Evaluation of Family Planning Program Transitions in Selected Countries

August 2024

USAID FROM THE AMERICAN PEOPLE

DATA FOR impact

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Cover photo: "A woman and her child near a house in progress," Peru 2011, by Auriana Koutnik, USAID/OFDA, from USAID Flickr.

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Abbreviations

BKKBN	National Population and Family Planning Board (Indonesia)
DHS	Demographic and Health Survey
ENDES	Encuesta Demográfica y de Salud Familiar – National Demographic and Family Health Survey (Peru)
FP	family planning
FPE	FP Effort Index
FP/RH	family planning/reproductive health
HDI	human development index
HIV	human immunodeficiency virus
HMIS	health management information system
IUD	intra-uterine device
KII	key informant interview
LAC	Latin America and Caribbean
LARC	long-acting reversible contraception
LGBTQI+	lesbian, gay, bisexual, transgender, queer, and intersex
M&E	monitoring and evaluation
mCPR	modern contraceptive prevalence rate
MOH	Ministry of Health
NCIFP	National Composite Index on Family Planning
NGO	nongovernmental organization
PMA	Performance Monitoring for Action
SBCC	social and behavior change communication
SDG	sustainable development goal
SES	socio-economic status
TFR	total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Executive Summary

The United States Agency for International Development (USAID) is the largest bilateral donor of family planning (FP) assistance, having provided financial support and technical assistance to countries around the globe for more than five decades. Such assistance has contributed to significant increases in modern contraceptive use and reductions in fertility in recipient countries (USAID, 2023). More than two dozen countries have since transitioned out of USAID's financial support over the last three decades[1][2] and demonstrated sustained programmatic achievements at the country level.

Despite the remarkable FP results and USAID's emphasis on long-term sustainability, there have been only a handful of large-scale evaluations of the extent to which FP programs and outcomes have been sustained after the transition. A common limitation of these evaluations is that they were implemented retrospectively, without an *a priori* monitoring and evaluation (M&E) plan guided by a framework; most of them were compilations of lessons learned focusing on program outcomes and outputs. Our exercise, therefore, was aimed to advance the work of strategic transition planning, implementation, and evaluation of large-scale global health programs by developing a guiding framework for this process.

- Employing a FP transition framework to assess post-transition FP outcomes in four countries (Honduras, Indonesia, Morocco, and Peru), we found that FP outcomes have been sustained to different extents. However, some inequities remained.
- We highlighted key factors contributing to FP outcomes and inequities, including leadership, commitment, and coordination between multiple sectors.
- We highly recommend the transition framework to be used by donors, implementing partners, and local stakeholders for future planning, implementation and M&E of program transitions. The framework can also be easily adapted to each country and program.

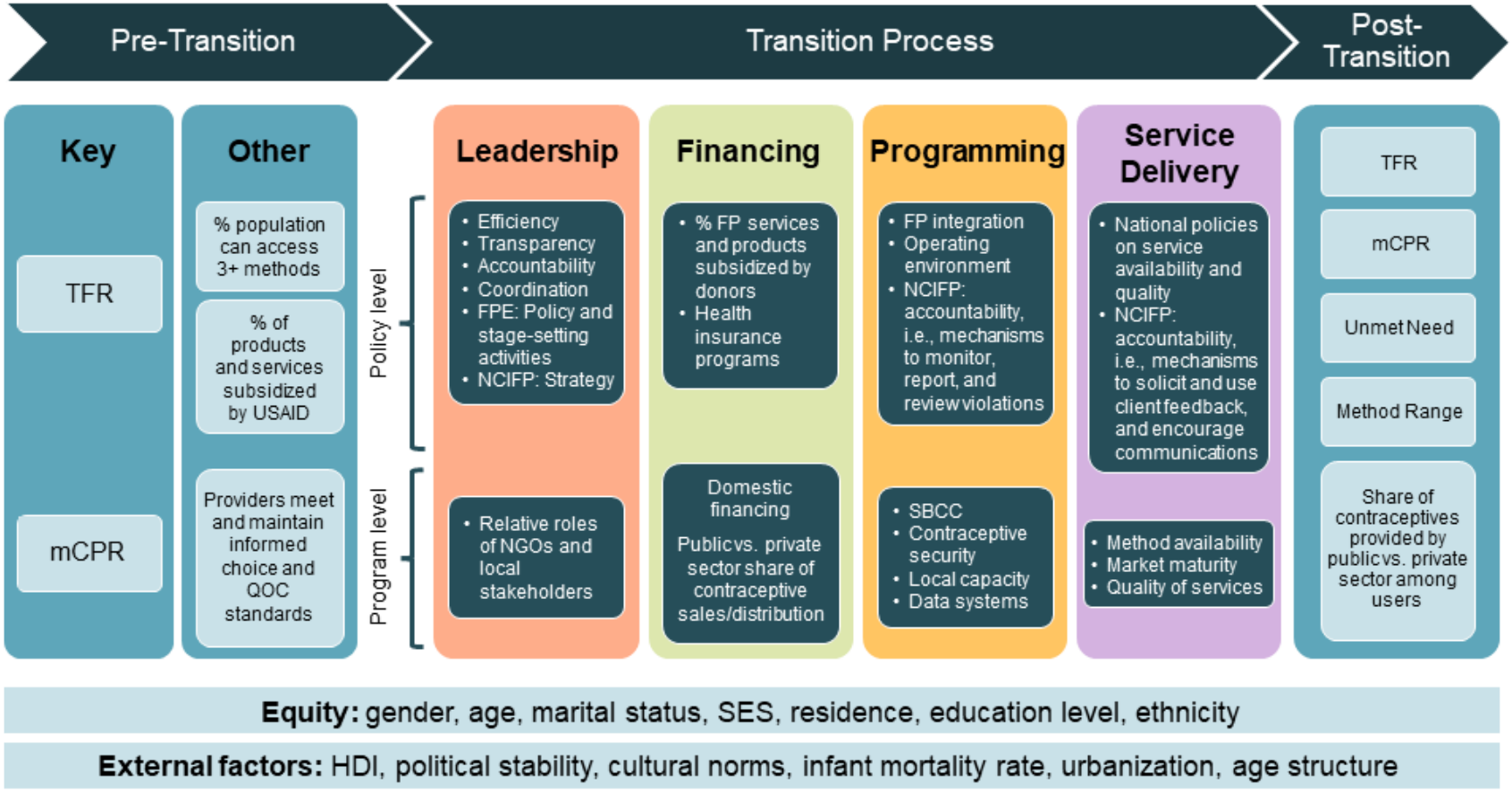
The earlier phase of this activity involved the development of the FP program transition framework (Figure E1) to guide the planning and M&E of the FP/ reproductive health (RH) program transition through a thorough literature review. In this report, we discuss the application of the framework to the evaluation of FP programs in four selected countries after they transitioned out of USAID support. While the evaluation was still retrospective and focused on the post-transition period, we discussed how the framework could be useful in the future for the pre-transition assessments, planning, implementation, and evaluation of FP program transitions. Four countries—Honduras, Indonesia, Morocco, and Peru—were selected, in consultation with USAID, for two main reasons: (1) they presented different geographical regions and (2) distinct graduation periods.

[1] Some of these countries transitioned out of USAID's support prior to the 2005 Technical Note on Phase Out of USAID FP Assistance, so the processes might have been different from the other countries. Morocco and Indonesia in this study belong to the former group, whereas Honduras and Peru are in the latter group.

[2] In this report, "USAID's support" is used to refer to USAID's bilateral financial support.

Data employed in this study included both quantitative data from existing population-based surveys and qualitative data primarily collected through key informant interviews (KIIs). Key domains of the FP transition framework guided the focus of both quantitative and qualitative data collection. Specifically, we used quantitative data to assess the sustainability of FP outcomes post-transition, while qualitative data were used primarily to assess the current state of the country's FP policies and programming, while KIIs, who were involved in the transition process, may also reflect on the transition. The latter came from open-ended interviews with 34 key informants, who had been heavily involved in FP programs in the four selected countries, using two interview guides: one for policy makers and one for program implementers and service providers. All interviews were conducted virtually—either via Zoom or WhatsApp—and audio recorded for transcription.

Figure E1. FP program transition framework



In this report, we define FP program sustainability as the extent to which key FP outcomes, as well as the principal components of the program (including leadership, finance, programming, and service delivery policies and practices), and equities across sub-groups of populations, have been maintained since USAID ended their support in the countries. Our findings showed that FP programs and outcomes had been sustained in all four countries, albeit to different extents. Several key factors were considered critical for a successful and sustainable transition of FP programs. Leadership, commitment, and coordination between multiple sectors were highlighted as key contributors to sustainability, particularly in Morocco and Indonesia. Indonesia had also been considered a success story by many in the field, until Indonesia's National Population and Family Planning Board's (BKKBN's) priorities shifted in 2017, resulting in drops in the Ministry of Health (MOH) budget for FP, which then had implications for the quality of FP counseling and services.

The second important finding from this study is that even when the overall TFR, mCPR, and unmet need were sustained, there may remain challenges to the long-term sustainability of FP programs. Factors such as the balance in the mix of methods and of contraceptive sources should be considered. For instance, in all study countries, contraceptive use heavily leaned towards short-acting methods, reported by key informants as due to lack of investment in personnel, commodities, quality, and social behavior change communication (SBCC) efforts to sensitize the population about long-term methods, coupled with individuals preferences for short-acting methods in some cases. Similarly, contraception continued to be primarily sourced from the public sector, with the for-profit private sector's share varying across time. The nonprofit sector's share remained minimal, which posed challenges to reaching marginalized populations.

The third key message from this exercise is that even with large-scale population data, inequities across groups were not easy to assess. While the quantitative data revealed little inequity, all key informants highlighted inequities in access and use of FP methods across different groups; rural vs. urban and age groups remained the key categorizations of inequity in all countries, while inequities across education and wealth groups seemed to have decreased. Related to this, participants underlined the importance of a robust health management information system (HMIS) to not only monitor and assess the quality of services but also to provide reliable data on FP access and use across groups for decision making.

The pilot of the FP program transition framework in our study proved that the framework was very useful in guiding evaluations of this type. The three transition phases in the framework were helpful in guiding the interview question development and the interviews themselves. The different domains and indicators within each of the three phases guided our sampling scheme, ensuring that we intentionally recruited participants who were familiar with these phases and domains. The framework also served as a reference point throughout our fieldwork, since our study team periodically reviewed the participants that had been interviewed, discussed key domains that had been covered by those interviews, and strategized our next recruitment(s).

Our key recommendation for FP program donors, decision makers, program implementers, and evaluators is to employ a framework, like the one used here, to guide strategic planning for program transition as well as to evaluate the long-term sustainability of FP programs. Having a framework will assist international and bilateral donors, like USAID, and implementing partners to strategically plan for the transition of FP/RH and other health programs out of international donor support, moving towards sustainability in a

systematic way, consistent with USAID's localization vision and approach (USAID, 2022). By employing a framework, donors are more likely to have a clear process for aligning the priorities and investment of the FP/RH program with those of the local government and the MOH, making adjustments during the transition process possible and the process itself more efficient.

Our FP program transition framework can easily be adapted to include domains and indicators critical for a specific country or program context. A pre-test and revision of the framework would make it more relevant and appropriate for a specific FP program and, therefore, help design recruitment strategies and data collection further. In addition, while inequities are cross-cutting, it is important to assess them at minimum across geography, age, and marital status, in addition to post-transition FP outcome indicators regarding fertility and contraceptive use.

In conclusion, by employing the transition framework in a post-transition assessment, we found evidence of FP outcome sustainability in the study countries and highlighted major domains and indicators that should be considered in the evaluation, in addition to key quantitative FP outcomes. More importantly, we strongly recommend that a framework of this type be used in the future by international and bilateral donors and implementing partners to plan for the transition. The framework provides guidance in terms of domains and indicators for use in pre-transition self-assessment, monitoring of the transition process, and evaluating long-term outcomes. The work presented here has the potential to make significant contributions to FP/RH program sustainability planning and evaluations, as it highlights domains critical for the long-term sustainability of FP achievements.

Introduction

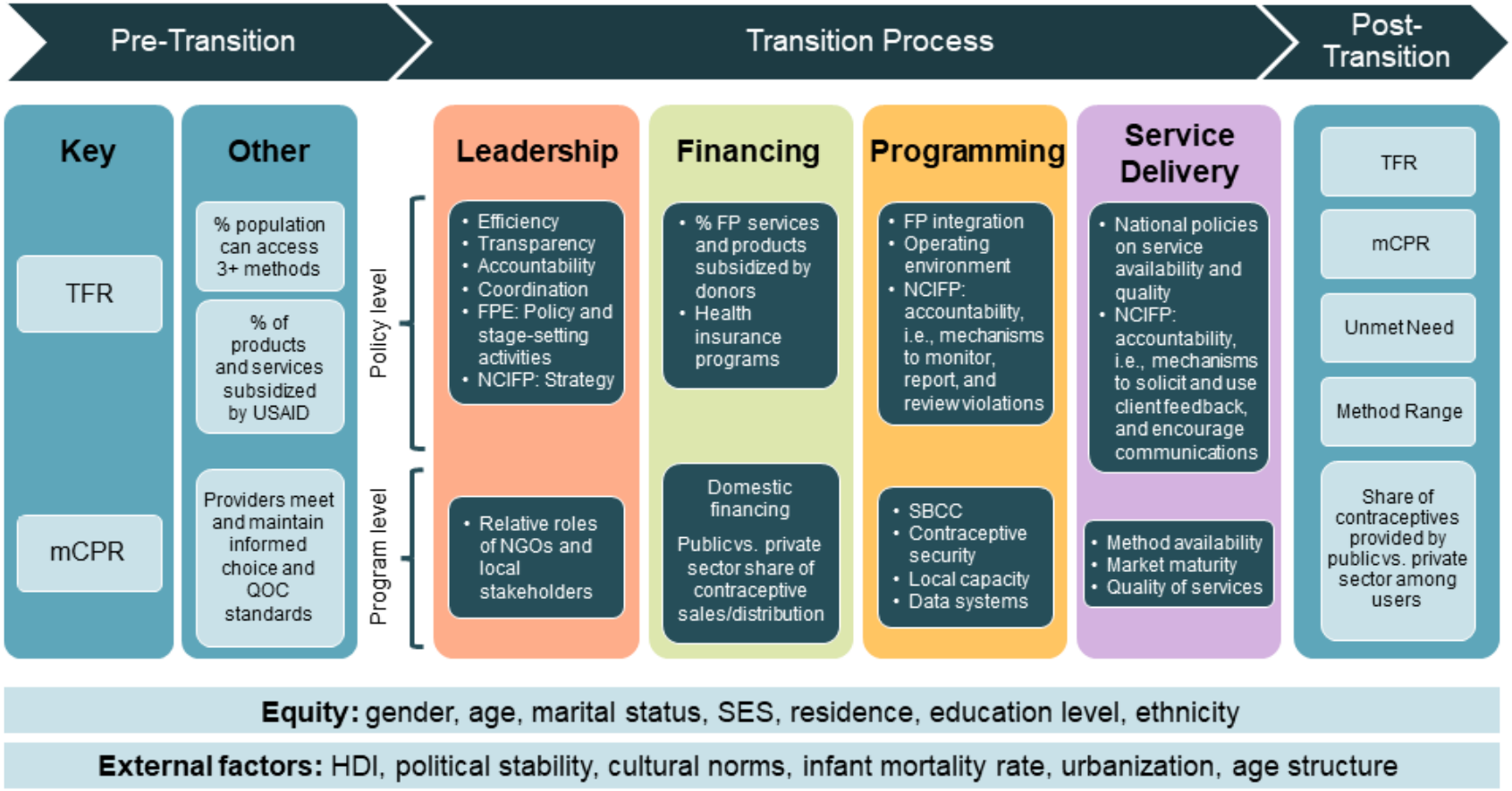
Voluntary family planning (FP) has proven to be a lifesaving intervention that protects an individual's rights. It benefits women's and children's health in communities and societies through reducing poverty and minimizing the impacts of population pressure on natural resources and political stability. The United States Agency for International Development (USAID) is the largest bilateral donor of FP assistance, having provided financial support and technical assistance to countries around the globe for more than five decades. Such assistance has contributed to significant increases in modern contraceptive use and reductions in fertility in recipient countries (USAID, 2023). More than two dozen countries have since transitioned out of USAID financial support (Chaudhry et al., 2012; McDade et al., 2020); however, the process has varied by country. Since 2004, major demographic trigger indicators have been used to inform USAID about the country's readiness for transition. These indicators include: total fertility rate (TFR), modern contraceptive prevalence rate (mCPR), access to FP methods, shares of FP products and services offered in the public and private sectors, and providers meeting and maintaining quality of care standards (O'Hanlon, 2009). Such indicators have been used in combination with other considerations regarding access to FP methods, finance, and quality, as well as the government's commitment and in-country partners' capacity, to determine a country's readiness for transition (USAID, 2004). Once a country was deemed ready, USAID began working with stakeholders on the planning and implementation of transition to support the sustainability of FP programs.

Despite a growing interest in defining and measuring the sustainability of global health interventions and programs, there has not been a consensus on the definition of programs' long-term sustainability (Speizer et al., 2019). Earlier efforts to measure sustainability often focused on the extent to which program components and outcomes were maintained after financial support had ended (Scheirer, 2005; Tibbits, et al., 2010). In this report, we define FP program sustainability as the extent to which not only key FP outcomes but also principal components of the program (including leadership, finance, programming, and service delivery policies and practices, as described later) and equities across sub-groups of populations, have been maintained or improved since USAID ended their bilateral support in the countries.

There have only been a handful of large-scale evaluations of the extent to which FP programs and outcomes have been sustained after the transition, for example, Bertrand et al. (2015), Chaudhry et al. (2012), USAID (2013), and Cromer et al. (2004). A recent report by USAID and the Census Bureau showed that countries that had transitioned tended to have better measures of development, such as the human development index (HDI), than countries that had not transitioned (Goodkind et al., 2021). A common limitation of these evaluations is that they were implemented retrospectively, without an *a priori* monitoring and evaluation (M&E) plan guided by a framework. Most of them were compilations of lessons learned focusing on program outcomes and outputs (Bao et al., 2015). Consequently, while findings were useful for FP/RH programs and countries, they did not necessarily contribute to USAID's strategic transition planning and evaluation, or that of other global donors, in a systematic way. Our exercise, therefore, was aimed to advance the work of strategic transition planning, implementation, and evaluation of large-scale global health programs by developing a guiding framework for this process.

The framework used in this exercise was developed based on a thorough literature review. A detailed description of the framework was included in a technical brief (Data for Impact 2022). In this report, we applied the framework in the evaluation of the FP programs in four countries after they transitioned out of USAID financial support. While the evaluation was conducted retrospectively, we discuss how the framework could be useful for future planning, implementation, and evaluation of FP program transition.

Figure 1. FP program transition framework



Source: D4I (2024) Evaluating Family Planning and Reproductive Health Program Transition from Donor Support: A Proposed Framework. Available at: Evaluating Family Planning & Reproductive Health Program Transition from Donor Support: A Proposed Framework - DataForImpactProject (data4impactproject.org)

Methods

Country Selection

Four countries—Honduras, Indonesia, Morocco, and Peru—were selected, in consultation with USAID, for two main reasons: they represented different geographical regions and transition periods.

Table 1. Selected countries for the study, by year of transition

Country	Year of transition	TFR	At graduation time		Data source
			mCPR among married women	Unmet need among married women	
Morocco	2002	2.5	54.8%	10%	(Ministère de la Santé [Maroc], ORC Macro and Ligue des États Arabes 2005)
Indonesia	2007	2.6	57.4%	13.1%	(Statistics Indonesia (Badan Pusat Statistik—BPS) and Macro International 2008)
Peru	2012	2.6	51.8%	9.3%	(Instituto Nacional de Estadística e Informática 2013)
Honduras	2013	2.9	63.8%	10.7%	(Secretaría de Salud [Honduras], Instituto Nacional de Estadística (INE) and ICF International 2013)

Table 2. Criteria for FP program transition

Criteria	Imminent candidate	Near-term candidate
TFR	<3.0	3.0 – 3.4
mCPR among married women of reproductive age	Greater than 55%	48% – 55%
% population who can access 3 or more FP methods within a reasonable distance	At least 80%	At least 70%
% FP products and services subsidized by USAID	No more than 20%	No more than 30%
Major providers meet and maintain standards of informed choice and QOC	Yes	Yes
Countries	Morocco, Indonesia	Honduras, Peru

Except Morocco, these countries were selected for transition[3] at the time following the guidelines laid out in the technical note on the approach to USAID's FP program graduation (USAID 2004). A FP program would be considered either an imminent or a near-term candidate for graduation according to the criteria laid out in Table 2. Other factors, such as gross national income per capita and the population structure, were also taken into consideration. We provide a brief overview of the transition process in each country below.

