding mission led by Population Foundation of India (PFI) on the sterilization deaths in Bilaspur, Chhattisgarh in November 2014[21]. It also made specific recommendations to the government to improve the quality of services being provided under the family planning programme. Although, post the Supreme Court judgment, states have paid more attention to follow up on making QACs more effective, much remains to be done to strengthen them.

Issues, like inadequate number of FP counsellors, lack of required skills, non-adherence of standard practices in FP service provision, lack of clarity on monitoring quality among counsellors, have also been noted in two studies conducted by Population Foundation of India namely, *"Family Planning Counsellors- An Exploratory Study in Bihar"* as well as *"Perception of service providers and users of injectable contraceptives study" in Madhya Pradesh and Bihar.*

While efforts have been made for setting up of family planning corners, recruitment of counsellors and their skill building is still unaddressed. **A review of the state wise data on number on RMNCH+A counsellors** (available and required) indicates barring a few, none of the states have the required number of counsellors **(annexure 2).** Details of counselling

services are not being captured in the health management information system (HMIS) or being reviewed at the district or state level. Facility based registers are maintained by the counsellors but in most cases, the data does not adequately track counselling trends.

In a 2019 study conducted in the states of Uttar Pradesh and Bihar, around 22% clients had received any FP counselling, out of which only 4% received quality counselling [22] . As compared to women reporting no FP counselling, those who received lower-quality FP counselling had 2.5 times greater likelihood of reporting current use of any modern contraceptive method and those who received higher quality FP counselling had over 4 times likelihood of reporting modern contraceptive use. Women receiving higher-quality counselling also had higher likelihood of continued use as well as new use or initiation of modern contraceptives.

There is an urgent need to create and strengthen a cadre of certified and qualified FP counsellors, which requires budgetary investments. Investments for training of RMNCHA+/FP counsellors under the National Health Mission has received less attention from the government and is highly inadequate. ***Barely 1% of the FP training budgets was allocated for this component in the last three years beginning from 2017-18 up to 2019-20[23].*** However, it should be noted that some states like Bihar, have demonstrated some level of urgency and inclination in changing the current trends in FP counselling. Over the last two years Bihar has spent significant resources in setting up FPCC in all its 38 districts and on training its counsellors. On the other hand, there are states like Rajasthan and Assam where there has been very little or no spending on strengthening the FP counselling.

Addressing Provider Bias

Providers, like everyone else, hold stereotypes (often subconsciously) based on a patient's race, gender, class – and these stereotypes can affect health-related communication and clinical decisions. Several studies have shown a provider bias against provision of FP services to unmarried adolescents or unmarried young couples. The evidence from many countries has shown that most young people do not routinely seek reproductive health services. The most cited barrier for poor care seeking behaviour was health care provider's attitude that contraceptive services are inappropriate for young people[24], their unwillingness or inability to provide age-appropriate sexual and reproductive health information to young people [25] . Furthermore, many counsellors are scared to provide information on family planning methods to clients below 18 as sexual activity below the age of 18 stands criminalized under the Protection of Children from Sexual Offences (POCSO) Act, 2012. Health care providers need to be sensitized towards the importance of extending reproductive health services to unmarried adolescents and young people and also trained to offer these services to them.

FP Counselling in the COVID-19 Era

The COVID-19 outbreak has placed public health systems, infrastructure and support systems under considerable strain. As the world diverts majority of its health care funding and more towards the emergency response to COVID-19, other health needs, particularly of the vulnerable population, including women and girls and boys, are at risk of being significantly compromised, as has been witnessed at the time of previous outbreaks. Reproductive health and rights of girls and women is an important public health issue that requires higher attention during pandemic situations.

As per a recent analysis by Foundation for Reproductive Health Services (FRHS) India, in a likely case scenario 25 million couples will be unable to access contraceptives, which is likely to result in an additional 2.4 million unintended pregnancies[26]. UNICEF has estimated that in the nine months span dating from when COVID-19 was declared a pandemic, India is expected to have the highest number of forecast births, at close to 20 million.

The nation-wide lockdown has also led to an exodus of migrants from cities back to their villages. This phenomenon, in normal course, is witnessed during major festivals, and is directly proportional to an increase in the number of pregnancies in states like Bihar, which have a huge migrant population. Restricted access to contraceptives will lead to a spike in the number of unexpected pregnancies, adding to India's huge unmet need for family planning.

In the current scenario, delivering high quality counselling services to promote informed choice, at clinical and operational levels will serve as a catalyst for future demand and expansion of service delivery for FP. While it is true that one on one counselling cannot be replaced and needs to be strengthened at all service delivery levels, tele-counselling coupled with a mechanism to popularize tele-medicine during and in the post-COVID-19 era will have a significant role to play.

