

Role of Financial Incentives in Family Planning Services in India: A Qualitative Study

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Abstract

Background: In an effort to encourage Family Planning (FP) adoption, since 1952, the Government of India has been implementing various centrally sponsored schemes that offer financial incentives (FIs) to acceptors as well as service providers, for services related to certain FP methods. However, understanding of the role of FIs on uptake of FP services, and the quality of FP services provided, is limited and mixed.

Methods: A qualitative study was conducted in Chatra and Palamu districts of Jharkhand state. A total of 64 interviews involving multiple stakeholders were conducted. The stakeholders included recent FP acceptors or clients, FP service providers of public health facilities including community health activists (ASHAs), government health officials managing FP programs at the district and state level, and members of development partners supporting FP programs in Jharkhand. Data analysis included both inductive and deductive strategies. It was done using the software Atlas ti version 8.

Results: It emerged that there is a strong felt need for family planning among majority clients, and FIs may be a motivator for uptake of FP methods only among those belonging to the lower socio economic strata. For ASHAs, FI is the primary motivator for providing FP related services. There may be a tendency among them and nurses to promote methods which have more financial incentives linked with them. There are mixed opinions on discontinuing FIs for clients or replacing them with non-financial incentives. Delays in payment of FIs to both clients and the ASHAs is a common issue and adversely effects the program.

Conclusion: FIs for clients have limited influence on their decision to take up a FP method while different amounts of FIs for ASHAs and nurses, linked with different FP methods, may be influencing their service provision. More research is needed to determine the effect of discontinuing FP related FIs for clients.

Background

Financial incentives (FI) serve as one of the key factors contributing towards increasing access and quality of healthcare services globally [1]. They are seen as extrinsic factors of motivation both, for the healthcare providers as well as the clients [1]. One of the popular approaches which has been widespread in countries such as the United States, Australia, Germany, Canada, UK etc., is 'Pay for performance (P4P)' where, an explicit amount of financial incentive is paid to the healthcare provider based on special performance measurements [2]. FIs have been offered in a wide range of health care services to the clients for promoting uptake and maintaining adherence to services [3,4]. For example, FIs in the form of \$5 grocery coupons were used in antiretroviral therapy to maintain adherence and continue tuberculosis prophylaxis in the USA [5]. FIs were also used to promote uptake of HPV vaccinations among young adolescent girls in England [6], as well as to promote access and increase institutional deliveries in India [7]. When offered as a reward for clinicians' effective performance, FI effectively decreases the number of medical errors and enables fewer events of malpractice [8]. Whilst for patients, FI is believed to be an encouraging factor influencing the uptake and compliance to the prescribed services [1].

With an aim of exploring pragmatic solutions to control the growing population, incentives were introduced in the realm of family planning (FP). The Government of India (GoI) in 1952, launched the first ever-FP program emphasizing primarily on fertility-regulation and stabilizing the population at a level consistent with socio economic development with an overarching aim for improving access to maternal and child healthcare [9].

In an effort to encourage FP adoption, the GoI has been implementing various centrally sponsored schemes that offer FI to providers as well as acceptors of certain types of FP services [10]. The first FI scheme was deployed in 1956, in Tamil Nadu state, where INR (Indian National Rupee) 30 was provided to male and female acceptors of sterilization, to compensate for the loss of wages and for the aftercare [10,11]. A central FP board was formed in 1956, and an equivalent of around 10 million USD of funds were allocated towards the initiation of a truly nation-wide FP action program [12, 13].

Since then, numerous FI have been introduced in various health programs either to increase the coverage or to promote the uptake. One such example is Janani Suraksha Yojana (JSY) in India which has been effective in achieving high institutional delivery within a span of few years. This meant that FI has a potential to increase institutional delivery which also serves as access points for post-partum FP [14, 15].

In addition, FIs were also introduced for uptake of various FP methods such as intra uterine device, sterilization, oral contraceptive pills (OCPs), emergency contraceptive pills (ECPs), and some new FP methods for acceptors as well as healthcare providers in India [11,16,17]. The details of which are mentioned below in Table 1.