[3] The term "graduation" was used at the time to indicate that a program has achieved certain thresholds and no longer receives external assistance, in this case, bilateral assistance from USAID. The term "transition" is used to indicate a more gradual change from one type of assistance to another over a period of time.

Morocco: USAID had been the principal external partner in the FP program since the early 1970s. By the mid-1990s, the public health systems had been functioning reasonably well, so it was then predicted that the country would be ready to graduate by 2000. USAID would support a limited program during the period 2000–2005. The USAD/Morocco Transition Plan was developed in 1995–96 as a result of the collaborative efforts of many key players, both at USAID headquarters and in the country (Gresham 1998). Priorities were given to sustainability without compromising capabilities; consequently, USAID and the Ministry of Health (MOH) began to plan for a transfer of financial support from USAID to the MOH (MEASURE Evaluation 2002). At the time, a diversified method range and promoting long-term methods was a key objective for the long-term success of the FP program; some challenges included provider biases and client misperceptions or lack of awareness of methods (Ministry of Health [Morocco] 1997). Other objectives included: (1) strengthening the logistics system to become self-sufficient in contraceptive procurement and distribution; (2) increasing capacity of in-country partners in the support systems, including social and behavior change communication (SBCC) (or previously: information, education, and communication IEC), quality management, training, M&E, and HMIS; and (3) diversifying FP sources to include the private sector, both for profit and not for profit.

Indonesia: At the time that decisions were made about graduation, Indonesia had already been recognized internationally for the success of its FP program, due in large part to a 30-year partnership between the host government and USAID. Not only had the trigger indicators been achieved, but the FP program was also known for a strong commitment by the government, a high level of involvement by the private sector, and the small family norm among couples (USAID 2004). By the early 2000s, USAID's assistance to Indonesia had already been limited to technical assistance and advocacy. Yet challenges to the program's long-term success had emerged, including decentralization and shifting budgetary decision making from the central government to district leaders. The government began decentralization in 2001. In January 2004, BKKBN officially decentralized; authority over FP services was transferred to local districts. Funding issues became a major concern as insufficient resources were provided at the local levels, and it was unclear how districts could access special funds from the Ministry of Finance and the Ministry of Home Affairs. Meanwhile, very few districts continued reporting to BKKBN, limiting its management's capacity to monitor FP services and the impact of decentralization on services. Other programmatic challenges included a method range dominated by temporary, supply-dependent methods (e.g., injectables), quality, and disparities (USAID 2004).

Peru: USAID had provided assistance to the FP program since the 1960s. By 2004-05, the country had achieved some successes, including a TFR of 2.5 and an mCPR approaching 50%; USAID also no longer provided subsidized FP products and services in the public sector. The success was considered fragile as the other criteria had not been met or no data were available to measure them; yet due to decreases in FP funding for the region, it was recommended that a five-year phase-out strategy would be developed and adopted for Peru (USAID 2006). Major challenges identified by USAID at the time included: (1) the public health systems remained weak, while the private sector was underdeveloped; (2) health data for decision making was unreliable due to a fractured health information system; and (3) inequalities in access and quality of services remained, among others. The 2006–2010 phase-out strategy included five major components that addressed these challenges: (1) decentralization of the MOH service delivery functions; (2) strengthening the MOH logistics system and commodity procurement; (3) expanding the role of the

private sector in FP method provision; (4) institutionalizing quality improvement systems; and (5) strengthening health data systems for decision making (USAID 2006). While some progress was made during this period, notably in the expansion of the private sector and building sustainability for the DHS (or ENDES), USAID's assessment in 2010 revealed that Peru was still unlikely to sustain a strong FP program. A revised phase-out strategy, with USAID's termination of funding in 2014, focused on the following areas: (1) promoting policy commitment to FP at national and regional levels; (2) making FP a priority within decentralization; (3) contraceptive security within the public sector; (4) quality improvement; and (5) sustainable health data systems (USAID 2011).

Honduras: Like Peru, Honduras began receiving USAID's support for the FP program in the 1960s; USAID was the primary donor to the program and a major supplier of FP commodities. By 2006, the program had shown some success in increasing mCPR, with TFR approaching 3.0, and it was expected that by the end of 2008, USAID's subsidization of commodities would end. Yet challenges existed as the program was heavily dependent on the public sector; there were funding and human resource constraints and challenges in maintaining quality standards in all sectors (USAID 2008). With decreases in FP funding for the region, like Peru, Honduras was nominated as a candidate for graduation. A five-year phase-out strategy was developed to focus on contraceptive security, expanding FP access and quality, ensuring the financial and technical sustainability of the DHS, and building management capacity and domestic resource mobilization (USAID 2008).

Data

Data employed in this study included both quantitative data from existing population-based surveys and qualitative data primarily collected through key informant interviews. Key domains of the FP transition framework (Figure 1) guided the focus of both quantitative and qualitative data collection. Specifically, we used quantitative data to assess the long-term sustainability of FP outcomes post-transition, while qualitative data were used primarily to reflect on changes that might have taken place since the transition and the current status of the FP programs.

Quantitative Data

Existing survey data and reports were examined for each of the four countries; these surveys primarily included the DHS, or in some cases, country-led surveys such as the National Demographic and Family Health Survey (Encuesta Demográfica y de Salud Familiar ENDES) in Peru, reports from Track20, Performance Monitoring for Action (PMA), and the United Nations Population Fund (UNFPA). We focus on indicators of FP transition outcomes, including TFR, mCPR, unmet need, method range, and shares of different sources of contraception among current users, for the population and sub-groups, when available. Country-level data from the USAID Global Health Supply Chain Program,[4] as well as Track20's data on the FP Effort Index (FPE) and National Composite Index on Family Planning (NCIFP),[5] were also used to assess some indicators related to leadership, financing, programming, and service delivery.

[4] https://www.ghsupplychain.org/CSI-Survey-Landing-Page

[5] https://www.track20.org/pages/data_analysis/policy/FPE.php and https://www.track20.org/pages/data_analysis/policy/NCIFP.php. FPE was used to measure FP program effort until 2014, when it was revised to NCIFP.

Qualitative Data

Qualitative data came from in-depth interviews with 34 key informants, who had been heavily involved in FP programs in the four selected countries (Table 2). Most participants were located in the country; a few worked in the country but were based somewhere else, including the two participants at the Latin America and Caribbean region level. The key informants were initially recruited through professional networks of the study team and USAID; these contacts then referred other individuals for recruitment. We purposely recruited participants who had been involved in FP at either the policy or the program/service provision level. The list of participants in each country is in Appendix A.

Two interview guides (Appendices B and C) were developed following the transition framework and in consultation with USAID. The first guide was for participants at the policy level, including policy makers, and international and bilateral donors; it focused on their assessment of the country's preparedness for transition and the leadership and financing domains of the transition process. The second interview guide was used with participants at the program and service level, including program managers, coordinators, and service providers (e.g., physicians, midwives, etc.). This guide was focused on assessments of FP programming and service delivery, primarily at the time of the interview. Both interview guides included questions on the overall assessment of FP program sustainability, the transition process developed and implemented in collaboration with USAID, equity issues, and external factors that may have affected the transition process and outcomes.

All interviews were conducted virtually—either via Zoom or WhatsApp—and audio recorded for transcription; members of the study team conducted the interviews in English, French, or Spanish based on the participant's preference. Ethical approval was obtained from Tulane University's Institutional Review Board for human subject research.

Table 3. The number of participants in each country

Country	Number of Participants		Total
	Policy Level	Program/Service Provision Level	
Morocco	4	3	7
Indonesia	3	5	8
Honduras	7	3	10
Peru	5	2	7
Latin American & Caribbean Region	2	-	2
Total	**21**	**13**	**34**

Methods

Quantitative Data

Data and reports from existing surveys were graphed to examine trends in FP outcomes over time and differences in these indicators across population sub-groups in each country. We attempted to analyze the

trends from before to after the transition; however, in some cases, data were only available before the transition.

Qualitative Data

The interviews were transcribed in their original language (English, French, or Spanish) by either a team member or via web-based transcription services (Landmark and Sonix), then translated into English as applicable. Every transcript was reviewed and edited by the study team prior to being analyzed; the NVivo qualitative analysis software (Lumivero 2023) was used for the analysis. Inductive-deductive approaches were employed. An initial codebook was developed by two members of the study team, including the team lead, guided by the domains in the transition framework. Each of the four team members then coded two transcripts from a country where they did not personally conduct interviews; thus, each of the initial eight transcripts was coded by two team members. Team members then shared notes and discussed discrepancies, clarifications, and additional codes as needed.

Two codes were added to the codebook as they were frequently mentioned by participants across countries: (1) “FP integration with other health programs” as a strategy at the policy level under “Leadership,” and (2) “information systems” under “Programming” at the policy level for any mentioning of data integrity, data reliability, or the need to improve the systems, etc. for better FP program and service M&E. The revised codebook was then used by all team members to code the rest of the transcripts; every week, team members gathered their coded data and notes; discrepancies and solutions were discussed and agreed upon. Once coding was completed, the team lead synthesized the codes for major themes with inputs from the rest of the team. All team members, including interviewers, reviewed the emerging themes to ensure that the results accurately reflected the discussions during the interviews. A draft report was also sent to participants for review to ensure that the content adequately reflected their views.

Data Limitations

A few limitations were worth noting before interpreting the results. With regards to quantitative data, we were limited to data and reports available; thus, we could not examine some FP outcomes post-transition compared to those pre-transition. The sample for qualitative data collection was relatively small, constrained by participants’ availability and the time frame of this activity. Due to our purposive sampling scheme, i.e., participants who were heavily involved in the FP program, those who were aware of the transition were likely to be senior, both age-wise and career-wise. On the one hand, they may have insights into the transition process. On the other hand, due to the time that had passed since the transition, recall biases were unavoidable. It is also possible that participants who agreed to be interviewed had strong opinions about the transition process, based on their level of involvement at the time and recollection. Information biases due to selection were therefore also possible.

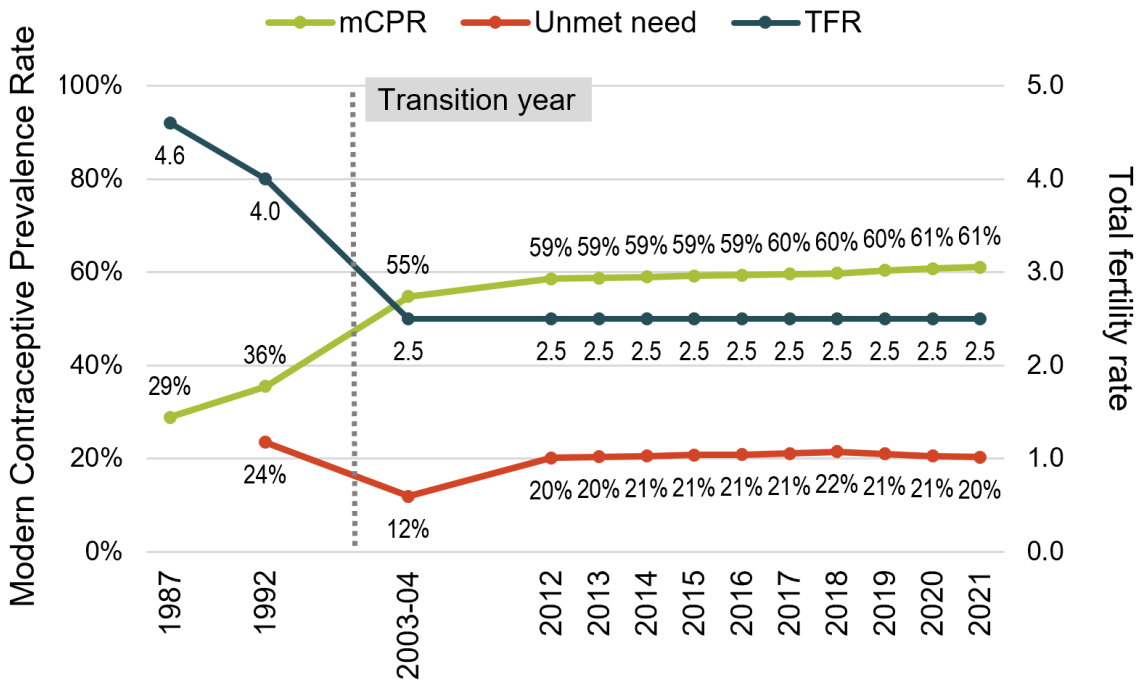
Results

Have the FP programs been sustained?

Figures 2–5 below show the trends in ***TFR, mCPR, and unmet need*** among married women in the four study countries before, during, and after the transition. In general, there were substantial changes in these outcomes prior to the transition, where TFR decreased while mCPR increased, whereas there was a decreasing trend in unmet need, although it was not as evident.

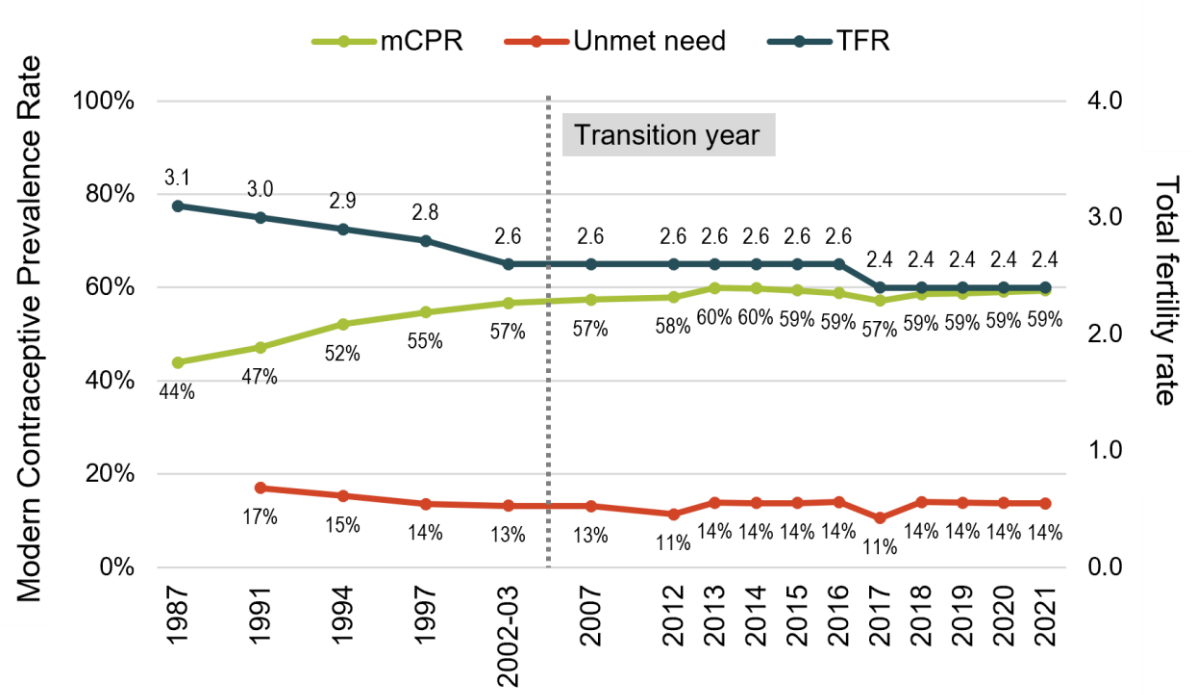
After the transition, the data showed that all outcomes have been sustained in the four countries, i.e., they have been maintained at similar levels without significant increases or decreases. For example, for the 10-year period of 2012–2021, mCPR in Morocco increased slightly by 2.5%. In Indonesia, both mCPR and unmet need remained at approximately the same levels since transition, while there were some slight decreases in TFR. Peru was the only country that showed both increases in mCPR and decreases in TFR since the transition. In the figures below, the vertical, dotted line represents the year of transition in each country, except in graphs where only pre-transition data are available.

Figure 2. FP outcomes among married women in Morocco



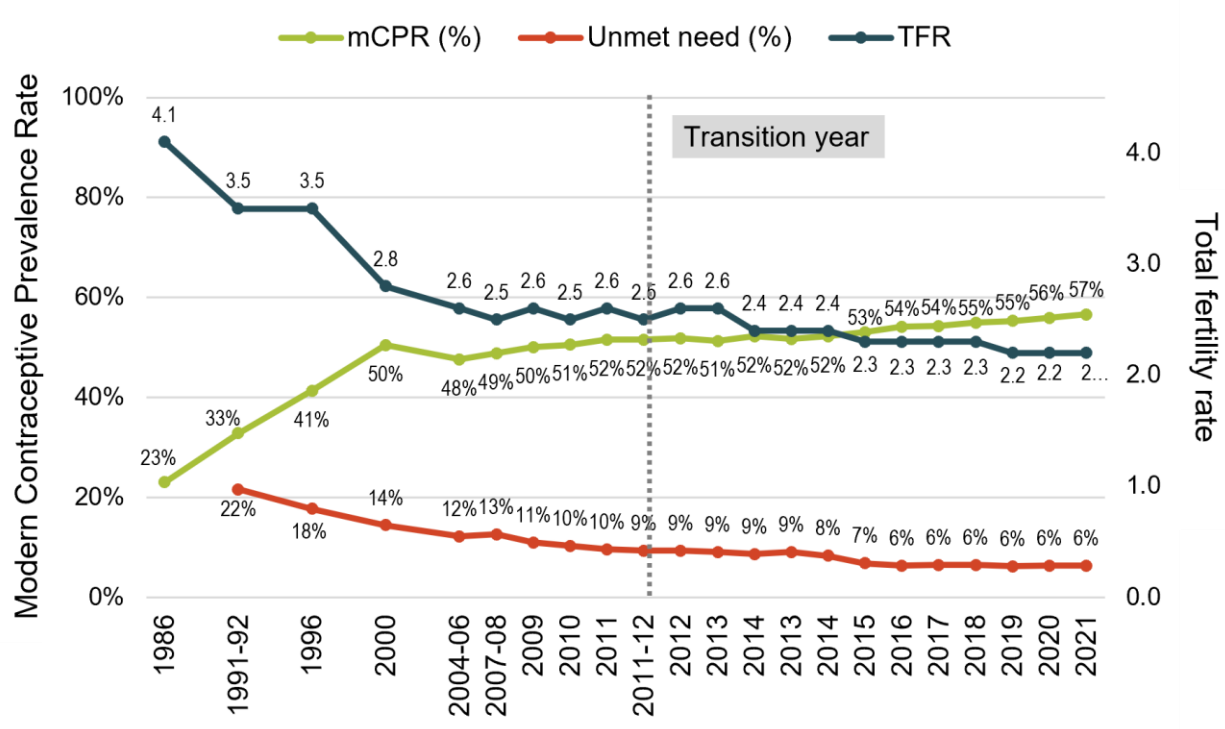
Source: DHS and Track 20 data.

Figure 3. FP outcomes among married women in Indonesia



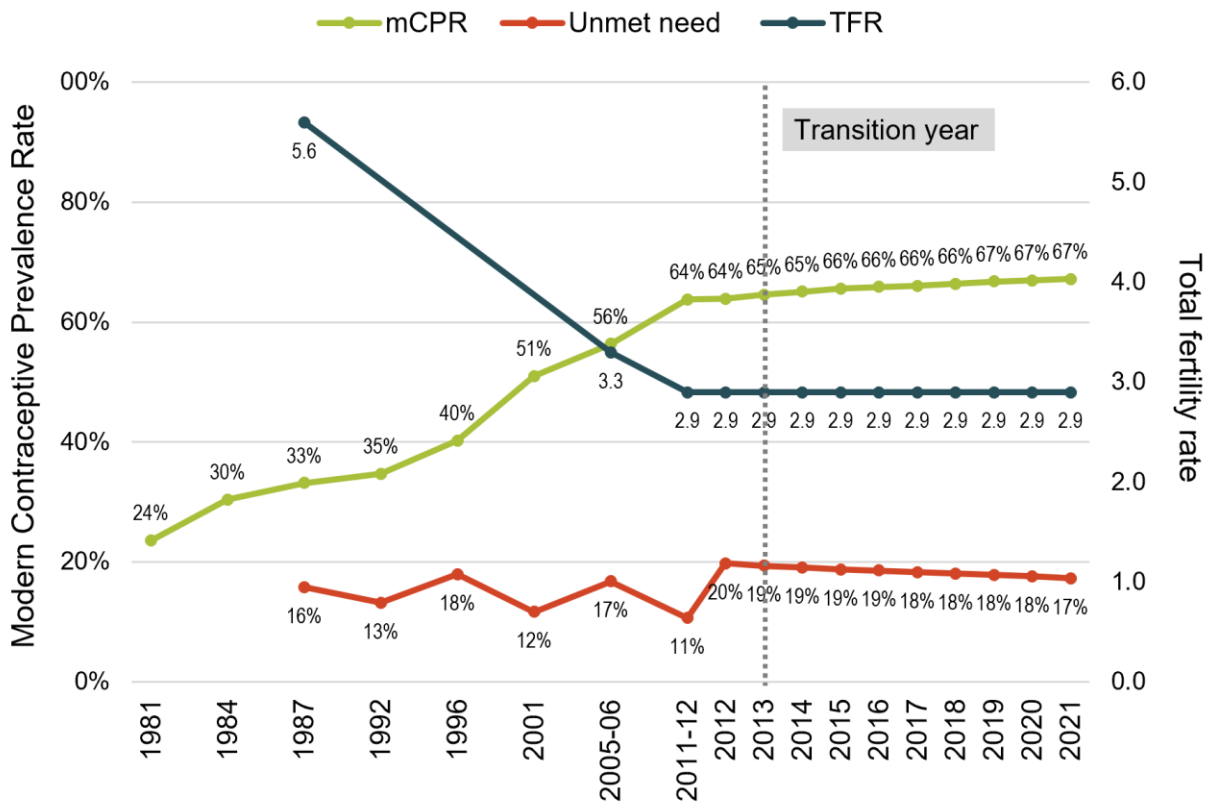
Source: DHS and Track 20 data.