Recommendations to Strengthen FP Counselling

From the evidence available, it is clear that there are gaps in the provision of FP counselling that come across as a barrier in improving contraceptive behaviour outcomes. It has also been established that counselling can play a definite and crucial role in turning the tide. We recommend following steps to strengthen the FP counselling service delivery.

1. **Greater prioritization of FP counselling** through infrastructural provisions, skill-building of service providers, counsellors, ASHAs and ANMs for improving uptake (for both new and existing users), continuation and method switch[27]. The health and wellness centres under the umbrella of the Aayushman Bharat Programme, mandated to strengthen primary health services, including reproductive health services, can be leveraged to strengthen FP counselling

2. **Strengthening tele-counselling services** will play a substantive role in strengthening family planning service provision during and in the post-COVID-19 era as well as other public health emergencies.

3. **Upgrading FP counselling guidelines** under RMNCH+A to include guidelines for new methods. While the MPV guidelines include counselling for newer contraceptives, the RMNCH+A manual for counsellors needs to be updated immediately.

4. **In the wake of Covid-19, explore innovative mechanisms** not only to provide counselling to people who need it but to train counsellors and monitor its quality. This would entail providing counselling through phone, mobile, etc, training using virtual platforms and collecting feedback from clients as an indicator to measure quality.

5. There is a need to **prioritize couples counselling**, which is particularly important for low parity couples. Couples counselling will also help engage men as not just enablers but also beneficiaries of family planning.

6. **Increasing budget allocation for FP, including specific funding** for FP counsellors' recruitment and regular training. One of the biggest gaps in the provision of counselling services is the lack of trained human resources, which has also been acknowledged in the RMNCH+A guidelines. Budgetary allocations are also needed for creating effective counselling content such as brief audio visuals.

7. **Investing in social and behaviour change communications through multiple channels.** Due to restriction on movement and social distancing norms in place, digital and innovative ways to provide FP counselling will be critical. It will require long term investment and innovation in communication approaches on part of both the government as well as civil society. Sustained awareness raising activities are critical for attracting users to new contraceptives as well as address provider bias. Clients may be spread out across a large geographical area and may have limited access to mainstream media. Thus, health promotion messages about the new contraceptives such as injectables must be disseminated though different communication channels.

8. **Strengthening monitoring of FP Counselling** is also an important component. With inadequate training (new and refresher/follow up), lack of supervision and poor reporting mechanisms, the quality of counselling being offered is often compromised. To institutionalise quality FP counselling, one must monitor the existing quality of counselling and build mechanisms to improve it further. Some of the ways through which the monitoring mechanisms can be strengthened are as follows:

    a. Incorporating family planning counselling components into the existing government reporting platforms (RCH and HMIS portal/application): Although counsellors are placed at district hospitals, community health centers and in selected primary health centers for generating awareness and demand for family planning services along with other

RMNCH+A services, data related to counselling is neither captured in the government operated Health Management Information System (HMIS)[28] nor on the Reproductive and Child Health (RCH)[29] portal.

b. Digitalization and capturing additional information on counselling like FP method discussed, information provided, issues related to discontinuation should be incorporated in the method adoption registers provided at the facility along with the client's unique RCH ID number.

c. Supportive Supervision for quality FP counselling: In order to ensure quality of FP counselling, supportive supervision can play a crucial role. The health officials are suggested to provide supportive supervision by:
   - Reviewing counselling sessions done at facility by RMNCH+A /FP Counsellor
   - Reviewing documents/registers maintained by RMNCH+A /FP Counsellor
   - Validating Data (cross verification of HMIS/RCH data with facility registers and telephonic client interview)
   - Capacity building/hand holding support

d. Feedback from beneficiaries: one of the critical indicators of quality od counselling is the client feedback, which should be collected on a regular basis, evaluated and follow-up or refresher training should be organized basis the feedback received. Feedback from the beneficiary/client can be collected in the following ways:
   - A IVRS could be developed to capture the beneficiary feedback on the FP counselling received from RMNCH+A /FP Counsellor.
   - A digital beneficiary feedback mechanism on a 5-pointer Likert scale (1-Very Bad, 2-Bad, 3-Average, 4-Good, 5-Very Good) on 2-3 quality indicaotrs could be set up at the exit of the facility or sent to the beneficiary's registered mobile number.

Conclusion

With the importance of and ever increasing need for accurate information on the available methods of contraception, the role of a counsellor becomes crucial in helping clients take appropriate decisions best suited for them based on their unique circumstances. There is enough evidence linking lack of or inadequate counselling with skewed contraceptive uptake, poor adherence and continuation rates. Apart from it accorded least importance, poor counselling infrastructure (unavailability of privacy and confidentiality) and skills among counsellors comes across another challenge in ensuring availability of quality FP counselling.