Table 1
Financial incentives for FP methods in India (in INR)

	PPIUCD	PAIUCD	Antara	Post-abortion sterilization (PAS)		Postpartum sterilization (PPS)		NSV Non Scalpel Vasectomy	
				Districts with TFR >=3	Districts with TFR <3	Districts with TFR >=3	Districts with TFR <3	High focus districts	Non high focus
Provider	150	150	n/a						
Accredited Social Healthcare Activist (ASHA)	150	150	100	300	200	300	400	200	200
Acceptors	300	300	100	2,000	1,400	3,000	2,200	1100	1100
Drugs / dressings	n/a	n/a	n/a	100	100	100	100	50	50
Surgeon	n/a	n/a	n/a	200	150	325	200	100	100
Anesthesiologist	n/a	n/a	n/a	50	50	75	50		
Nurse / ANM	n/a	n/a	n/a	40	20	50	50	15	15
Operation theatre Technician(OT Tech.)/helper	n/a	n/a	n/a	40	30	50	50	15	15
Clerk./ documentation	n/a	n/a	n/a	30	20	n/a	n/a	n/a	n/a
Refreshment	n/a	n/a	n/a	20	10	n/a		10	10
Miscellaneous	n/a	n/a	n/a	20	10	n/a		10	10

Source: India M. Schemes/Guidelines- FP: National Health Mission [Internet]. 2020 [cited 30 April 2020]. Available from: <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=963&lid=470>

1 USD= 73.48 INR (as on 13th Sept, 2020).

Whilst there is enough global literature available on the effects of FI in healthcare services, the evidence thus far on the role of FI on uptake of FP services and the provision FP methods is limited and mixed [18, 19]. In addition, there is growing ethical concern regarding provision of FI to providers, where providers may have been promoting family planning methods that were linked to higher incentives, thus violating free and informed choice [1,3]. While incentives can be believed to deviate a women's choice from the norm of full voluntarism, they also increase the number of options open to an individual [10]. A study by T.S. Sunil on FP in India found that the likelihood of adapting a FP method increased when financial incentives were provided to a socio-economically homogenous population [11]. However, the study also showed that motivational programs were more effective than cash incentives in improving the long-term use of temporary family planning methods [11].

While most non-FP services have a fixed incentive amount, there are varying amounts available for uptake different FP methods (Table 1). Owing to the limited evidence on the role of incentives in opting for FP method within a resource-limited setting as well as the lack of in-depth understanding of how providers and clients view and respond to the FI in India, we have conducted this qualitative study to understand the role of FIs in the uptake and provision of FP services.

Methodology

Study Design

We conducted this qualitative study in October-November 2018.

The study involved key informant interviews (KIIs) and in depth interviews (IDIs) with participants from different stakeholder groups. The stakeholder group included government health officials, members of development partners working in FP, FP service providers at public health facilities, ASHA/ Sahiyas (women from village who work as field level health workers to motivate their community members for availing health services in public health facilities & get incentivized for their services) and clients (male and female) who have recently accepted a FP method linked to financial incentive.

Study site and Sampling

We conducted the study in the state of Jharkhand which is one of the high priority states of India with high total fertility rate (TFR) of 2.6 which is above the national average of 2.2 [20]. The state also witnesses high unmet need for contraception (18.4%) and spacing (9.0%) [20]. Only 37.5% women use any modern FP method, out of which female sterilization (31.1%) is the most preferred [20]. Every two out of five women are illiterate and 37% of its population lives below line of poverty [20].

In Jharkhand, we purposively selected two districts: Chatra and Palamu, which differ from each other in terms of performances on key health and socio-economic indices, to allow for maximum variation. Chatra is a district with Total Fertility Rate (TFR) > 3 and is among relatively poor performing districts of Jharkhand in terms of the development and administrative parameters, whereas Palamu is a district with TFR less than 3 and better development and administrative parameters. Within each district, two blocks were selected. We selected one block that is located at proximity (within 10 kms) and one remote to district headquarter.

Study participants and sample size

A total of 64 interviews were conducted, which included: 11 KIIs with government health officials and members of development partners working in FP; 33 IDIs with FP service providers of public health facilities and the ASHA/ Sahiyas working in facility's catchment area; and 20 IDIs with clients (male and female) who had recently availed incentive linked FP services. (Table 2)

We purposively chose those clients, who were motivated to take up FP method by the ASHAs/Sahiyas included in our study. This enabled us to get critical insights into differences that exist between the perspectives of the clients and their motivators on the quality, process and decision making around adopting a specific method of family planning.