Figure 4. FP outcomes among married women in Peru



Source: DHS, ENDES, and UN data. Note: ENDES only reported FP outcomes among all women.

Figure 5. FP outcomes among married women in Honduras

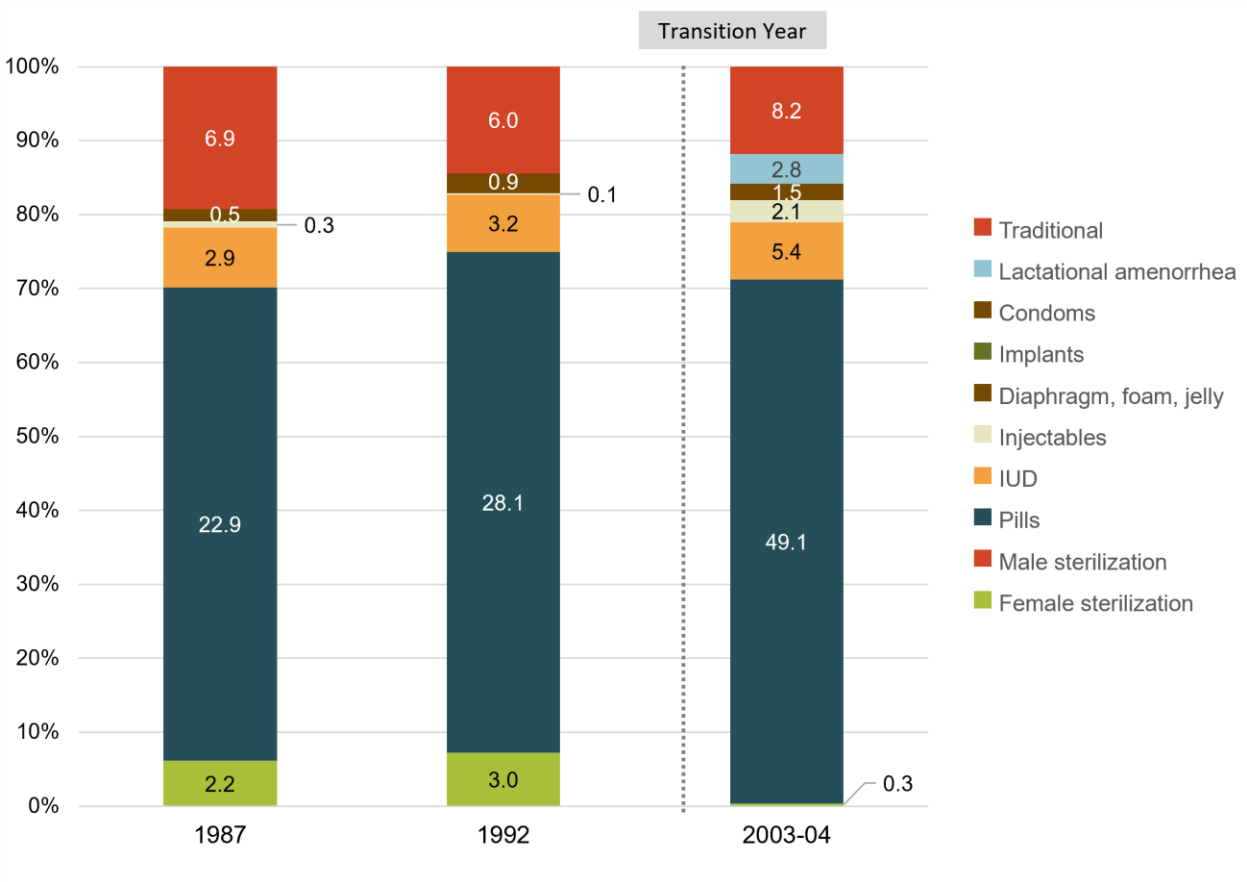


Source: RHS, DHS , World Bank, and Track 20 data.

Contraceptive method range, while important to ensure the needs for FP of couples and individuals at different stages of their reproductive life were met, did not show changes in the diversity of method types and the number of methods currently used over time. Figures 6–9 show the distribution of methods among current users. The four countries shared some similarities, where short-acting methods seemed more frequently used than any other method of contraception. Long-acting methods, like intra-uterine devices (IUDs), enjoyed initial increases in use in the mid-to-late twentieth century along with many technological developments of the product (Reproductive Health Access Project, 2024), but saw decreases in the prevalence later, largely due to side effects (Costescu et al., 2022), which were also highlighted by our participants.

In Morocco (Figure 6), oral pills remained the most frequently used method, followed by condoms, while there was a small increase in injectable share of contraceptive use from 1987 until shortly after the transition (2003–04), although overall there was still evidence of method skew towards oral contraceptives with the majority of users taking pills. Meanwhile, the share of female sterilization was significantly reduced (only 2.7% of married women of reproductive age were using it in 2003–04). Some participants noted that quality of services and client preference due to side effects associated with other methods had an impact on the skew towards the pill. It should be noted that only data from before the transition were available; nevertheless, the relative importance of these three modern methods seemed to remain, as evident from our qualitative data (discussed later).

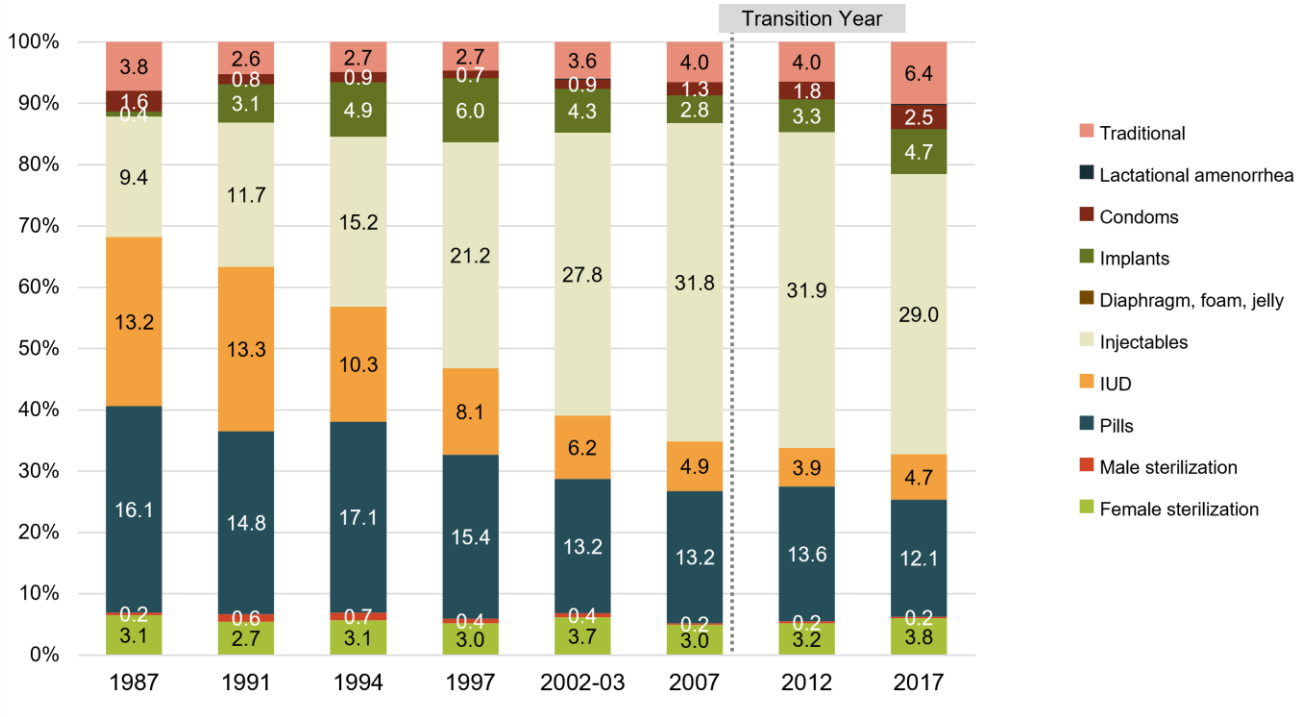
Figure 6. Contraceptive method range among married women, Morocco



Source: DHS data.

Figure 7 shows data from Indonesia, from before the transition to ten years post-transition. Over time, IUDs were being replaced by injectables, while oral pills remained among the three most frequently used methods, and the share of users of female sterilization was stable. Like in Morocco, there was a small proportion of married women who continued to rely on traditional methods in Indonesia.

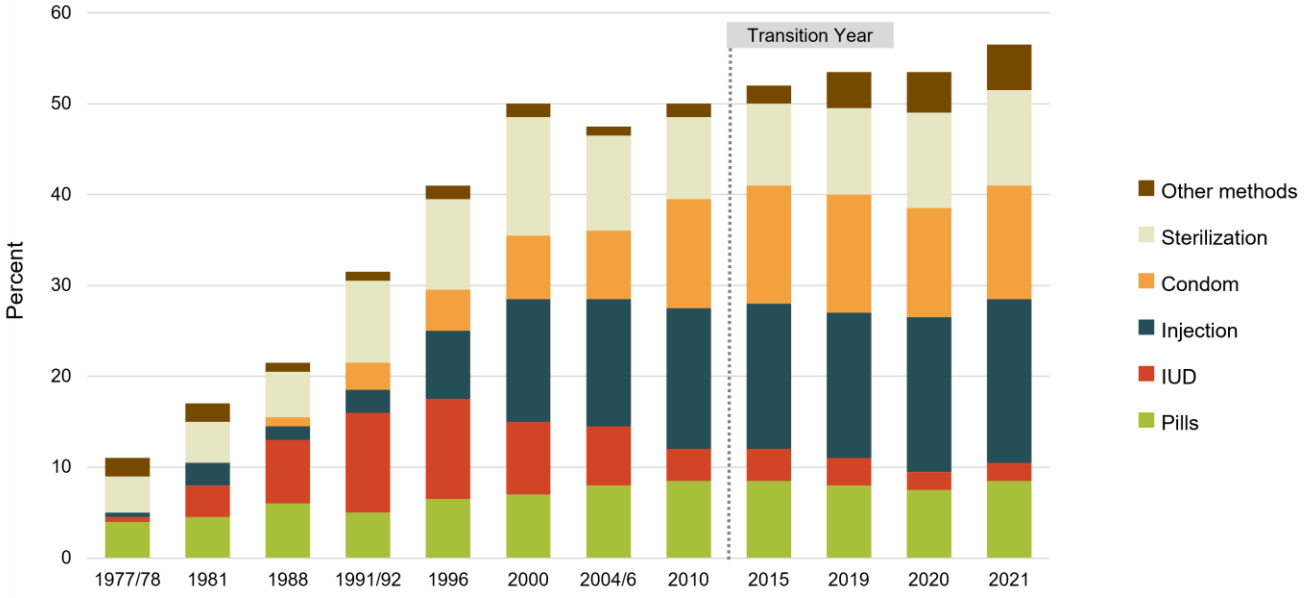
Figure 7. Contraceptive method range among married women, Indonesia



Source: DHS data.

In Peru (Figure 8), where we obtained the most recent quantitative data from one of our key informants at UNFPA, injectables and condoms were most often used among married women, followed by sterilization. Oral pills had a small but not insignificant share among users, while IUD use was also declining and replaced by injectables, as observed in the other study countries.

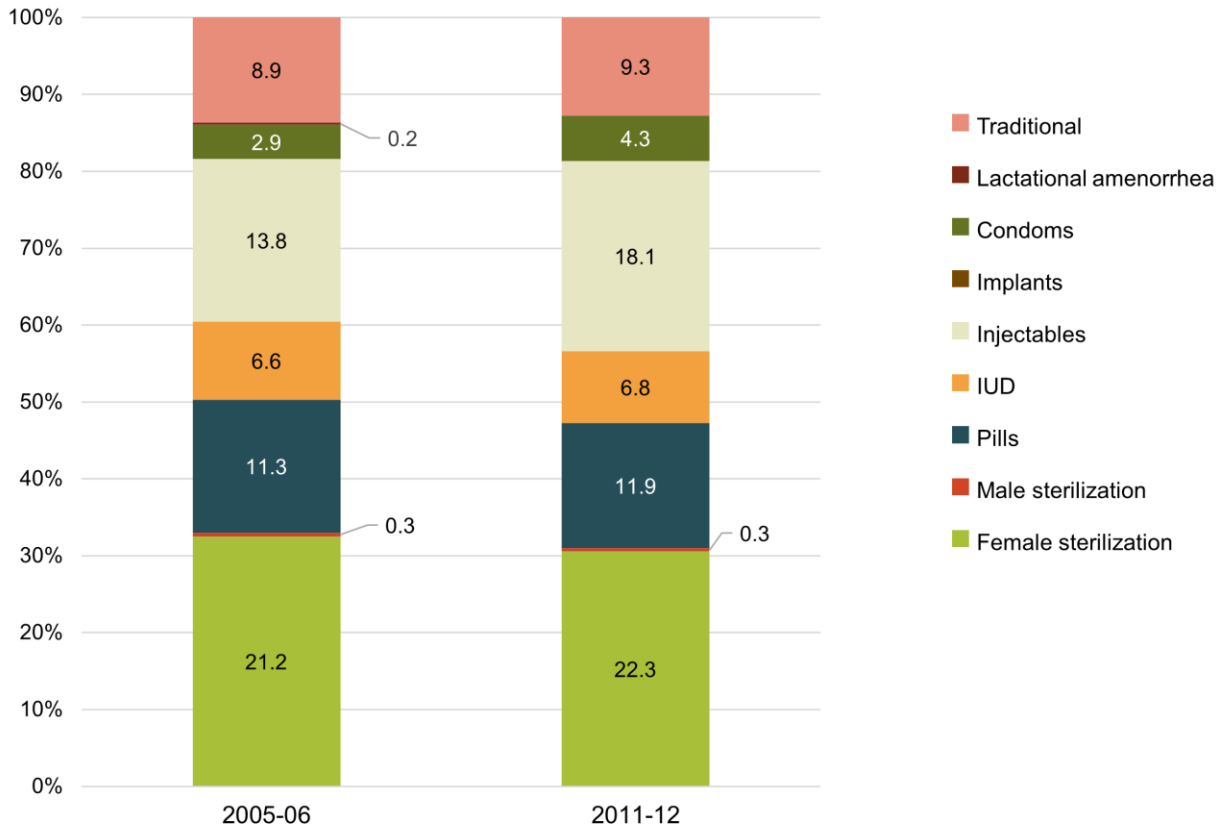
Figure 8. Contraceptive method range among married women, Peru



Source: Walter Mendoza, UNFPA, 2023. Exact numbers not given.

Finally, in Honduras (Figure 9), where we also only had pre-transition data, female sterilization was most common, followed by oral pills, injectables, and IUDs—a similar pattern in short-acting methods seen in the other study countries. The range of methods did not change over time until the transition. During the interviews, our key informants stated that the same short-acting methods remain popular at the time of the interview; this will be discussed in the subsequent section.

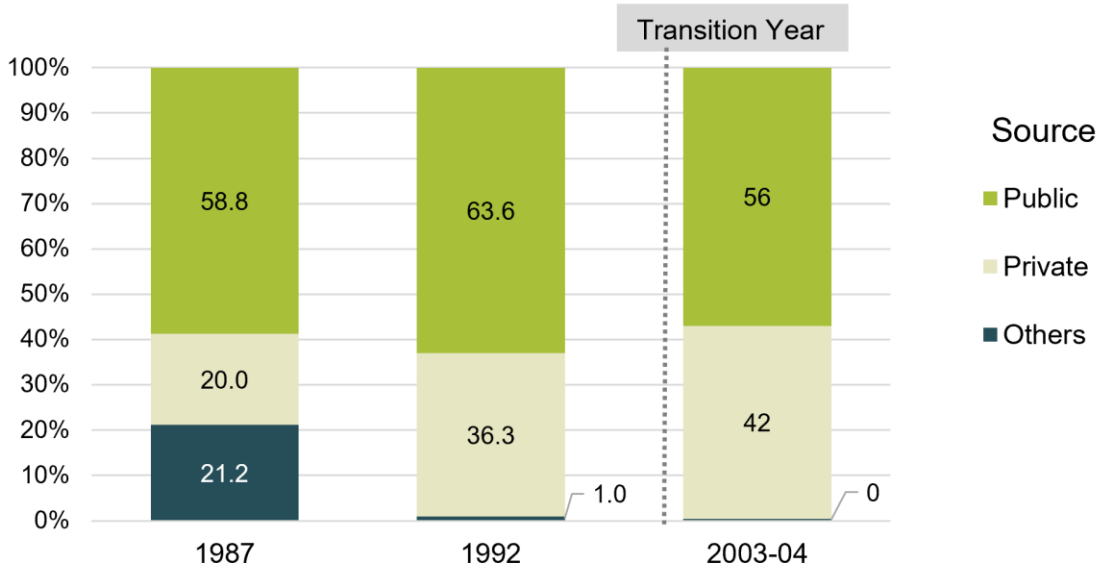
Figure 9. Contraceptive method range among married women, Honduras



Source: DHS data

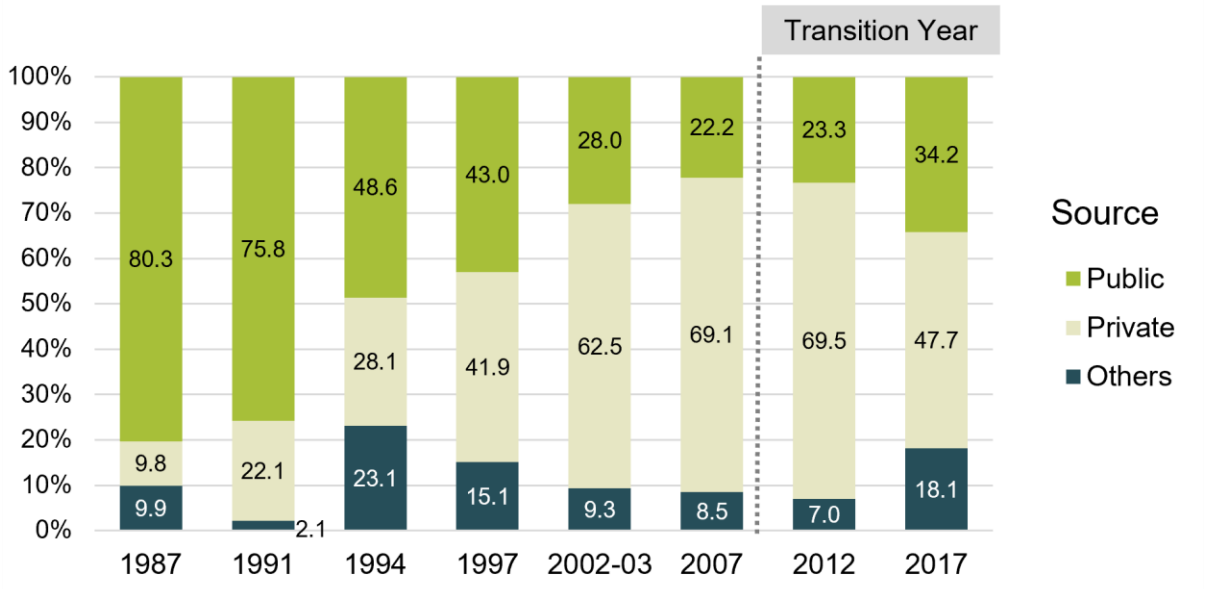
Lastly, we examined the ***source of methods*** among current users (Figures 10 through 13). While we had only pre-transition data in Morocco and Honduras, the data showed similar patterns among the four countries. The public sector was the major provider of contraceptives in three out of the four countries, except Indonesia, where the share of the private, for-profit sector started increasing well before the transition but seemed to decline by 2017. In Peru and Morocco, the share of contraceptives provided by the private sector increased slightly leading up to the transition years. The share of the nonprofit sector among contraceptive users remained very small in all countries. These patterns were consistent with the narratives from our participants and have implications for the sustainability of FP programs.