The recommendations made in this paper will be helpful in strengthening the FP counselling service provision and augment the efforts of the government in creating a client-driven choice-based FP program.

Annexure 1:

1. Government of India Manuals for FP including counselling: https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=963&lid=470

2. Ayushman Bharat - Health and Wellness Centre Comprehensive primary health care- training modules and guidelines- https://ab-hwc.nhp.gov.in/document/6

Annexure 2: This data has been taken from each state's NHM PIPs (2018-19) and compiled by PFI.

Sr No.	State	State Population	Total number of disctricts	No. of RMNCH Counsellors(required)	No. of RMNCH Counsellors(Available)	Remark
1	Rajasthan	68548437	33	52	46	
2	Bihar	104099452	38	161	102	
3	Madhya Pradesh	72626809	50	51	22	
4	Uttar Pradesh	199812341	71	290	254	
5	Jharkhand	32988134	24	0	0	Not mentioned in PIP
6	Andhra Pradesh	84580777	23	33	21	
7	Chhattisgarh	25545198	18	108	80	
8	Goa	1458545	2	32	32	
9	Gujarat	60439692	26	105	91	
10	Haryana	25351462	21	0	0	Not mentioned in PIP
11	J & K	12541302	22	0	0	Not mentioned in PIP
12	Karnataka	61095297	30	80	61	
13	Odisha	41974218	30	34	21	
14	Tamil Nadu	72147030	32	*	178	Requirement is not mentioned in PIP
15	Maharashtra	112374333	35	0	0	Not mentioned in PIP
16	Punjab	27743338	20	25	10	
17	Uttarakhand	10086292	13	0	0	Not mentioned in PIP
18	West Bengal	91276115	19	72	46	
19	Telangana	*	*	28	21	
20	Himachal Pradesh	6864602	12	14	13	
21	Kerala	33406061	14	6	6	
22	Arunachal Pradesh	1383727	16	9	9	
23	Manipur	2855794	9	0	0	Not mentioned in PIP
24	Assam	31205576	27	58	29	
25	Meghalaya	2966889	7	16	16	
26	Mizoram	1097206	8	9	9	
27	Nagaland	1978502	11	3	3	
28	Sikkim	610577	4	0	0	
29	Tripura	3673917	4	*	21	Requirement is not mentioned in PIP
TOTAL				1186	1091	

Note- *Could not get the data

Source: NHM PIPs 2018-19

Annexure 3: The following monitoring indicators[30] can be used during supportive supervision to ensure quality of FP counselling

Sl.no.	Indicator	Definition	Possible Means of Verification
1	**Service Provider Competency**		
1a	Availability of FP counsellor		Facility HR register
1b	% (and #) of Service providers (RMCH+A/FP Counsellor) trained to provide FP Counselling	Proportion of service providers that have gained knowledge through an initial training to provide FP counselling	Training and certification reports
1c	% (and #) of trained providers who have received refresher training/continuing education/on-the-job training after initial training	Proportion of service providers who have maintained competency through refresher trainings (within a year of the initial training) to provide counselling.	Training and certification reports, training certificates
2	**Quality Control**		
2a	% (and #) of facilities having a designated place for FP counselling	Proportion of the health facilities with designated space allocated for FP counselling.	Direct observation
2b	% (and #) of providers who have Job-aid for counselling sessions.		Direct observation (whenever feasible)
2c	% (and #) of providers who have used any Job-aid during the counselling sessions.	Proportion of providers who have used any job aid such posters, anatomic models, audio video aids and contraceptive models during the counselling sessions.	Facility registers Direct observation (whenever feasible)
2d	% (and #) of type of counselling provided: a. General FP b. Method-mix c. Return/Follow-up	Proportion of specific type of counselling provided by the counsellor at the facility.	Facility registers Direct observation (whenever feasible)
2e	% (and #) of counselling done by type of beneficiary: a. ANC b.Labour pain/After delivery c. PNC d.Other	Proportion of specific type of counselling method based on the type of beneficiary.	Facility registers Direct observation (whenever feasible)