Figure 10. Sources of contraceptive methods among current users, Morocco



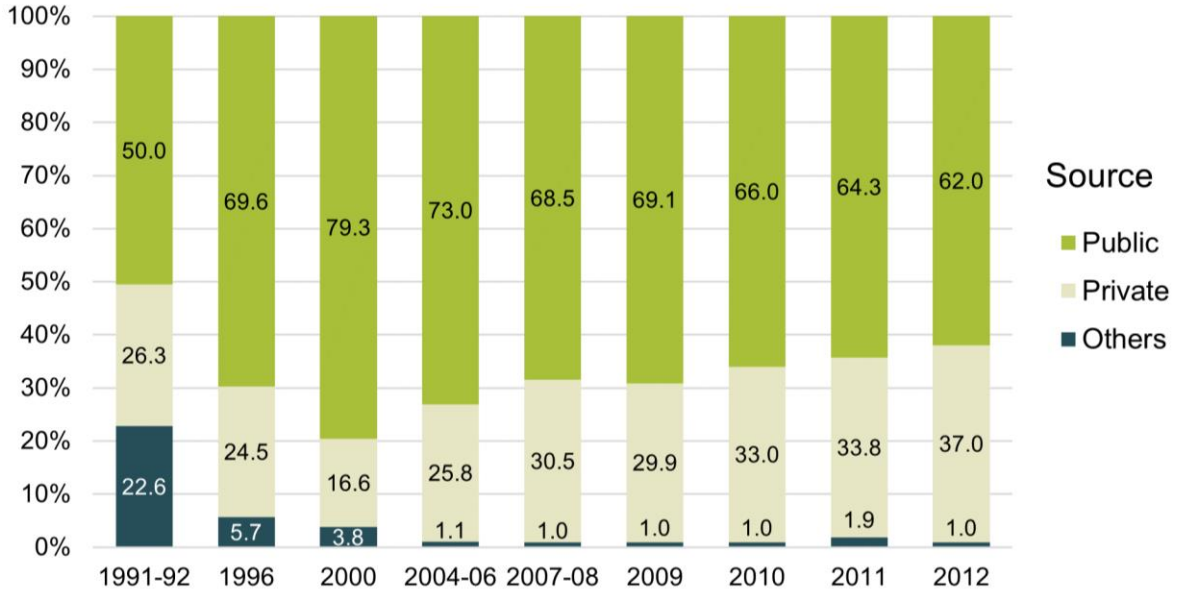
Source: DHS data.

Figure 11. Sources of contraceptive methods among current users, Indonesia



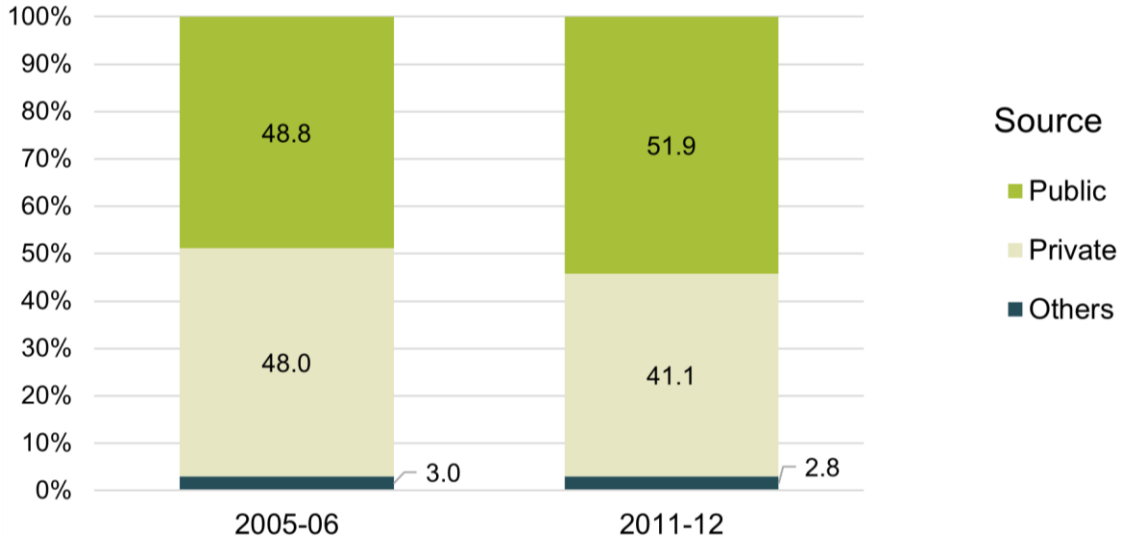
Source: DHS data.

Figure 12. Sources of contraceptive methods among current users, Peru



Source: DHS and ENDES data.

Figure 13. Sources of contraceptive methods among current users, Honduras



Source: DHS data.

Qualitative data showed mixed responses about the level of success and what contributed to it across countries. "Success" was defined by our participants primarily as improvements in key FP outcomes (TFR, mCPR, and unmet need), although in some cases, like Morocco, participants acknowledged that it was much harder to increase mCPR since it was already high. Participants attributed success, or lack of it, for each respective country to a few key factors, including the roles of governments and stakeholders, emphasizing the levels of political and financial commitment, policies, and governance—factors highlighted in our transition framework. Most participants from Morocco shared very positive comments on the commitment from the highest levels, including USAID, the Mission, and the MOH, which contributed to a gradual and smooth transition process. The commitment and investment of efforts and finance led to strong partnerships and collaborations across sectors in this country, as one participant said:

> "The Ministry of Education was involved, as was the Ministry of Labor. There have been conferences in mosques on the subject… [omitted] there were conferences, there were meetings, there was a lot of that." (M7)[6]

In contrast, a participant noted the lack of long-term commitment in Peru:

> "So, when USAID decides they're going to leave a country and not fund it anymore, because priorities have changed, most of the other donors leave, too, if they haven't left already [omitted]. So, then the country—there was a lot of thinking initially, well, other donors can take this on. Well, that doesn't happen because they all leave. [omitted] But a lot of it is always about politics. Who is in charge? What are their priorities?" (Regional 2)[7]

On the population side, participants underscored the high level of overall FP knowledge as a sign of success in Morocco—near "universal," as one participant (M1) noted. Furthermore, it was so widespread that there were no perceived differences between rural and urban areas; consistently, no differences were observed in FP outcomes between urban and rural in Morocco.

> "…no disparities between urban and rural areas, the demand is there, the needs are expressed, and there has been a response to these expressed needs in terms of contraception." (M6)

Have there been changes in FP outcomes in recent years?

Participants were asked to describe changes, if any, in FP outcomes since the transition. Participants generally agreed that FP outcomes in their countries had not changed significantly recently, for very different reasons in each country. In Morocco, participants stated that contraceptive use was already so high that it was hard to increase much further and that contraceptive use had already become a widely accepted behavior at the time of the transition. Participants again attributed the absence of rural vs. urban disparities to the transition process and the continued strength of the program.

> "Rural women use modern contraception in such a way that there's no difference between urban and rural areas. This means that the program has maintained its growth and consolidation despite the withdrawal [of support] [omitted] Things were prepared calmly and in a good time." (M7)

[6] For participant quotations, abbreviations for countries are Morocco (M), Indonesia (I), Honduras (H), and Peru (P). The number refers to the participant number. For example, "M7" means "Morocco, participant 7."
[7] "Regional" refers to the participants at the regional level from Latin American and Caribbean countries.

However, in Honduras and Peru, participants attributed the lack of changes in FP outcomes since the transition largely to the absence of commitment at the high levels of management, e.g., the MOH at the central level. A policy maker in Honduras talked about the lack of actions and its consequences:

> "When the programs disappeared, we had difficulties…. [omitted] we have been dragging until now, we are seeing that we have high incidence of teenage pregnancies, also high rates of unwanted pregnancies, unsatisfied need. That is what we are experiencing now. [omitted] If we put a lot of interest and commitment into these FP programs, we can reverse the situation." (H9)

An additional contributor to the lack of progress in Peru was the reliance on traditional methods in conjunction with the lack of promoting modern methods, especially male and female voluntary sterilization, in part because "many providers have been accused and have criminal trials" in the past, related to the former President Fujimori[8] (P6). The same participant said:

> "Contraception here in the country is a topic that is talked about but not internalized." (P6)

It is worth noting that the participants' points of view need to be interpreted within a larger context. On the one hand, some participants in Honduras and Peru might have seen the lack of changes in FP outcomes as stagnancy. On the other hand, it could mean that FP outcomes in these countries have remained stable, despite the perceived lack of commitment and investment. This is consistent with quantitative data, which indicated a stable TFR and some improvements in mCPR and unmet need in Honduras (Figure 5), and improvements in all three indicators to a larger extent in Peru (Figure 4).

Slight increases in mCPR and decreases in TFR were also observed in Indonesia post-transition. In addition to the already high mCPR at the time of transition, many participants attributed these small changes to the shifting of priorities of BKKBN from FP to a focus on child nutrition and stunting in recent years, coupled with the lack of investment, financial and otherwise, within the MOH. The quality of FP counseling and services was also a concern raised by several participants, leading to increasing discontinuation rates, which might have limited further increases in mCPR. The rise in conservatism among some groups, particularly the highly educated, was another concern raised by participants in Indonesia and Morocco.

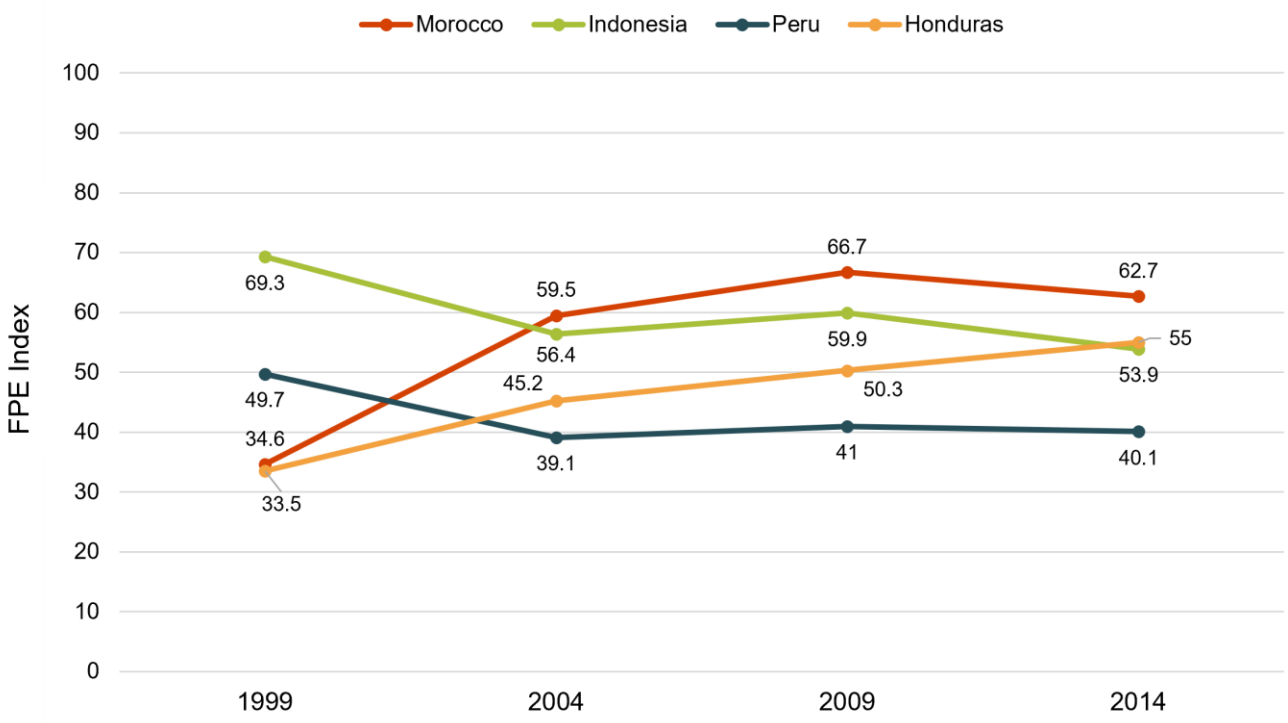
What changed during and after the transition?

Figures 14 and 15 below show the overall FP effort scores in the four study countries. Due to changes in the definitions and scales of the scores, we present the FP Effort Index from 1999 to 2014 and the NCIFP from 2014 to 2021 separately. The figures indicate that FP program efforts in Morocco were increasing prior to the transition (2002) and became stable for ten years post-transition, which is supported by qualitative data; however, the score seemed to have declined since 2014. Indonesia saw a different trend with the FPE index, which declined between 1999 and 2004 but seemed stable after that; meanwhile, the NCIFP has been on the increase since 2014. Peru saw a similar pattern in FPE index, as in Indonesia, between 1999

[8] After gaining power in 1992, President Fujimori gained much popularity in the country as well as the international community through achieving economic growth and creating a favorable environment for FP. The government put explicit emphasis on equal access to FP/RH services for all women. However, in the late 1990s, the government established quotas on female sterilization, resulting in sterilizations that were forced or coerced (through providing incentives to women and families), tarnishing the government's reputation for years to come. (Del Aguila, E. V. (2006). "Invisible women: forced sterilization, reproductive rights, and structural inequalities in Peru of Fujimori and Toledo." Estudos e pesquisas em psicologia **6**(1): 109-124, Boesten, J. (2007). "Free choice or poverty alleviation? Population politics in Peru under Alberto Fujimori." Revista Europea de Estudios Latinoamericanos y del Caribe/European Review of Latin American and Caribbean Studies: 3-20.

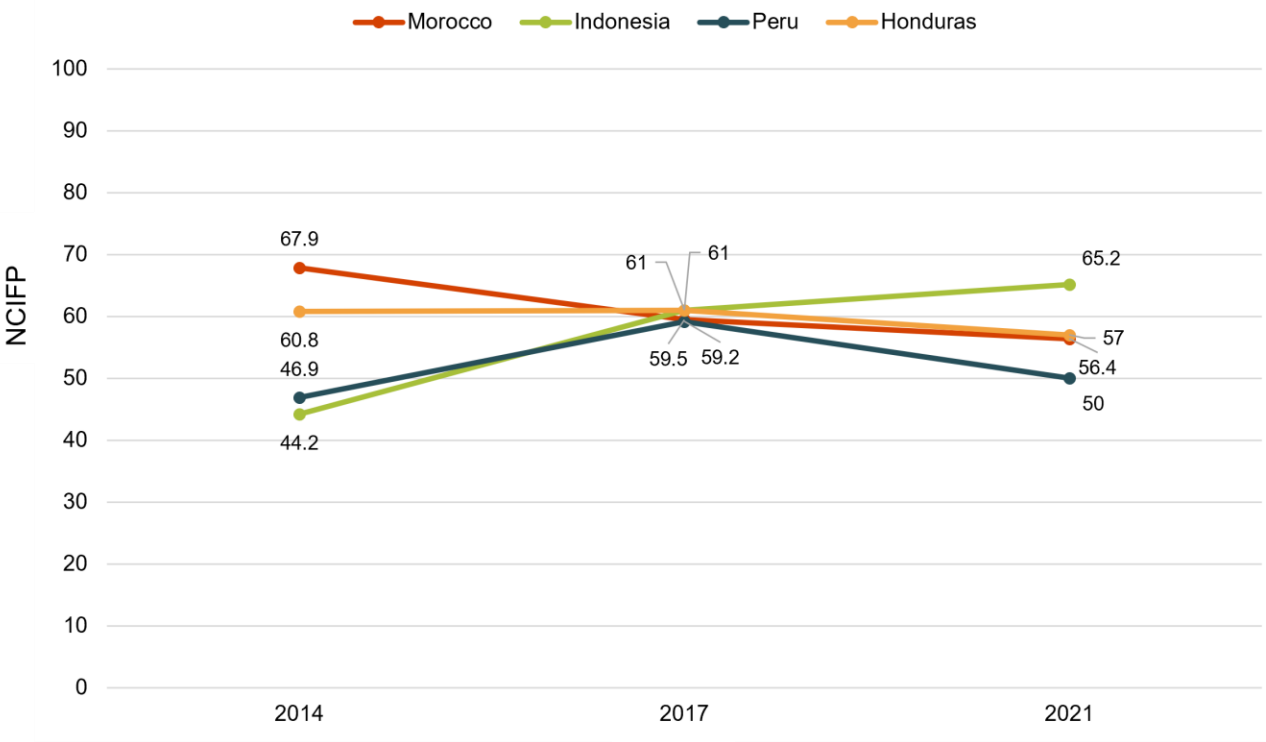
and 2014, although the FPE index in Peru was the lowest in the four countries between 2004 and 2014. Honduras, however, saw an increasing FPE index up until 2014, primarily due to increases in the policy, services, and access domains (not shown). After the transition, the NCIFP score in Honduras was relatively flat, with significant decreases in two domains: strategy and data (not shown).

Figure 14. FP Effort Index in four study countries, 1999–2014



Note: Dashed line signifies transition year

Figure 15. NCIFP in four study countries, 2014–2021



"So what happened? What changed in the program?" We also asked participants. ***Morocco*** was an example of success, where participants talked positively about the process of transition at both policy and program/service levels. Three key factors were highlighted by participants: (1) the gradual process of transition, (2) the involvement of multiple partners, and (3) FP program integration.

> "It has been very positive in terms of progressive integration of a comprehensive approach." (M2)

The commitment and leadership of the MOH were mentioned by several participants from the beginning of the transition process and since the transition. A policy maker in Morocco emphasized how USAID and the MOH were able to implement a comprehensive transition process that moved the country from financial dependency to self-sufficiency and complete autonomy. This process involved many conferences and meetings with multiple stakeholders to bring everyone on board and ensure a smooth transition of all components of the FP program.

> "USAID and the management team at the Ministry did a smart job when moving from dependency in terms of the components like training, commodities, etc. to the MOH and within it… [omitted] how delicately they moved. It has worked." (M1)

Another participant emphasized the leadership of the MOH since transition:

> "Since 2002, the MOH has taken two major actions. The first was to secure the purchase of contraceptive methods completely… [omitted] The second was the involvement of the liberal sector [i.e., the private sector]." (M3)

The latter, the involvement of multiple sectors, including the private sector, religious groups, and UN agencies, was key to maintaining FP program outcomes.

> "We involved religion, religious people. We involved private sector, then TV, media, etc…. Right now, they are working on integration." (M1)

The role of the private sector was recognized through several projects mentioned by our participants, including the Social Marketing Project and the Public-Private Partnership, two major USAID-funded projects in Morocco. However, our participants also recognized Morocco's reliance on short-acting methods and the need to increase long-acting reversible method use through "more emphasis at the community level in terms of sensitization and information sharing [about contraceptives]" (M2). Coordination across sectors was another area that could be improved, according to several participants.

Indonesia showed a more complex picture of changes during and since the transition. It was generally thought that at the time of transition, "the program was progressing very well" (I1), and mCPR was at 57.4% (Figure 3). The focus at that time had already shifted from increasing contraceptive use to increasing the quality of services and promoting human rights in decision making related to FP, where women could choose if and when to use contraception. The private sector was going strong with quality improvement programs, including the Blue Circle and the Gold Circle programs.

Since the transition, many changes have taken place. Like in other countries that experienced transitions, although USAID had already limited their support to technical assistance by the time of transition, the field of FP got smaller in Indonesia when USAID completely stopped their support, which affected the FP program directly and indirectly.

> "There are not many players in the FP program, that's also the lacking in Indonesia, [so] recent development, new technology, new ideas in FP program was not as good as before." (I2)

Procedures and tools, such as those for M&E, previously developed with USAID's support, became less likely to be used, primarily because the infrastructure needed to implement these tools was no longer a priority.

> "There is no such systematic M&E of the providers. That's what USAID started its program at the time. They tried to help the government to develop the fundamental, the basic, like quality improvement, and so on. The tool is there, but the government is not really implementing the tool now." (Anonymous)

Another significant barrier to maintaining the high profile of the FP program that emerged in 2017 and was highlighted by nearly all participants was the shift in the strategic priority of BKKBN from FP/RH to child nutrition and stunting reduction, reportedly as directed by the President. While the leadership of BKKBN remained extremely strong, the priority resulted in the shifting of investments within BKKBN. Finally, the central government's decentralization, moving much of the policy decision-making power to the district governments, was noted by many participants to contribute to the lack of consistency between the central government's policies and the actual practices and implementation of such policies by the local governments. Coupled with a lack of infrastructure to ensure the quality of implementation, most of the participants expressed uncertainty about the delivery of FP services at the grassroots levels.

In ***Peru***, several leadership factors, notwithstanding the shadow of Fujimori's policies, were mentioned by participants as key changes in the FP program during and after the transition. In-country political leaders were important in several ways. Frequent government leadership turnovers led to political instability; e.g., several participants mentioned the country having seven presidents in the last six years, with the new government possibly more conservative than the last. More directly impacting the FP program were the lingering effects of former President Fujimori. He was credited by participants for his commitment to FP and actions that he took in the 1990s to "open the doors to the creation of a sexual and reproductive health policy, a specific sexual and reproductive health program, and this opened the possibilities for everyone to have totally free [FP] methods." (P6) However, later government corruption and the scandal related to involuntary sterilizations led to program declines. Combined with reductions in donors' financial support and technical assistance, challenges in these areas of leadership within the country contributed to some extent to the loss of services and quality of services due to reduced supervision.

> "I think that [i.e., quality] has been lost. It's not that it doesn't exist in writing because yes, it is in writing. It's just that providers don't do it and that's it… [omitted] there are no sanctions either… there is no supervision." (P6)

This theme from participants is consistent with USAID's 2010 assessment on the progress of the transition (USAID, 2011). The report indicated that there was weak government commitment to FP, which could lead to confusion at the program level. An example was that while FP services were included in the Seguro Integral de Salud insurance package, promotion materials of the plan did not mention FP, resulting in providers' confusion about whether some FP services, e.g., female sterilization, could be reimbursed. The report also indicated that there were few strong champions for FP. While advocacy was an area of focus in the transition plan, the Mission supported little or no advocacy activities. The assessment team then recommended that the transition period be extended to 2014 (USAID, 2011).

The middle management, on the other hand, was credited for keeping the program running, despite the lack of leadership commitment and investment. A participant said:

> "Even if we don't have the political will at the highest levels, we still have a mid-level bureaucracy that maintains the program." (P2)

In addition, the civil society was recognized as an important force that helped maintain the program:

> "We have a civil society that is very vocal and very loud, and it's ready to jump to court if necessary… a strong society support to the program even if we don't see any huge activities from Presidents and first ladies." (P2)

In ***Honduras***, the participants' views of the transition and its implications were less positive compared to the other study countries. It was universally stated that the transition seemed to be an "overnight kind of thing", and that "we don't think it was the best time for graduation." (H2)

> "In 2013, the State decided to get rid of the program, and activities were left without 'a godfather/sponsor' to use a word at the central level." (H3)

Several participants mentioned that they did not recall an explicit transition plan and process.

> "I don't remember that there was an explicit plan in terms of developing capacities for training or maintaining the capacities of training, supervision, adequate projection of needs for procurement and how to make sure that the DHS will continue over time." (H5)

In reality, a phase-out strategy was developed in 2008 (Farrell et al., 2008), when the USAID/Honduras program had met two indicators for imminent transition: mCPR and the percentage of subsidized FP products and services. Several challenges were identified at the time, including high TFR and unmet need in some departments, poor market segmentation with the MPH serving about 44% of the population, and limitations in funding, human resources, and technical capacity. It was recommended that the transition of USAID's financial support should be completed by the end of 2012, although some activities might carry over until 2013. The transition strategy focused on contraceptive security, expanding FP access and quality, ensuring the financial and technical sustainability of the DHS, and building management capacity. An example is the work with the MOH, in collaboration with UNFPA, to ensure FP commodities (Meza et al., 2005). In addition, USAID continued working with the government and the MOH beyond 2012 to provide technical support in developing service delivery plans (see, for example, Unidad Local de Apoyo Técnico para Salud/Management Science for Health (ULAT/MSH) 2012, 2014.)

Nevertheless, participants tended to attribute the perceived lack of a transition plan to the weakening of many critical elements of the FP program, from supply procurement and distribution to personnel training and service quality assurance. The budget was cut, leading to rural coverage being cut in half. The diversity in FP methods was also reduced while challenges in introducing new, long-acting reversible methods, such as implants, persisted. The Assurance and Supplies Committee that coordinated the civil society, such as ASHONPLAFA (or Honduran FP Association), and the government, MOH, and the Honduran Social Security Institute worked well with USAID's support; regular, coordinated meetings with stakeholders were conducted. However, this coordination stopped functioning in 2015. In addition to these changes, the integration of the FP program and changes in priorities led to the absence of a formal FP program. Instead, there were now a series of FP activities within the Directorate of Health Service Networks. Changes in people in leadership positions contributed to the decreasing attention to the FP program.

> "When USAID left, the Ministers were not interested in the subject, they were not interested in giving it the importance it had been given… [omitted] It was not the institution that changed, but the people. [omitted] It did hurt us much because we did not look at indicators, and they were not monitoring, e.g., key indicators or the process of purchasing supplies. Equipment was not purchased. Personnel were not trained. So that has affected us a lot." (H9)

Another participant summed up the current program below:

> "I would say that the program was definitely operational… but maybe some of the things that we would've been doing on a regular basis, I wouldn't say had dropped off entirely, but maybe had tapered off a little bit. A lot of the training around counseling, supervision around counseling, etc." (Anonymous)

Factors Influencing FP Program Sustainability: Key Framework Domains

In this section, we discuss in detail how each domain, along with its key indicators, outlined in the transition framework (Figure 1) contributed to the extent to which the FP programs and outcomes have

been sustained in the four countries. Major emergent themes from interviews across the four countries are discussed, and differences between countries are highlighted when relevant. Depending on the country, some domains might have been discussed more than others. For each domain, we only described findings from countries where there was a substantial discussion.

Leadership

Within this domain, discussions centered around the vision and commitment of the central leadership, namely the MOH, and the importance of multisectoral and multi-level partnerships and coordination to ensure continuous funding, training, and consistency in programming across government levels. In the discussion below, we focus on the key themes that emerged from the interviews, including: transparency and accountability, coordination, and FP program integration.

Transparency and Accountability

Participants often discussed these two topics in relation to each other. Most participants could define transparency and accountability, but a participant from Morocco summarized it the best:

> "Accountability and transparency mean [a] constellation [of things] related to the development of programs or national policies. In terms of monitoring, reporting, and evaluation of all institutions, all initiatives, etc. Also, in terms of how the institutions and individuals, health providers or eventually others are responsible for their actions when it comes to the provision of services and the integration of human rights, gender, and culturally sensitive approach in everything they do in terms of the possibility for NGOs [nongovernmental organizations] or civil society to have a say when it comes to the provision of services and the quality of services." (M2)

Many discussed transparency regarding finance and FP activities, including commodity procurement and distributions. Most participants from Honduras, Indonesia, and Morocco had fairly positive views of transparency and expressed a strong sense of trust with the public sector, nonprofits, UN agencies (Morocco), and with the MOH (Honduras) or BKKBN (Indonesia). Participants felt that there were standards of operation and external auditors that helped maintain financial transparency. However, participants in Peru had mixed perceptions about transparency; the major concern being public sector providers taking FP supplies from the public sector to sell in their private practice. While the practice may reflect gaps in private sector providers' access to affordable contraceptive commodities, it could create mistrust in providers and in the data reported and may bias the entire system of commodity projection, procurement, and distribution. As one participant stated:

> "It's all MOH implants, and then they wrote me a report saying that we have not been lucky with implants. This is plain robbery. Product disappears? Fake patients are created, and 1, 2, 3 implants are sold per day. It's a lot of money, especially if you can sell them in the private sector for $80, $100. It is unfortunate." (P2)

Transparency and accountability were also a concern in Indonesia, where participants were worried that public sector providers might take short-cuts in their work to spend more time providing the same services in their private practices, undermining access and quality of services in the public sector.

Specific to accountability, participants talked about the extent to which FP programs were committed to

delivering benefits to communities. Accountability also included mechanisms to monitor and assess FP activities and outcomes to ensure that such benefits were delivered. Two aspects of accountability were deemed important by our participants. On the policy front, there needed to be up-to-date FP policies to affirm commitment and facilitate service provision. On the data front, there needed to be a robust health management information system (HMIS) to monitor FP activities and indicators in a reliable way.

Coordination

Most participants stated that coordination was critical for FP programs, whether it was for a vertical program to ensure consistency across service delivery levels or for multisectoral partnerships. Many, however, felt that it had been missing since transition. Only in Indonesia did some participants say that there was some degree of coordination at the central level, but not at the lower levels.

> "In the central level in Jakarta, there is a MOH and BKKBN, in the province also, there are two separate agencies, and similarly at the district level. All the coordination is not running smoothly, so decentralization is definitely one issue." (I2)

Integration

The integration of FP with other health areas was a theme that emerged from our interviews and was considered by many participants an important factor in the continued success (or lack of it) of FP programs. In Morocco, FP integration was considered a major contributor to the smooth transition and the sustained success of the program. This is likely due to the MOH's leadership and close coordination with the USAID team in prioritizing the integration of FP and MCH programs during the transition process. Because of integration, the FP program was no longer seen as directed toward meeting service-specific demographic targets; thus, it faced less opposition. By being integrated with other health programs, FP also became part of development and became more important as a national priority. As a result, FP services became more widely available, and provider training was enhanced. A service provider shared:

> "There are health services and in particular health centers that provide FP services and contraceptive methods. It exists in health centers. It's the primary level at which contraception consultations take place. In maternity wards, in the postpartum period, we talk about FP after childbirth. And this is done in maternity wards in the public sector." (M3)

In Indonesia, the experiences were mixed. Program integration was positive as BKKBN shifted from quantitative targets to qualitative targets of health, which was welcomed by other ministries.

> "We link on the strong relations between FP issues, RH, and also stunting reduction. [omitted] This constellation has been also approved by other related ministries. Then BKKBN has shifted a little bit from quantitative into qualitative, which is for me very good, then also came the approval and support from other line ministries." (I1)

Other participants from Indonesia were less positive about the shift in priorities of BKKBN, however.

> "The head of BKKBN is very occupied with that priority [stunting]. Of course we want to see the linkage, but it is too far away… That really has big impacts on the way BKKBN delivers their programs because now BKKBN programs are very much on stunting." (Anonymous)

Participants in Honduras and Peru did not discuss program integration, except some in Honduras mentioned FP changing from a "program" to "activities" as a result of the integration.

Financing

Our participants did not have much discussion about the current financing situation or how it might have changed since program transition in their respective country, other than that commodity procurement had been covered 100% by the country's government. Data from the Kaiser Family Foundation showed declines in FP funding from USAID to these countries in the years leading to transition (The Kaiser Family Foundation 2023), while FP2030[9] offered only a snapshot of the government FP budget for Honduras in 2016 and Indonesia in 2021 (FP2030 2023), which made it not possible to assess the trends in the national FP budget over time.

Programming

Policy Level

Three major themes were discussed at the policy level: operating environment, accountability and monitoring of services and quality, and information systems. We discuss each theme below.

With regard to the ***operating environment***, the discussions were primarily centered on the role of the private sector in the FP program, which ranged from a strong network of private providers, e.g., midwives in Peru who directly provided services, to the private sector's participation in social marketing programs, e.g., in Morocco. As mentioned earlier, participants in Morocco emphasized service integration and multisectoral partnerships as key contributors to the program.

> "There was a social marketing program that involved the private doctors. There was the training of private doctors to take charges of FP services. The program has tried to involve pharmacists in social marketing, condom distribution, the pill, oral contraception, IUD here and there…. At the same time, we were involved in training private general practitioners as part of the Public-Private Partnership program launched between the MOH and USAID." (M7)

There remain, however, concerns about how such partnerships played out in practice, as a participant from Morocco said:

> "In terms of coordination, I think it is a little bit… I am not so happy about that. I think it is lack of confidence between the private sector and the public sector and our people. They come in fearing of taxation and stuff like that." (M1)

The same participant elaborated:

> "The private sector is not easy to approach. They fear taxation. The pills are there, you can go and buy them, no problems, but it is not dynamic in terms of really feeding information to the public sector. They don't give information." (M1)

Accountability and monitoring were believed to be critical to ensuring FP activities were taking place and achieving expected results. However, the general sense of our participants across countries was that while

[9] FP2030, funded by USAID, is a global initiative aimed to promote access to modern FP methods around the world and put FP at the center of global health, development, and gender equity through working with a wide range of partners across disciplines and sectors.

there were policies, standards, and procedures in place, the extent to which they were being followed was unclear. For example, in Indonesia and Honduras, participants mentioned decentralization as a factor contributing to the uncertainty of the implementation of policies and standards across sectors and levels. For example, in Indonesia, participants reported that BKKBN was responsible for demand creation while the MOH was responsible for providing FP services, however, there was little coordination between them, which could create confusion about who was responsible for what within the FP program. Most participants emphasized that increased coordination between sectors and organizations at the central level as well as between the central and local levels would positively contribute to accountability by all organizations.

One way to ensure accountability and monitoring is through supervision, but the scope of supervision, if any, was often limited, as in Peru:

> "There is supervision but I have the impression that supervision is rather limited to expenses, the availability of inputs for services. I don't think that quality of care is monitored in a systematic way." (P7)

Additionally, participants highlighted the needs for strengthening the information systems and reducing reliance on large population-based surveys, like the DHS, which could be costly. A participant from Honduras said:

> "One way we can hold FP accountable, to ensure that the government is not just relying on surveys that exist to look at how much progress they have made in modern contraceptive use and meeting different types of people's needs is creating a robust HMIS [health management information system]." (H1)

The need for a ***robust HMIS*** was echoed among many participants, who said that such a data system could provide supplementary data to the DHS, give insight to why women and couples did or did not use contraception, and assist in needs projection. However, concerns about data quality within the existing systems were common. One participant said:

> "The country has a tool called a logistic data consolidation tool… but the person who is looking at that does it almost on a voluntary basis. Nobody is holding him accountable." (H3)

A participant from Indonesia raised concerns about the connections between commitment at the high level of leadership and the actual implementation of data reporting and use:

> "The commitment is very vague, it is not really measurable in a way. We don't have smart indicators that we can really show that, ok, this is achievable or not. Many commitments are made in a very general term." (I2)

Accountability and the uncertainty with regard to HMIS data quality related to sensitive topics, such as abortion and contraceptive use among unmarried women, contributed to the hesitance in sharing data. A participant from Morocco talked about obtaining data from the public sector:

> "Sometimes it is not easy to get data from some government institutions. Sometimes it is just because they don't have the data. Sometimes it is because they feel the data are sensitive…. So I

> would say in terms of certain issues, it is very difficult to publicize or to disseminate studies. There is a risk that they end up in a drawer or something like that." (M2)

Political reasons contributed to some of the hesitancy to share real data, like in this case in Indonesia:

> "Because we get assessed on the progress and achievement of FP 2020, for example, and every time we want to report, we have a meeting to discuss what is the achievement. At that time, because people feel that this is for a global report, there is a tendency to show progress while actually it is not so." (I2)

Finally, participants mentioned that the local stakeholders' capacity for data use and interpretation might be a barrier to the availability of good data within the HMIS. For example, a participant said in Honduras:

> "They do have problems in understanding and monitoring an intermediate level between the DHS and the actual use of contraception. They continue using distribution of methods as the proxy, and they are still using indicators, such as the number of first-time users in the year, first-time users ever. That doesn't help the policymakers to make decisions." (H5)

Program Level

Discussions were centered around contraceptive security and local capacity in the management of supplies and logistics. Participants in Honduras expressed the most concerns about maintaining contraceptive supplies and cited many reasons, including the lack of diverse suppliers and the heavy reliance on a few big suppliers. When funding was reduced (in part due to the transition), similarly to many other countries in the region, the Honduran government did not have sufficient power to negotiate with the major suppliers. At the same time, local stakeholders were not prepared during and after the transition period to negotiate with other suppliers. Stockouts were frequent. One participant called it "failures in the systems" and said:

> "It is quite variable. It depends a lot on the person, the infrastructure, and the processes that have to be followed to guarantee access to contraceptive methods to the end users. In 2005 we implemented a policy of assured availability of contraceptives in the most distant health facilities; the national process for procurement and distribution was also designed. But many times you find in some facilities that there are no contraceptives and you ask why? And they are failures, most of the times they are operational failures that shouldn't happen." (H3)

Again, the translation from policies and standards to practice was uncertain for our participants, due to many reasons discussed above. Participants in Honduras also highlighted the multiple impacts of the COVID-19 pandemic on contraceptive security. As in other countries, the pandemic forced many health facilities to close, while budget and personnel were diverted to the pandemic responses and other health programs. Contraceptive supply procurement, if any, became a much more complex process that took longer, resulting in the lack of not just contraceptive methods but also necessary equipment, such as those for sterilization and IUD insertion, affecting the provision of these methods, even if the methods themselves were available.

In Honduras, as well as in Peru and Indonesia, participants discussed the need for strengthening local capacity in supply chain management. Participants in Honduras and Peru stated that the entire system

needed review and improvement, while those in Indonesia felt that the system was stronger at the central level but less so at the local level. Contraceptive commodities were produced locally, and BKKBN was thought to have strong supply chain management; however, participants were uncertain about how the management was implemented at the local level and cited high levels of stockouts and unmet need as reasons for the uncertainty. Only in Morocco did participants feel fairly confident in the supply system, primarily due to their ability to project needs and the system already in place.

> "The identification of needs at the level of the institutions is based on the demand of the population, on the consumption of contraceptive products. …. The establishment of needs at all levels is based on the consumption of the population, and of course, always taking into account a safety stock that we always have. We always have a safety stock to meet the needs in certain specific situations." (M6)

Estimating needs based on actual consumption, plus a safety stock, coupled with the strong capacity of local partners and of the National Association for FP (Association Marocain de Planification Familiale), which was very involved in raising the public's awareness of FP and providing technical assistance to the MOH, were some key factors contributing to contraceptive security in the country.

Finally, social behavior change communication (SBCC) was the last component of FP programming that was asked about during the interviews. In Morocco, SBCC seemed to remain a priority of the government and involved multiple sectors. The MOH recognized the need to not only promote FP methods but also to make women and couples aware of a diverse range of methods other than pills. Participants from Morocco emphasized communication efforts with health professionals and with the population, with involvement from the NGOs and the media.

> "There have been conferences in mosques on the subject. There have been conferences during the Friday sermon where imams at the national level talked about the benefits and advantages of FP." (M7)

This multi-sectoral approach had proven key in bringing sectors and organizations in Morocco together to work towards FP and health goals. Meanwhile, participants in the other countries agreed that much more could be done in SBCC, even in Indonesia, where SBCC efforts had been significant in the past but reduced in the last several years, and there had been increasing reliance on information on the internet. In Honduras, participants emphasized the needs for SBCC activities for demand creation, particularly for long-acting methods. One policy maker said:

> "We need to work a lot on the demand side as well because there have been cases in some years when the Ministry actually had an adequate supply of methods, but they end up sitting in their warehouses because the demand has not been sufficient… This includes educational campaigns, promoting cultural change, and trying to introduce comprehensive sexuality education more forcefully into the education system." (H4)

The mismatch between demand and supply sides in this case contributed to the slow growth of long-acting methods, as another policy maker said:

> "Newer long-acting methods haven't been rolled out in a coordinated fashion, there hasn't been

> demand generation around new methods, even if they do exist" (H1)

This led to oral pills, along with sterilization, being the most frequently used methods, despite the high dissatisfaction and discontinuation rates among pill users.

Service Delivery

When talking about service delivery, participants hardly talked about market maturity as an indicator for FP sustainability, largely because in every study country, short-acting methods accounted for the majority of FP users, particularly in Morocco and Indonesia, although participants expressed the need for a diverse mix of short- and long-acting reversible methods, as well as permanent methods, to meet differing FP demands of individuals and couples. Figure 6 (above) shows that oral pills and condoms were the leading methods of contraception in Morocco, while injectables and oral pills were the most frequently used methods in Indonesia (Figure 7). Instead, the majority of the discussion was centered on two major issues: the quality of services and accountability.

With regard to the ***quality of services***, at the policy level, our participants talked about the existence of policies and guidelines related to the quality of counseling as well as service provision. There were also mechanisms in place, in most cases, for supervision and provider support, even if the scope might be limited as mentioned above. Protection of human rights and assurance that FP use was voluntary were emphasized in these guidelines. Finally, many participants talked about the need to establish a mechanism for midwife certification for FP service provision.

At the program level, service availability remained a barrier. Participants talked about the availability of trained personnel, FP commodities, as well as equipment to provide FP services. Some examples were discussed above, such as the lack of equipment to insert IUD and sterilization, even when commodities were there, leading to these methods not being provided to clients.