Sl.no.	Indicator	Definition	Possible Means of Verification
3	**Beneficiary based**		
3a	% (and #) of new beneficiaries given full counselling on: a. All methods available b. Benefits of methods c. Side effects and expected changes d. Follow-up care	Ability of providers to provide quality, rights-based services as measured using the [31]Method Information Index, which assesses at the comprehensiveness of counselling, including information on: a. A full range of methods b. Benefits of each method c. Side effects and expected changes for each method d. Required follow-up care for each method	Facility registers and Exit interview Telephonic interview of beneficiaries
3b	% (and #) of beneficiaries choosing the any FP method (method wise)	Proportion of beneficiaries choosing any FP method after the counselling .	Facility registers Telephonic interview with beneficiaries
3c	% (and #) of beneficiaries switching FP method	Proportion of beneficiaries switching FP method after the counselling	Facility registers Telephonic interview with beneficiaries
3d	% (and #) of beneficiaries discontinued any FP method	Proportion of beneficiaries discontinued FP method	Facility register Telephonic interview with beneficiaries
3e	% of beneficiaries satisfied with the behviour of counsellors		Telephonic interview with beneficiaries

References:

[1] *FP2020 and Government of India, 2017*

[2] *National Family Health Survey (2015-16)*

[3] *https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=821&lid=222*

[4] *Sample Registration Survey*

[5] *Family Planning Counsellors- An Exploratory Study in Bihar by Population Foundation of India*

[6] *Phillips JF, Simmons R, Koenig MA, Chakraborty J. Determinants of reproductive change in a traditional society: Evidence from Matlab, Bangladesh. Stud Fam Plann 1988; 19 : 313-34.*

[7] *Halpern V, Lopez LM, Grimes DA, Stockton LL, Gallo MF. Strategies to improve adherence and acceptability of hormonal methods of contraception. Cochrane Database Syst Rev. 2013;(10):CD004317. Published 2013 Oct 26.*

[8] *Kamhawi S, Underwood C, Murad H, Jabre B. Client-centered counseling improves client satisfaction with family planning visits: evidence from Irbid, Jordan. Glob Health Sci Pract. 2013;1(2):180-192.*

[9] *Brittain AW, Loyola Briceno AC, Pazol K, et al. Youth-Friendly Family Planning Services for Young People: A Systematic Review Update. Am J Prev Med. 2018;55(5):725-735.*

[10] *https://www.guttmacher.org/journals/ipsrh/2008/12/effect-community-based-reproductive-health-communication-interventions*

[11] *https://www.engenderhealth.org/wp-content/uploads/imports/files/pubs/acquire-digital-archive/10.0_training_curricula_and_materials/10.2_resources/fp_curric_tm_part_1.pdf*

[12] *https://www.sciencedirect.com/science/article/pii/S0010782419304305?id=10.1371/journal.pone.0218187*

[13] *https://www.who.int/news-room/detail/25-10-2019-high-rates-of-unintended-pregnancies-linked-to-gaps-in-family-planning-services-new-who-study*

[14] *Singh et al. Lancet Global Health, The incidence of abortion and unintended pregnancy in India, 2015. (2018) Vol 6, Issue 1, E111-E120.*

[15] *https://www.who.int/news-room/detail/25-10-2019-high-rates-of-unintended-pregnancies-linked-to-gaps-in-family-planning-services-new-who-study*

[16] *Census 2011*

[17] *NFHS4*

[18] *(John Stover & John Ross)*

[19] *https://nhm.gov.in/images/pdf/programmes/family-planing/guidelines/Handbook-for-RMNCH-Counsellors.pdf*

[20] *In the Supreme Court of India Civil Original Writ Petition (CIVIL) No. 95 of 2012. Judgment-Devika Biswas versus Union of India & Ors; 2016. Available from: https://www.escr-net.org/sites/default/files/caselaw/devika_biswas_v_uoi.pdf, accessed on August 3, 2018*

[21] *Population Foundation of India. Robbed of choice and dignity: Indian women dead after mass sterilisation; situational assessment of sterilisation camps in Bilaspur district, Chattisgarh. PFI; 2014*

[22] *Dehingia, N., Dixit, A., Averbach, S. et al. Family planning counseling and its associations with modern contraceptive use, initiation, and continuation in rural Uttar Pradesh, India. Reprod Health **16,** 178 (2019)*

[23] *Analysis of NHM RoPs of 36 states including UTs - 2017-18, 2018-19 & 2019-20*

[24] *UNAIDS, WHO and UNICEF,2011*

[25] *McCauley,1995*

[26] *http://www.frhsi.org.in/images/impact-of-covid-19-on-indias-family-planning-program-policy-brief.pdf*

[27] *Both PFI studies*

[28] *https://nrhm-mis.nic.in/SitePages/Home.aspx*

[29] *https://rch.nhm.gov.in/RCH/*

[30]*https://www.familyplanning2020.org/sites/default/files/resources/2018/TSTWG%20Indicators_Updated_07Nov2018.pdf*

[31] *This indicator is an index that summarizes whether service providers supply adequate information to women when receiving family planning (FP) services. https://www.measureevaluation.org/prh/rh_indicators/family-planning*