Participants also expressed uncertainties and concerns about the quality of counseling and services, as well as the assurance of informed choice. In Honduras, one participant seemed to attribute the lack of counseling quality to providers' insufficient attention to this aspect of services:

> "Then the other thing is the counseling piece, [omitted] I don't mean to say they're not doing the counseling, but it's really easy for the counseling piece to fall by the wayside. Providers are super busy, people go in, they want a method, it's really easy, just sort of, here's your method." (H8)

Another participant in Morocco said:

> "I'm just saying this. I'm not stating that it's not happening, but what I would say, that right now we are in need for, how can I say? A good service. When I say good services, it should respect all the quality dimension in terms of information sharing, in terms of knowledge, in terms of environment, even the environment of the services." (M1)

In Indonesia, participants noted that IUDs were not commonly used, in part due to healthcare personnel lacking training in IUD insertions, and fees for short acting reversible methods which de-incentivize them recommending LARCs, and a lack of counseling, leading women to consider the IUD's side effects to be harmful.

> "Yeah, because from some study in Indonesia, the reason why mothers are dropping out of contraceptive use is because more than 90% of providers do not explain about the side effects. Rather, they just say, "You need to use this. This is good for you," only that. So, because they don't hear about side effects, when they experience them, they are gonna think it is abnormal, and want to stop using method(s)." (I8)

> "We have counseling. We have informed consent, informed choice. We have all that. But if you go to the field, very limited providers use that kind of standard. The dropout is really a good indicator for the quality. Second, if you look at inform choice. Inform choice is very low. Right now, the MII, Method Information Index, is around 23 percent, meaning that the provider does not really give the wide-range information to the client before they get the services. If you ask the provider about the counseling, 99.9 percent of midwife say that we give them counseling. When you just talk with the client and then the provider said, "We already give the counseling," so there is no standard about the counseling. There is no, like I said, monitoring system and then there is no reward and punishment." (I5)

Accountability, at the policy level, was expressed by our participants as the need to provide more information, and in different languages, about FP methods to the public. This is related to much of the discussion on inequities (discussed later), where women and couples of ethnic and indigenous groups were often left out in SBCC efforts, as well as service availability. At the program level, participants, particularly in Indonesia, raised concerns about clients' dissatisfaction with services provided and/or with FP methods. The latter was often due to poor counseling, leading to clients not understanding side effects and how to manage them. Consequently, method discontinuation was perceived to be on the rise.

> "I'm not saying they don't talk, doctors. I'm not saying they [doctors] don't talk. They talk. I would say right now I would not accept, in the context of Morocco, if I go to you as a user of pills and ask you about side effects, then they tell me they have not talked about side effect. This is not acceptable." (M8)

External Factors

Discussions on external factors that may have some influence on the sustainability of FP programs and outcomes largely fell into two groups: (1) political instability and (2) cultural norms.

Morocco was the only country where ***political stability*** was mentioned as a key for sustaining FP outcomes. Decentralization of the governance and the health system, coupled with strong support for FP from the King, were some of the factors highlighted by our participants. In contrast, in the other three countries, the political situation to some extent created challenges to the FP program. For example, the challenge in Indonesia came from the association of the FP with the former President Suharto, who was a strong supporter of FP. In Honduras, participants mentioned a challenge that came from the bureaucracy related to licensing of clinics and associated fees and requirements, resulting in hesitance to open more clinics for FP services. In Peru, conservatism seemed to play an important role.

> "Since the year 2000, we have had a democratic government that unfortunately was very conservative… [omitted]. Other Presidents have been lukewarm about the issue [FP]. First ladies, we have had some very Catholic first ladies. So this country is polarized between very Catholic populations and very Evangelical populations." (P2)

Cultural norms around fertility and FP were important in all countries, with Indonesia and Morocco being the countries where FP practice had become a norm. Yet, in all these countries, cultural beliefs and myths related to FP methods remained a significant barrier to contraceptive use. For example, women in Honduras and Indonesia may have preferred injectables and implants because they could hide them from their spouses. Women in Indonesia also believed that getting an injection was good because "If you get sick, you get injected. If you didn't get injected, that means nothing was done to you." (Anonymous) On the other hand, women in Peru did not understand or like some of the side effects of contraception, e.g., injectables, on their cycle.

> "With three-month injectables, Depo Provera, a consequence is little menstruation and amenorrhea. For many women, specially in the Andes areas, good menstruation means good health. Little menstruation is not good for health." (P1)

Similarly, another participant from Peru explained women's preference for short-acting (i.e. one-month) injectables.

> "In the private sector, women want the monthly injectables, because with a monthly injectable, they can see their menstruation every month and they feel better [about it]." (P2)

Religion was a key factor influencing FP norms and use in most countries, with the Catholic church playing a major role in Honduras and Peru. Even in Indonesia, where FP had gained approval from community and religious groups, there was a strong sense from many participants that conservative groups were growing in their influence, particularly among the highly educated.

Finally, ***gender norms*** were also important in all countries, as contraception was considered a woman's responsibility, but it was the male partner who made decisions about FP, even if the couple was not married. A policy maker in Morocco described it well:

> "Sometimes it is more difficult for women to access those services and contraceptives because they have to go to a pharmacy. [omitted] Women do not go, they stay at their homes, and the husbands are those who go to other villages. So, it depends on the husband to buy the pills in the pharmacy. Sometimes they forget. Sometimes they spend money on other things." (M2)

In Peru, participants also reported an increasing trend in divorce and separation, which raised a question of how to meet the needs for FP among unwed women, who likely want to maintain their privacy and prefer going to the private sector, where their privacy might be more likely to be protected.

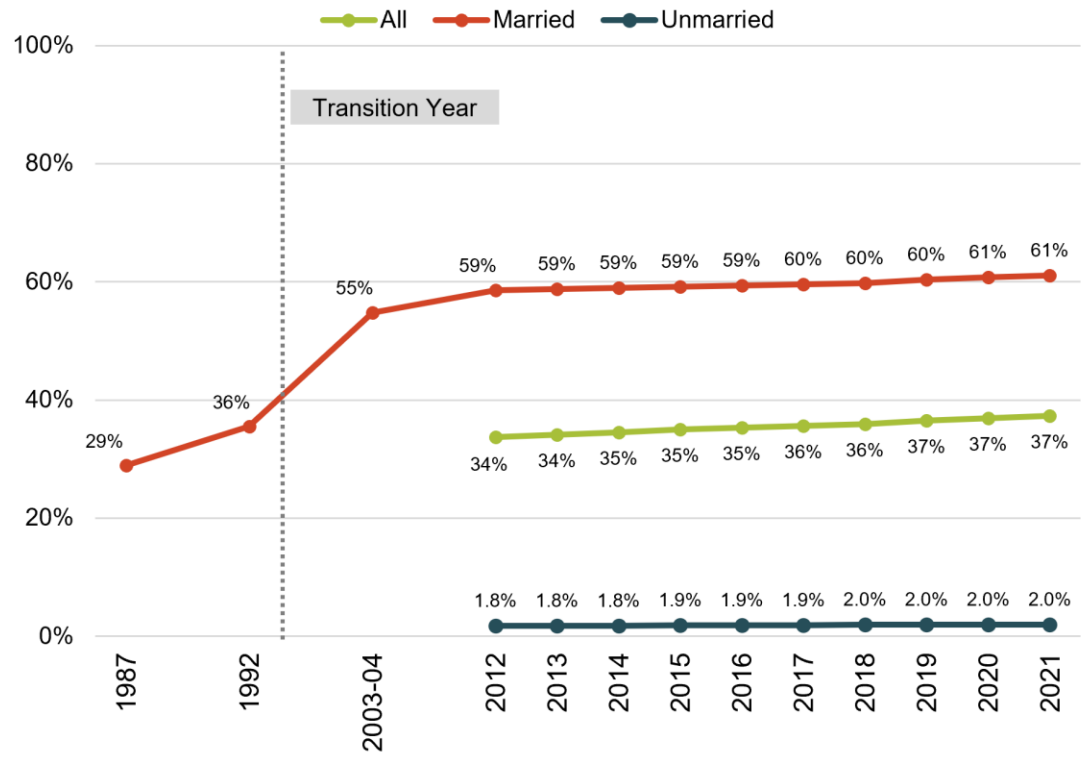
Other external factors, such as urbanization, infant mortality, the human development index (HDI), and the pandemic, were only briefly mentioned. For example, some participants talked about the changing population density between rural and urban areas as people increasingly moved to urban areas, which had implications for services to meet the needs of women and couples in urban areas. Infant mortality was mentioned as a long-term impact of FP programs rather than a driver of FP. Similarly, participants talked about the HDI as part of the SDG framework and how FP could contribute to economic development, not as a contributor to FP outcomes. Finally, several participants discussed the adverse effects of the pandemic on FP supplies and overwhelming the health systems, resulting in FP becoming a secondary priority.

Inequity

Inequity in the implementation of FP policies, program interventions, and consequently, in FP outcomes is a critical cross-cutting area. Transition plans in all countries included discussions of unequal access and quality of FP services by vulnerable and marginalized groups and set a priority to reduce these inequalities. In this report, using ***survey data***, we examined potential differences in mCPR, unmet need, and TFR by marital status, age, urban vs. rural residence, and socio-economic status (SES) (i.e., household wealth quintile) where possible. Because data on FP need were not available for all groups, we reported mCPR inequalities rather than inequities. Figures 16 through 19 below illustrate the patterns that we observed between marital status and age groups in Morocco and Indonesia; similar patterns were seen in Peru and Honduras.

In Morocco, for example, differences in mCPR between married and unmarried women have persisted since 2012, despite slight increases in contraceptive use among both groups. The level of unmet need also seemed stable in both groups, with unmet need among married women consistently much higher than that among unmarried women. This is consistent with the NCIFP score (only available since 2014) that was stable in the equity domain[10]: it was 58.2 in 2014 and 57.8 in 2021. Later in this report, we present some concerns among participants about the quality of survey data when sensitive topics such as needs for FP were discussed with young, unmarried individuals.

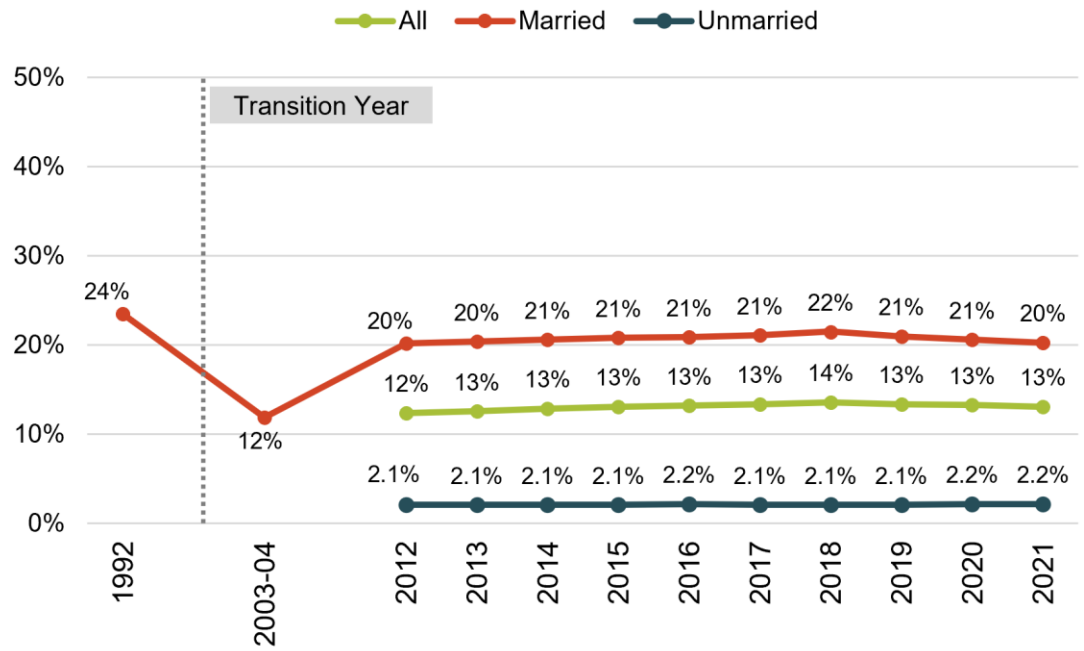
Figure 16. Modern contraceptive use by marital status, Morocco



Source: DHS and Track 20 data.

[10] The equity domain includes scores on: policies to prevent discrimination, (lack of) provider discrimination, community-based distribution for hard-to-reach areas, access to long-acting and permanent methods, and access to short-acting methods.

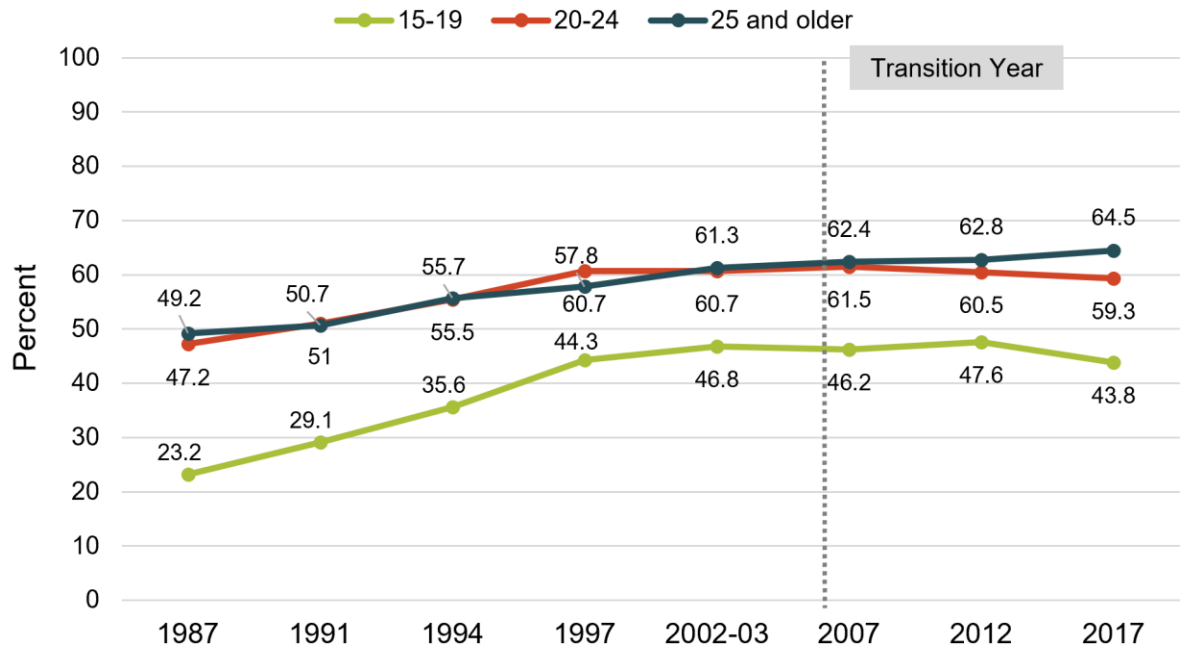
Figure 17. Unmet need by marital status, Morocco



Source: DHS and Track 20 data.

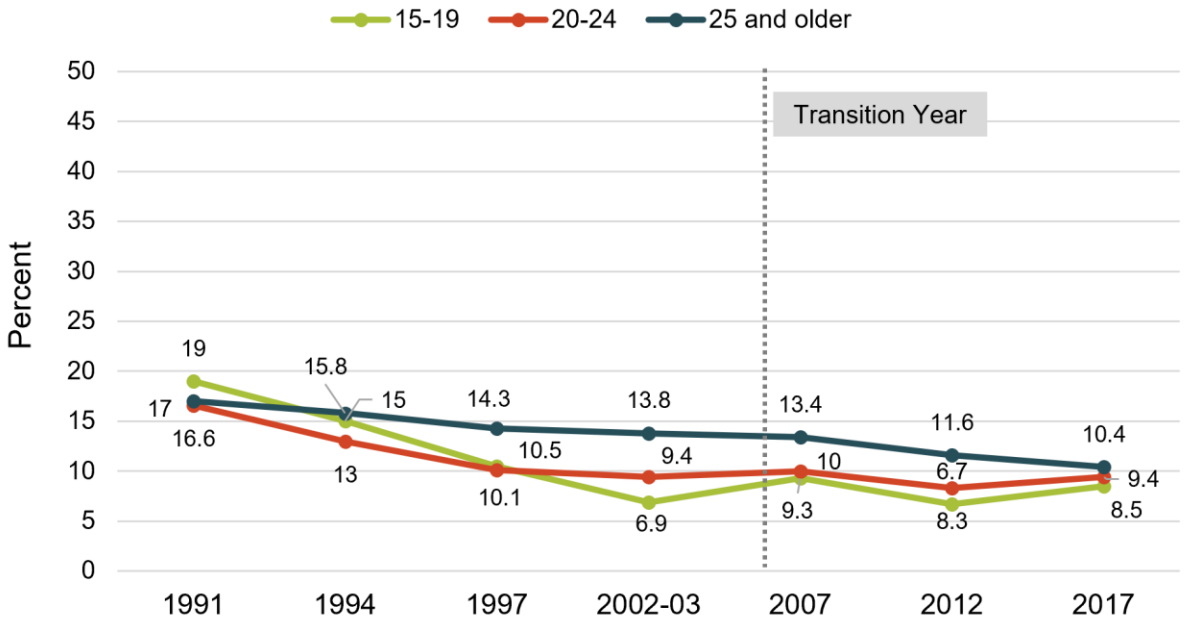
Similarly, Figures 18 and 19 show persistent differences in modern contraceptive use and unmet need among married women by age group both before and after the transition in Indonesia. Adolescents consistently had a lower level of modern contraceptive use compared to the two older age groups. Inequalities between age groups, particularly between adolescents and those older than 20, were declining from 1987–1997, perhaps coincided with the growth of the private, for-profit sector during this time. It was then stable and somewhat widened between 2012–2017 due to the declining use of modern contraception among the youngest group. Unmet need (Figure 19) among adolescents was also lower than that among the other groups since 2002. By 2017, unmet need was similar across age groups due to declines among the oldest group (25 years of age or older). Meanwhile, the NCIFP score in the equity domain increased from 51 in 2014 to 64.6 in 2021; however, this domain does not include nuanced indicators related to FP outcomes across sub-groups.

Figure 18. Modern contraceptive use among married women by age group, Indonesia



Source: DHS data.

Figure 19. Unmet need among married women by age group, Indonesia

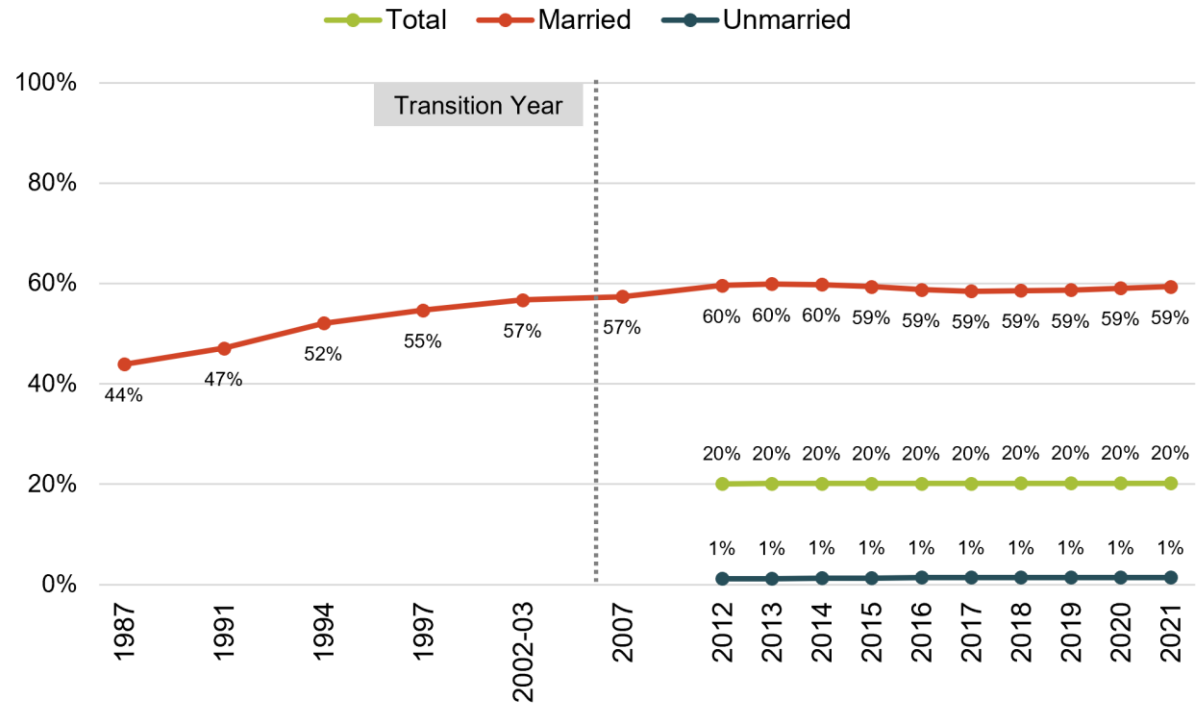


Source: DHS data.

Survey data show similar patterns in inequalities in FP outcomes by SES quintile (results not shown due to similarities with above results). In most countries, the differences across SES groups were declining over time. By the last survey available, which unfortunately was pre-transition for all countries except Indonesia, the differences across quintiles became hardly detectable.

Data on inequalities in FP outcomes by marital status were not consistently collected in all countries. In Morocco and Indonesia, estimates from the World Bank and Track20's FP Estimation Tool[11] showed no significant changes in the differences in mCPR and unmet need between those married and unmarried after the transition. Figure 16 above and Figure 20 below show the time trends in mCPR in these two countries; unmet need followed very similar patterns. In Peru, mCPR among the unmarried group became higher than that of the married group in 2004–2006; the gap was narrowed somewhat by 2014 (Figure 21). In Honduras, however, there were not enough data points to examine the trends either before or after the transition.

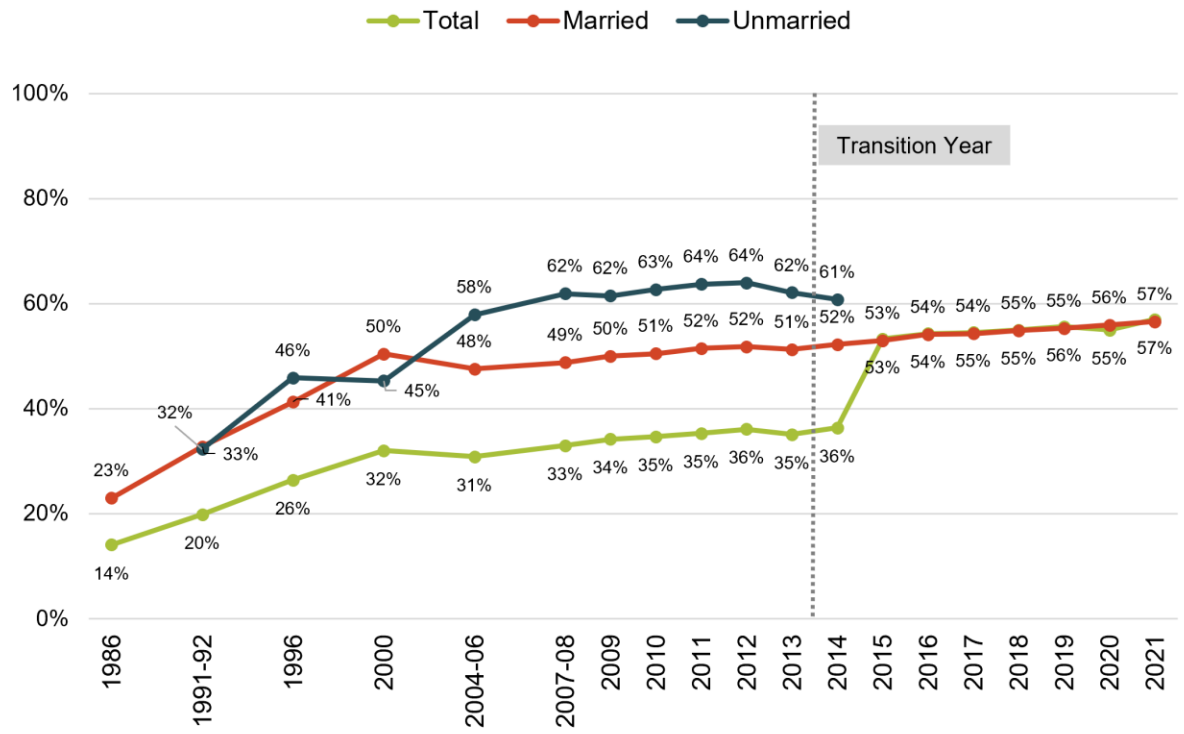
Figure 20. Modern contraceptive use by marital status, Indonesia



Source: DHS and Track20 data. Prior to 2012, data were only collected from married women.

[11] Information about the FP Estimation Tool is available on the Track20's website: https://www.track20.org/pages/data_analysis/publications/methodological/family_planning_estimation_tool.php

Figure 21. Modern contraceptive use by marital status, Peru



Source: DHS, ENDES, and Track20 data. From 2014, only data from married women were available.

Overall, both Peru and Honduras also saw slight increases in the NCIFP equity scores between 2014 and 2021, increasing from 53.1 to 56.3 in Peru and from 61 to 66.7 in Honduras.

Our ***in-depth interviews*** reveal narratives that supplement findings from survey data. Across study countries, participants in our interviews acknowledged that many population groups remained marginalized in their access to and utilization of FP services. Participants also emphasized that in most cases, such disparities across subgroups were hard to identify using survey data, like the ones reviewed above, for various reasons. Consistent with quantitative data, ***young, unmarried individuals*** were reported by most participants as remaining left out of FP policies and services in three out of the four study countries. In Morocco, while the national strategy might allow these individuals to access FP services, the reality remained ambiguous, and sometimes the decision was left to the providers' interpretation of the policy. A policy maker in Morocco said:

> "If you come to our facilities, you should be married… We leave it for the provider to decide. Unmarried women are not only sex workers. What about students? [omitted] the whole issue is that the program, when it was developed, it was developed for women." (M1)

Urban versus rural differences continued to exist in most countries, primarily due to funding reductions and priority shifts, resulting in less investment in rural and remote areas, although these are areas where many of the vulnerable groups concentrate. However, the gaps were narrower after the transition compared to before, particularly in Morocco, where participants underlined the absence of disparities owing to a strong mobile strategy where providers went in medical caravans to these areas to provide

services. External factors such as education and economic development were also thought to contribute to lessening differences between urban and rural areas in Morocco.

It is important to note that when talking about inequity, most participants put emphasis on the availability and quality of data, as many of the inequities mentioned above were not readily measured. Except for Peru, participants in the other countries mentioned the end of support for DHS and similar types of population-based surveys when the countries transitioned out of USAID support. They also emphasized the need for quality data that would allow disaggregation by subgroup, particularly marginalized groups, e.g., unmarried, sexually active young people and LGBTQI+ groups. Even in countries like Morocco where data for some of these groups were available, there were questions about data quality.

> "In some cases, you can access the data and the data are available, but the data are biased because of the fact that in Morocco, like in other Arab countries, let's say sexual intercourse outside marriage is penalized by law." (M2)

There was also much discussion on factors contributing to inequities, which were grouped into two levels: structural and program. At ***the structural level***, participants discussed infrastructure in place that could help reduce disparities to some extent. For example, in Honduras, the Honduran FP Association was thought to have an infrastructure to provide contraceptives to marginalized groups, while the private sector (namely pharmacies) could carry condoms.

The lack of adolescent-friendly services was a key factor contributing to lower contraceptive use among unmarried young people. Legal barriers existed in most countries, such as in Honduras, where these services "remain[ed] somewhat of a pilot experience" (H4) and "there is no comprehensive, systematic, and institutionalized way of reaching adolescents." (H5) In addition, biases from both providers and communities contributed to young people's reluctance to seek services:

> "There are legal barriers as well… For example, there are services where adolescents are required to come with their parents to receive counseling or to receive methods, even though the law allows them to go alone. But due to cultural or behavioral reasons, the service providers themselves create such barriers." (H4)

The situation was similar in Peru where the situation was ambiguous, according to our participants:

> "We do not have a clear policy to prevent adolescent pregnancy. This is very conservative. [omitted] services were provided mostly by the private sector and private clinics, because the public sector requires parents permissions, especially for young people under 18, to get FP and contraception." (P7)

The same situation was seen in Indonesia, where:

> "The government doesn't want to push issues on contraceptives for adolescents because adolescents are mostly unmarried, who cannot access contraceptives, it is not allowed by our law." (I2)

At ***the program level***, service availability and quality were thought to be key contributors to inequities. Service availability was a particular concern in the two LAC countries. In Honduras, for example,

emergency contraceptives were prohibited by law until this year. Participants also reported a lack of FP products in rural, remote areas:

> "Not all methods are permanently available in all units… The more rural the area or the more hard to reach the area, you find less and less options. I think having the combination of all methods in all health centers always, I think that's a challenge." (H5)

In Peru, the situation was similar:

> "Peru has a strong network of midwives who provide FP services, but the barrier there is that not all the networks of these midwives have access to affordable FP methods that they can procure." (Regional 1)

Inequities could also come from the lack of trained providers, for example in Morocco:

> "Inequities can come from having [or not having] some providers. For example, trained nurses and IUD insertion is not happening in all those remote health centers. [omitted] This is something that really needs to be worked on. It is not easy. If I'm talking about equity in access, we should be at the same level in terms of having the right provider and having the service in the right place." (M1)

Even when providers were available, they might not be adequately trained, like in Indonesia or Honduras, where participants emphasized the need for training of "new personnel, who are not trained, who still have and believe in myths." (H9)

On the other hand, inequities could be related to provider biases in certain areas or with certain groups of clients. In Indonesia and Honduras, many participants discussed the adverse effects of having quotas or fees for services, which could influence a provider's recommendation of FP methods to clients, e.g., this participant said in Honduras:

> "The decision of a method is also influenced by the health personnel, e.g., it is easier to recommend a quarterly injectable than to put in an IUD" (H3)

Or, as another one said in Indonesia:

> "Because they have to get the fee from the client, that's why they try to sell the injectable and pills, and the client is coming back to them." (Anonymous)

Such biases also affected postpartum FP services; since the fee was included in the delivery services under the public insurance scheme, providers would not get paid for FP services. Consequently, they often discharged the mothers without a FP method and asked them to come back for a postpartum visit to get one. Practices like this undoubtedly would add a challenge to promoting postpartum FP.

Finally, participants in Peru underlined providers' biases against adolescents and individuals and couples in remote areas that were still prevalent. A participant recited this exchange between a provider and an adolescent girl:

> "So what do you want today, honey?
>
> And say, well, I want to see the FP unit or the RH unit.
>
> But you're only 14 or 15, why would you want to see them, you want condoms, huh?
>
> And then, of course, the girl turns around and goes to the pharmacy." (P2)

Discussion

As far as we know, this study is the first effort to apply an FP transition framework in evaluating the extent to which FP programs have sustained their outcomes after transitioning out of USAID support. Building on an existing framework that guides the M&E of global health programs in other fields, our framework pushes the field of FP programming towards having a systematic and comprehensive mechanism to plan for, implement, and monitor and evaluate the outcomes of FP program transitions. By doing so, this assessment makes significant contributions to advancing USAID's efforts to learn from and replicate programs and policies that support sustainable, locally led development.

FP Program Sustainability

This four-country assessment showed that FP programs and outcomes had been sustained in all countries, albeit to different extents and despite changes in FP policies and programming since the transition. Existing quantitative data from large-scale population surveys showed that TFR, modern contraceptive use, and unmet need had all gone in the right direction or been stable. However, FP program efforts—measured by FPE and NCIFP—tended to decline post-transition, except in Indonesia, where NCIFP continued to increase. Our key informant interviews underlined continued efforts of the government and local stakeholders to maintain FP programs and activities. Available survey data showed that inequities in FP outcomes across major groups, such as age, marital status, residence, and SES, either remained the same as pre-transition or declined post-transition, although participants also mentioned other vulnerable groups, including migrants and LGBTQ+.

Key Findings

- FP programs and outcomes had been sustained in all four countries, albeit to different extents. Factors critical for FP program transition included leadership, commitment, and coordination between sectors.
- Although TFR, mCPR, and unmet need may be stable, challenges, including method range and sources of contraception, may remain and have long-term implications for FP service provision.
- Inequities remain in all countries, despite some decreases post-transition compared to pre-transition. Quantitative and qualitative data are both needed to understand and address them.

Our participants highlighted several key factors that they considered critical for a successful and sustainable transition of FP programs. The most important ones that emerged in all countries were leadership, commitment, and coordination between multiple sectors. Leadership commitment, particularly that of the MOH in coordinating and leading the transition process, was perceived as a key contributor to success in Morocco and Indonesia. Indonesia had been considered a success story by many in the field, until recently, when BKKBN's priorities shifted, resulting in drops in the MOH's budget, which had implications for the quality of FP counseling and services. Peru and Honduras were only meeting a few of the criteria for transition at the time that transition decisions were made. In Peru, the lack of leadership commitment might have slowed down progress, as it contributed to confusion in service provision at the lower level and few FP advocacy activities.

The second important finding from this study is that even when FP outcomes had been stable post-transition, some challenges remained, such as balances in the mix of methods and of contraceptive sources. In each of the study countries, short-acting methods were frequently used, which was attributed by some participants to the lack of investment in personnel, commodities, quality, and SBCC efforts to sensitize long-acting reversible methods. This is of concern because in Indonesia, for example, where injectables and pills were prevalent, many participants raised concerns about increasing discontinuation rates due to the poor quality of FP services of short-acting methods.

While the data reflected the mix of methods among users, and not necessarily the mix of supplies, it is worth emphasizing that a diverse mix of short- and long-acting methods should be offered to ensure voluntary choice of methods to meet differing FP demands among individuals and couples. This finding underlines the need to consider key components of FP programs, including regulatory and service delivery environments, in addition to external factors like social norms, in examining FP program sustainability. Similarly, contraception continued to be primarily sourced from the public sector, with the for-profit private sector's share varying across time. The nonprofit sector's share remained minimal, which posed challenges to reaching marginalized populations. In the long term, the heavy reliance on the public sector for free contraceptives could put financial constraints on the national budget for FP, especially when FP programs already compete with many other health programs. In addition, such a reliance on the public sector may limit access to free FP methods for those who could not access contraceptives elsewhere, creating challenges for the sustainability of FP programs. All these factors combined suggested that if nothing changes, the countries will continue to rely on short-acting methods, and inequities across certain sub-groups will remain.

The third key message from this exercise is that even with large-scale population data, inequities across groups were hard to assess. While the quantitative data revealed some of the commonly seen inequities, all our participants highlighted inequities in access and use of FP methods across different groups; rural vs. urban and age groups remained the key categorizations of inequities in all countries. Participants also identified other vulnerable groups that are often difficult to identify from surveys. Related to this, our participants underlined the importance of a robust HMIS to not only monitor and assess the quality of services but also to provide reliable data on FP access and use across groups for decision making. The latter was critical in the absence of DHS-type data, since USAID no longer supported this type of survey in countries that have transitioned out of their support.

Application of the FP Program Transition Framework

The pilot of the framework in our study proved that the framework was very useful in guiding evaluations of this type. The three transition phases in the framework were helpful in guiding the interview question development and the interview itself. The different domains and indicators within each of the three phases guided our sampling scheme, ensuring that we intentionally recruited participants who were familiar with these phases and domains. The framework also served as a reference point throughout our fieldwork, since our study team periodically reviewed the participants that had been interviewed, discussed key domains that had been covered by those interviews, and strategized our next recruitment(s).

However, despite these efforts, there were some limitations related to our sample. First, the sample was skewed towards participants who currently or previously worked at the policy level, especially in Honduras

and Peru. Similarly, since our interviews focused on the transition and changes in the FP program since then, our participants tended to be more senior than average, both professionally and age-wise. Time limitations prevented the study team from continuing recruitment of program/service level participants, as well as those who were more knowledgeable about financing aspects of FP programs. The latter resulted in very limited information on finance emerging from our interviews, since participants were not deeply involved in this area of FP programs. More focused time and investment would likely allow recruitment of finance personnel, as well as examinations of financial data if obtainable. In addition, in several cases, only pre-transition data were available, limiting our examination of trends in FP outcomes post-transition.

Despite the limitations, the delineation of the policy and the program/service provision level in the framework was helpful in focusing the discussions. Not only did it help guide the recruitment, but in many instances, participants clearly distinguished policies and standards versus the reality of FP programs and services.

We also found that some concepts remained somewhat ambiguous, such as transparency, accountability, and efficiency. Our participants seemed to have a general good understanding of these concepts, and all agreed that increased communication and coordination could help improve these factors, but we did not reach our objective of defining indicators to measure concepts. On the other hand, new concepts emerged from our interviews, including FP program integration and HMIS, that should be included in the transition framework. A review and adaptation of the framework prior to employing it in a country could be very useful.

Recommendations

Our key recommendation for FP program donors, decision makers, program implementers, and researchers is to employ a framework, like the FP program transition framework used here, to guide the strategic planning for program transition as well as to evaluate the long-term sustainability of FP outcomes. Having a framework will assist international and bilateral donors, like USAID, and implementing partners to strategically plan for the transition of FP/RH and other health programs out of international donor support, moving towards the goals of localization in a systematic way, consistent with USAID's localization vision and approach (USAID 2022, USAID 2023).

Recommendations

- A framework, like the one employed here, could be very helpful for the strategic planning for program transition, as well as to evaluate the long-term sustainability of FP outcomes.
- The framework could also facilitate active engagement by governments, ministries of health, FP agencies and other local stakeholders in the transition planning and implementation.
- The framework should be adapted to include specific domain(s) and indicators important to each country/program.

A framework like this, consisting of three phases of the transition, main domains, and key indicators under each, is helpful for countries and programs to develop a thoughtful and purposeful approach to transitioning, which should consist of a pre-transition self-assessment, a roadmap with clearly identified benchmarks for the transitioning periods, and key indicators to assess the sustainability of outcomes. The

framework also includes domains and indicators on finance and private sector involvement, both key to ensuring sustainability. Leadership was found to be a critical domain for FP/RH program sustainability; by employing the framework, donors and country stakeholders are likely to have a clear process for aligning the priorities and investment of the FP/RH program with those of the local government and the MOH, allowing for adjustments in the transition and a more efficient process.

The entire process of transition planning, implementation, and evaluation should include active engagement by governments, ministries of health, FP agencies, and other local stakeholders, following USAID's vision and approach to localization (USAID 2022, USAID 2023). Recently, USAID reinforced its commitment to shift power to local actors for development efforts. With the local government and the MOH leading, the strategic transition process would be more likely to involve partners across multiple sectors and to increase transparency and accountability across different phases and domains when there is an agreed-upon roadmap and benchmarks. As a result, FP/RH programs and outcomes are more likely to be sustainable.

Our FP transition framework can easily be adapted to include specific domains and indicators critical for a specific country or program. From this exercise, we have several recommendations for utilizing the framework. First, while inequities are cross-cutting, it is important to assess them at minimum across geographical, age, and marital status groups, in addition to post-transition FP outcome indicators regarding fertility and contraception. Second, a pre-test and revision of the framework would make it more relevant and appropriate for a specific country FP program. In doing so, the framework can help identify critical domains and sub-domains for a country program and therefore contribute to the development of the transition roadmap, inform data requirements, develop milestones and benchmarks, and schedule data collection.

Conclusion

This study piloted a transition framework to evaluate the extent to which FP programs and outcomes have been sustained in selected countries after they transitioned out of USAID's support. We found mixed results in the level of FP outcome sustainability and highlighted major domains and indicators that should be considered in the evaluation, in addition to key quantitative FP outcomes. More importantly, we found that a framework of this type has strong potential to help international and bilateral donors and implementing partners plan effectively for the transition. The framework provides guidance in terms of domains and indicators for a self-assessment prior to transition, monitoring of the transition process, and evaluating long-term outcomes. The FP transition framework can also be adapted to include domains and indicators critical for specific countries and programs. The work presented here makes significant contributions to advance the evaluation of FP/RH programs in general and specifically USAID's strategies in localization and long-term sustainability.

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Appendix A. List of Participants Interviewed

Morocco

Yartaoui Hafida	Ministry of Health and Social Protection
Abdelyllah Lakssir	Independent consultant
Luis Mora	UNFPA, Morocco
Anonymous	
Anonymous	
Anonymous	
Anonymous	

Indonesia

Eddy Hasmji	Independent consultant
Melania Hidayat	UNFPA, Indonesia
Ukik Kusuma	BKKBN Jakarta
Istiyani Purbaabsari	JHPIEGO, Indonesia
Fitri Putjuk	Johns Hopkins University Center for Communication Programs, Indonesia
Jose “Oying” Rimon II	(Retired) William H. Gates Sr. Institute for Population and Reproductive Health (formerly Bill and Melinda Gates Institute for Population and Reproductive Health)
Budi Utomo	University of Indonesia
Anonymous	

Peru

Carlos Eduardo Aramburu	Catholic University
Daniel Aspilcueta	Ministry of Health
Maria Calle	Organismo Andino de Salud Convenio Hipólito Unanue (ORAS CONHU)
Milka Dinev	Reproductive Health Supplies Coalition
Walter Mendoza	UNFPA
Maria Rosa Garate	Independent consultant
Alfredo Guzman	(Retired) Ministry of Health

Honduras

Jose Cipriano Ochoa	Independent consultant
Carlos Carias	Licenciador de la Direction General de Redes Integrales de Servicios de Salud
Marcos Carias	UNFPA
Shiza Farid	Avenir Health
Emma Margaria Iriarte	Mesoamerica Initiative
Gustavo Adolfo Avila Montes	(Former) USAID/Honduras
Rosa Marlen Flores Oviedo	Maternal health care provider
Anonymous	
Anonymous	
Anonymous	

Latin America and Caribbean

Nora Quesada	FP2030
Mary Vandenbroucke	(Retired) USAID

Appendix B. Interview Guide for Policy Makers

Interview Guide | Policy Makers

Note to Interviewer(s): Be familiar with national FP/RH milestones documentation prior to the interview. Refer to the timeline during the interview as needed.

Objectives

1) To assess the extent to which the national FP program in the respective country has continued to move program priorities forward by sustaining FP outcomes and equities across sub-populations, and factors contributing to the sustainability of the program.
2) To explore how the domains and indicators in the proposed conceptual framework for the M&E of FP program transitions can be operationalized and measured in a specific country context.

Subject Population

This qualitative component will involve conducting a series of open-ended interviews with up to 15 key informants from each country. Key informants will be purposively selected with the following eligibility criteria:

- Age 18 or older
- Have been involved in the country's FP program, either as the policy level, program level, or in service delivery
- Have in-depth understanding of how the FP program has evolved, at least from the time of transition
    - Reference country-specific FP profile during interview
- Provide verbal agreement to be interviewed either virtually or in-person about the FP program

[Beginning of recording, after obtaining verbal consent]

Interviewer: This is [Interviewer Name], conducting interview with [participant ID#], on [Today's Date], at [Beginning Time]. A reminder that your personal information and any information relevant to identifying you and quotes used in this interview will not be attributed to you in any way."

	Background	
1	What is your phone number: Email:	
2	How old are you? Between the ages of 18-24 ___ 25-35_____ 36 -49_____ 50+ _____	Start with open-ended and if there seems to be sensitivities, ask them to select the age range that is accurate.

3	Gender:	
4	Job title & sector representing:	
5	Office/Department:	
6	Highest educational level:	
7	Number of years in current position:	
8	Number of years working in FP field:	
9	What are your primary responsibilities?	

10.0 | Overall assessment of FP programs

	Questions	**Probes**
10.1	Please tell us about your overall assessment of the FP programs in your country in meeting the needs for FP/ RH among couples and individuals?	What do you think are some key contributions to these achievements since you began working on this? Conversely, what are key factors that may have hindered the success? (Probe for: resources including money, supplies, staff, policies and political will, cultural and population-specific factors)
10.2	What are the important milestones of the FP/RH programs that you are aware of, or have been involved in? And how have they contributed or not contributed to the current state of the FP program or to the overall national population & development policy in your country?	Tell us about how the FP programs or related health care programs have evolved during the time you have worked in this field and how external donor funding has also evolved during that time. How have priorities of FP/RH programs changed over time?

10.3	Following those milestones, please tell us if and when you have observed significant changes at the national or sub-national level that may have influences on the provision and access of FP/RH services or demand for services.	Ask about external factors, including economic development, women's education, urbanization, stability of political leadership, cultural norms, aging of the population, infant mortality, etc.
11.0 | LEADERSHIP		
	Questions	**Probes**
11.1	*[Transition sentence] We're going to move into questions related to FP stakeholders.* Following the milestones, you have mentioned above, how have you seen the roles of external and in-country organizations change over time (USAID, other bilateral donors, UNFPA, or world Bank pharmaceutical companies or other commercial actors)	Please discuss the relative roles of the organizations involved in the FP program and how they have changed over time. To what extent are these organizations clear about their responsibilities and roles? Describe the commitment and contributions of the government and the MOH over time. To what extent is there a mechanism for coordination between these agencies and organizations?
11.2	Let's spend a few minutes talking more about *accountability* and *transparency* of FP programs stakeholders?	Can you define what accountability and transparency means to you? How do you think these concepts have manifested in the organizations your mentioned above? How have you seen it change over time? Without naming names if you don't want to, would you say that some organizations were more transparent and/or accountable than others? What make you think so, i.e., what would you consider an organization to be transparent and/or accountable?
11.3	Have the needs for FP/RH of the most vulnerable groups been	Who are the most vulnerable groups in your country?

	incorporated in FP/RH policies and programming? If so, how?	To what extent have they received attention/priorities in national FP policies and programs? How successfully or unsuccessfully do you think their needs for FP have been met? How has that changed in the past X years? How often are the policies defined- 5-10 years?

12.0 | FINANCING

	Questions	**Probes**
12.1	Can you tell us about external funding for FP programs and how they may have changed over time?	Let's talk about USAID and other prominent donors. How have these changes affected availability (procurement and distribution) of commodities?
12.2	Approximately, what percentage of the national budget is allocated toward FP services and commodities, facilities, supplies, maintenance, provider training, communication, and research?	How has this changed over time? What contributed to these changes?
12.3	To what extent are contraceptives manufactured locally or regionally?	How are government regulations facilitating or impeding the importation of contraceptive supplies?
12.4	Have there been significant changes in how FP commodities are funded since the transition? If so, what are they and how have they positively or negatively affected service provision.	Please talk about planning, forecasting, procurement, distribution of commodities, if you can. To what extent are contraceptive commodities covered through government resources vs. private and nonprofit sectors? If respondent mentions "decentralization", ask them to describe it.

		Is universal healthcare/ national healthcare plan available and utilized?
13.0	**PROGRAMMING**	
	Questions	**Probes**
13.1	Transition: This question may seem similar but regarding FP programs specifically, what types of efforts have there been toward FP improvements and how have they changed since the transition?	How have you seen FP programs [different from the roles of external orgs] and their priorities change over time? How so? Can you think of specific efforts such as communication efforts- that you may have observed- and how they may have contributed to FP outcomes? What were the goals of those efforts and how do you think they may have succeeded or not?
13.2	What are the most common methods of family planning/contraception used in (country specific/region)?	Why do you think women and couples choose these methods and not others? Are there methods that seem to be more readily available than others? What are they? Why do you think they may be more available?
13.3	Please describe any mechanisms currently in place at the national and/or sub-national level to ensure that access to FP information and services is voluntary and non-discriminatory.	Are there mechanisms in place to monitor denial of services on non-medical grounds or coercion? How are such violations reviewed and addressed? How have these mechanisms changed over time?
13.4	What is your assessment of the capacity of local organizations to conduct FP service and commodity planning, commodity procurement, distribution, M&E, policy and advocacy?	What data sources are being used to track progress? And, what is your view on the quality of these data?

		How would you define as an organization being capable or not being capable in any of these aspects? How would you define as an organization being accountable in any of these aspects?
14.0 | SERVICE DELIVERY		
	Questions	**Probes**
14.1	In your opinion, how do you think healthcare facilities could provide higher standard of quality FP services?	How do you think the services should be delivered? What is a good FP service in your opinion? What are some mechanisms in place, or could be in place to ensure quality? How is the quality of family planning service provision monitored and evaluated? in govt facilities, in NGO and other private facilities? Who should deliver the services? What roles can clients and users play? What would it take for facilities here to provide higher quality FP services? (policy change, additional resources, etc.)
	EQUITY	
	Questions	**Probes**
15.1	What are some of the barriers and enablers to accessing family planning/contraceptive services in your area?	Explore categories such as age, sex, marital status, rural vs urban, SES, etc. ▪ urban/rural disparities ▪ unmet need showing marked disparities by wealth quintile

		▪ Inequities by wealth quintile, ethnic groups, education, religion? Can you speak to which areas of country not easily serviced by clinics or other service points are covered by Community Based Distribution programs for distribution of contraceptives (especially rural areas)?
15.2	What are some gaps in the existing health systems that can be strengthened so that unmet need for FP especially among vulnerable individuals and couples will be met?	

16.0 | Conclusion	
16.1 What else would you like to tell us about family planning/contraception that we did not ask you about?	
16.2 Would you be able to refer up to three other key informants for this type of interview? If you need to ask them for their permission first, please do so and email us later at…	Please share reference contact information and association: Name 1: Email: Phone number: Position title: Name 2: Email: Phone number: Position title: Name 3: Email: Phone number:

	Position title:

Interviewer: OK, thank you for your time. I'm going to turn off the recording. This is [Interviewer Name] with participant [ID#], on [Date], at [End Time].

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Appendix C. Interview Guide for Program Implementers and Service Providers

Interview Guide | Program Implementers and Service Providers

Note to Interviewer(s): Be familiar with national FP/RH milestones documentation prior to the interview. Refer to the timeline during the interview as needed.

Objectives

1) To assess the extent to which the national FP program in the respective country has continued to move program priorities forward by sustaining FP outcomes and equities across sub-populations, and factors contributing to the sustainability of the program.
2) To explore how the domains and indicators in the proposed conceptual framework for the M&E of FP program transitions can be operationalized and measured in a specific country context.

Subject Population

This qualitative component will involve conducting a series of open-ended interviews with up to 15 key informants from each country. Key informants will be purposively selected with the following eligibility criteria:

- Age 18 or older
- Have been involved in the country's FP program, either as the policy level, program level, or worked/have been working at one of the organizations listed in Appendix 1
    - Reference country-specific FP profile during interview
- Have in-depth understanding of how the FP program has evolved, at least from the time of transition
- Provide verbal agreement to be interviewed either virtually or in-person about the FP program

[Beginning of recording, after obtaining verbal consent]

Interviewer: "This is [Interviewer Name], conducting interview with [Interviewer ID#], on [Today's Date], at [Beginning Time]. A reminder that your personal information and any information relevant to identifying you and quotes used in reported from this work will not be attributed to you in any way"

	BACKGROUND	
1	What is your phone number: Email:	
2	How old are you? Between the ages of 18-24 ___	Give option of open ended or choose an age range that is most accurate.

	25-35_____ 36 -49_____ 50+ _____	
3	Gender	
4	Job title & sector representing:	
5	Office/Department:	
6	Highest educational level completed:	
7	Number of years in current position:	
8	Number of years working in FP field:	
9	What are your primary responsibilities?	a. Program implementation b. Service provision c. Both

10.0 | OVERALL FP KNOWLEDGE, ATTITUDES and PRACTICES

	Questions	**Probes**
10.1	Please describe what constitutes FP and RH services in your region or country.	Describe the different contraceptive methods you know about and how effective they are in preventing pregnancy? Probe for different methods. · Voluntary surgical contraception · Male vasectomy and female sterilization, such as mini laparotomy · Long-Acting Reversible Contraceptives ex: IUD, implants and their removal · STM ex: male or female condoms, diaphragms, OCs like combined oral contraceptive pills, progestin only contraceptive pills, emergency

		contraceptive pills, injectables (subcutaneous or intramuscular -1-,2-, or 3-month formulations) · Fertility Awareness Methods: LAM, Standard Days Methods · Natural FP methods (these may be commonly practiced in country - like withdrawal, rhythm, etc) Probe about services: How do you provide information about various methods being offered and how to access them? Are the products offered at your facility/site? Who do you think should use FP services? Probe for marital status, parity, age (including adolescents), etc. Apart from preventing pregnancy, what are **pros** (or advantages) for clients such as couples, women and girls, men and boys, to using contraceptives? Probe for specific things they do/ don't like about different methods. What might clients such as couples, women and girls, or men and boys- consider as **cons** to using contraceptives?
10.2	What notable changes have you seen in FP/RH programs since the transition (year XXXX)?	
10.3	What developments or changes in FP policies and programs have you found to be especially useful for providers and/or clients?	Please speak to the policy and organizational level and then to operational and procedural developments. And, what about developments in FP services or programs that you have found to be least useful for providers and/or clients.

		Following those developments, have you personally noted an impact or significant changes on those accessing and/or using FP services? Probe: Ask about external factors, including economic development, women's education, urbanization, stability of political leadership, cultural norms, aging of the population, infant mortality, etc.
11.0	**LEADERSHIP**	
	Questions	**Probes**
11.1	Following the developments in FP/RH policies you just mentioned, how have you seen the roles of external and in-country organizations change over time?	How has that changed how you or your organization provide FP services? In what ways?
11.2	To what extent is there coordination between your organization and national agencies? How about between your organization and external agencies?	What does "coordination" mean to you? What does coordination look like for you in your day-to-day practice? Probe: Can you elaborate how this can be changed or improved upon to facilitate improved FP services? What structural changes or resources would be necessary for improvements to happen?
12.0	**FINANCING**	
	Questions	**Probes**
12.1	Could you tell us about the funding structure for your organization?	What are some of the factors considered when making decisions about what FP products to procure and how many?

	How are the FP commodities, procured and distributed? And funding for supplies, training, communication, utilities, maintenance and other essential cost factors?	Can you walk me through a typical procurement process from planning to distribution? In your experience, are supplies meeting the demand of clients?
12.2	How are clients paying for FP services and commodities in your organization/region/facility?	What do they need to pay for, e.g., FP products only, or consultation only, or both? Are they using the national healthcare coverage? Is it private? Is it out of pocket? How is the cost compared to average household income in this region? Are costs for a given product relatively stable or do they vary (and what causes the variation)? Are there means to assist those who cannot afford to pay?: If out of pocket payment is expected, are there means to assist those who cannot pay, such as vouchers, sliding scale, etc. Have there been changes in the funding structure over time and how have these changes affected demand for FP services?

13.0	**PROGRAMMING**	
	Questions	**Probes**
13.1	What FP/RH services are most requested in your facility? What contraceptive method is in highest demand in your facility/community) whether it is available or not?	· Voluntary surgical contraception · Male vasectomy and female sterilization, such as mini laparotomy · Long-Acting Reversible Contraceptives ex: IUD, implants and their removal · STM ex: male or female condoms, diaphragms, OCs like combined oral contraceptive pills, progestin only contraceptive pills, emergency contraceptive pills, injectables (subcutaneous or intramuscular -1-,2-, or 3-month formulations)

	And, what method is most commonly used?	· Fertility Awareness Methods: LAM, Standard Days Methods · Natural FP methods (these may be commonly practiced in country - like withdrawal, rhythm, etc) Why do you think this method is in highest demand? What methods are routinely offered? Why do you think this is the method most commonly used? Do women and their partners often switch between contraceptive methods? Do they often discontinue? Explore why, what methods and frequency of change and discontinuation.
14.0 | SERVICE DELIVERY		
	Questions	**Probes**
14.1	What is your overall assessment of the FP services in your country/region in meeting the FP/RH info and service needs among clients, including couples, women and girls, men and boys, and any individuals?	Do you think the level of FP services are adequate or not and what makes you think so? Are there gaps and challenges with FP/RH services (i.e. in coverage or access, or in types or levels of services that clients what or request)?
14.2	What is your assessment of the capacity of your facilities (or facilities in your region) to provide FP/ RH services?	In general, do they have sufficient resources? What is lacking? Please explain who is on staff at your facilities: how many doctors, nurses, others? On an average day, what is your estimate of the number of clients seen at the facilities?

		How many clients come to your facilities for FP services? What community/communities are served by your facilities? How do new contraceptive methods, clinical updates or other changes get shared with service providers?
14.3	How would you define good quality FP/RH services?	What constitutes good quality of care? What is the standard process for a counseling session at your organization? How are service providers who are providing high standards of care recognized and acknowledged?
14.4	How have policies or development in FP programs over time (both positive or negative) affected the ability of your facility (or facilities in your region) to provide FP services?	Probe e.g., whether they may have put emphasis on one method vs. others, or prioritized one sub-group vs. others, etc. Has this affected stock out, commodities, and tests?
14.5	Does the government have systems in place for reporting service refusal without medical basis or coercion?	How are violations reported? Are violations reviewed on a regular basis? Are there legal restrictions to specific FP methods? Can you describe them?
15.0	**EQUITY**	
	Questions	**Probes**
15.1	What types of FP/RH services are there specifically for married women and couples in your area/facility?	Explore <u>what</u> these services are, and <u>where</u> they are. If there are services, explore their accessibility and whether they are used or not.
15.2	How about FP/RH services for unmarried women and girls in your area/facility? How are they the same or different from those for married women and couples?	If there are differences, probe how and why. Ask about needs of young and unmarried people and how they are different from those who are older or married.

		To what extent do you think that FP/RH needs of the young and/or unmarried individuals are being met by the healthcare providers?
15.3	In instances when a client is unable to receive the FP/RH services they request, what is usually done? How is the decision made?	Explore barriers and enablers from the client side. ● Explore categories such as age, sex, marital status, rural vs urban, SES, etc. ● urban/rural disparities ● unmet need showing marked disparities by wealth quintile ● Inequities by wealth quintile, ethnic groups, religion, education? Also probe on available resources, number of staff, operation hours, number of rooms available vs number of clients attending the facility, waiting time, etc.
15.4	What do you think the community, or the government can do more or better to ensure continued access to FP services in your region?	What are your recommendations for improving community engagement with health care providers in FP service provision? Probe for consideration of age (teenagers vs older women), married vs unmarried, rural vs urban, women with or without children, etc.
16.0 | Conclusion		
16.1 What else would you like to tell us about family planning/contraception that we did not ask you about?		
16.2 Would you be able to refer up to three other key informants for this type of interview? If you need to ask them for their permission first, please do so and email us later at…		Please share reference contact information and association: Name 1: Email: Phone number: Position title: Name 2: Email: Phone number:

	Position title: Name 3: Email: Phone number: Position title:

Interviewer: "OK, thank you for your time. I'm going to turn off the recording. This is [Interviewer Name] with participant [ID#], on [Today's Date], at [End Time]. "

[End of recording]

Sources

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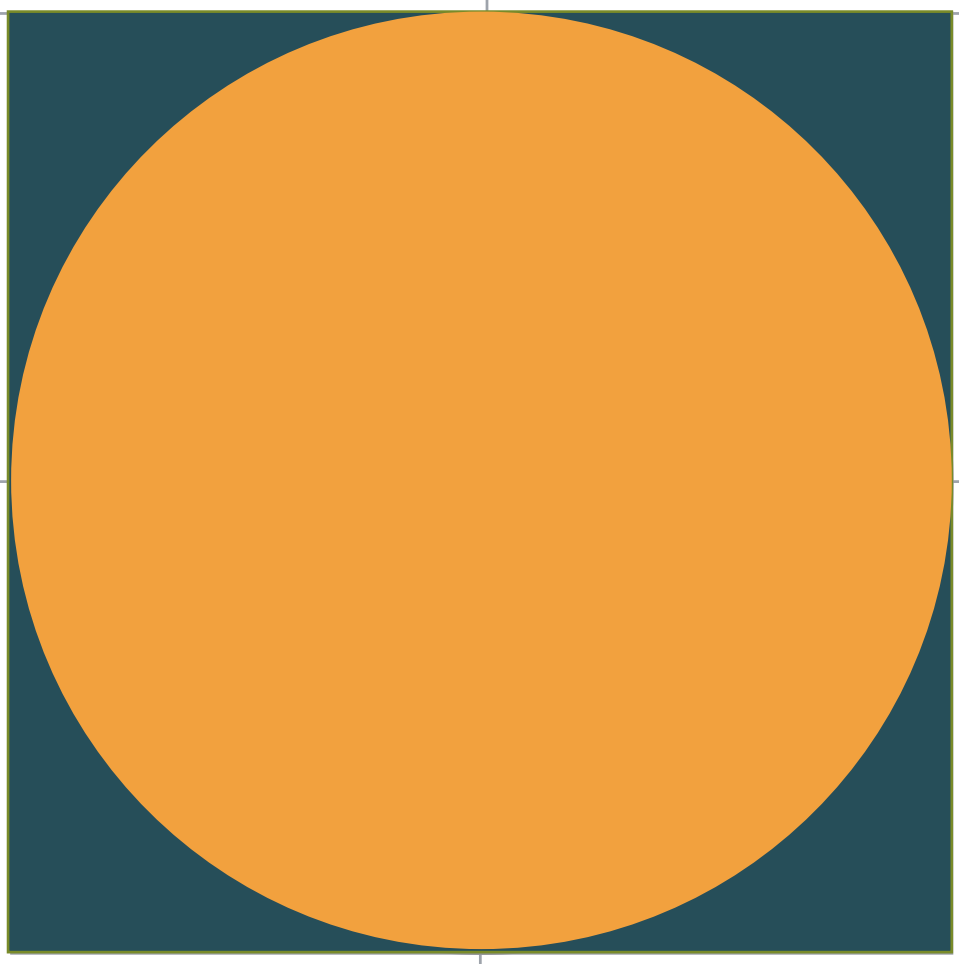

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