Table 2
Study participants across groups of stakeholders

Stakeholder group	Number of participants	Role with respect to family planning services
Decision maker at State level	2	Involved in managing the FP programs
Decision maker at district level	5	
Development partners	4	Members of Institutions /non –government organizations in Jharkhand which had been undertaking or supporting family planning programs for the past 2 years
Service providers	14	Doctors; nurses and auxiliary nurse midwives (ANMs) involved in providing FP services at public health facilities or platforms;
ASHAs or Sahiyas	19	Community health worker who serves as a link between health system and the community members and act as a informer and motivator for various health programs within her village.
Acceptors or clients of FP services (Men/Women) with incentives:		Acceptors (2 years prior of study) of incentive based FP methods who were motivated by the 19 ASHAs or Sahiyas included in the study.
i) Non Scalpel Vasectomy (NSV);		
ii) Female sterilization (FS)		
iii) Post-partum Intra uterine contraceptive devices (PPIUCD).	4	
	8	
	8	
Total participants	64	

The Jhpiego program team, which has been providing technical assistance in FP programs to both Government of Jharkhand and Government of India for more than 10 years, identified and recruited decision makers, development partners, service providers, and ASHAs/LHVs for the study. Potential participants from these stakeholder groups were recruited such that they have a minimum of 2 years of work experience in FP. The list of clients who availed FP services from public health facilities of the four blocks (of the two selected districts) in last 2 years, was solicited from ASHAs or ANMs serving in the catchment area of the public health facilities.

Data tools and Data collection

Separate semi structured interview guides were developed for each stakeholder group [Refer Additional File 1]. The questions were exploratory to allow perspectives of participants to emerge during the interviews. The questions for clients covered domains like their socio economic context, knowledge of FP method, decision making process in opting for the FP method, experiences of using the method and related services, role and use of FIs in the uptake of the method and opinion on monetary versus non-monetary incentives for FP methods. The questions for ASHAs/ Sahiyas and health service providers covered domains like their role and capacities, processes followed by them for different FP methods, their perspectives on what motivates client to take up a FP method (including the role of FIs) as well as role and importance of FIs for themselves to provide FP services. For government health officials and development partners, the domains included factors which influence FP service provision and uptake, their perspective on role of FIs in service provision and uptake of FP services, alternatives to FIs and its potential impact as well as suggestions or recommendations for improving services. These domains were decided based on available published literature, findings of a dipstick study, which was conducted prior to the study in another district of Jharkhand for informing the study design and content of study tools, as well as consultations between the authors which was guided by their experience with the family planning programs in India. All tools were translated into Hindi which is the local language in Jharkhand.

Before initiating data collection, approvals were obtained from the administrative authorities of the two districts. Potential participants belonging to the stakeholder groups of government health officials, development partners, health service providers and motivators were explained about the study and then recruited by Jhpiego program team. Those who agreed for participation were then contacted by the study team for conducting their interviews. Clients identified by ANMs or the ASHAs were first contacted by them to know about their interest in participating in the study. If they expressed interest, their details were passed on to the study team which then contacted them for conducting the interviews. The IDIs or KIs were conducted at a place and time chosen by the participant. For clients, the interviews were conducted at their homes or a health facility nearby, while for participants belonging to the other stakeholder groups, interviews were conducted at their work places. A written informed consent was obtained before the interview and only the participant and interviewer were allowed to be present during course of the interview. This ensured privacy and confidentiality, which enabled participants to speak freely about various issues that were discussed. None of the potential participants who were approached refused to participate and no repeat interviews were conducted. Before initiating the interviews, the interviewers made some general conversation with the participants to make them comfortable and build a rapport. All interviews were audio-recorded and the interviewers also made field notes after completion of each interview. On an average, the interviews took 40 minutes each.

Independent research consultants who conducted the interviews, were graduates with prior experience (at least five years) of conducting in-depth interviews, specifically in family planning related studies. They were all fluent in the native language Hindi. Female interviewers conducted the interviews with female clients while male interviewers conducted interviews with male clients. For participants belonging to other stakeholder groups, interviews were conducted by either male or female interviewers. Study team also included two experienced qualitative researchers, who transcribed and translated the interviews from local language Hindi to English. Two co-authors (AS, AG), who were involved in supervising data collection, crosschecked each of the transcripts against the original recordings to ensure quality. The transcripts were not returned to participants for their comments or approval.

Data analysis

The analysis of data was done using Atlas ti 8. The two qualitative research experts coded the transcripts and analysed the data using content analysis in the style of the constant comparative method. This analysis blended both inductive and deductive strategies. A hierarchical coding structure was developed based on the open iterative coding of interview transcripts as well as the pre identified domains of interview guides. The two qualitative researchers coded random selections to check for reliability, inter-coder agreement as well as appropriateness of the coding scheme. Finally, they used the established codes to illustrate the thematic categories that result for each category of study participant. Both theme saturation as well as consensus between the two coders was achieved. Illustrative quotations in English linked to the participant category have been used in the results section. Feedback on analysis was not obtained from participants.

Results

1. Profile of the participants

Family planning acceptors or clients were married men and women aged between 18 and 40 years, having at least one child and residing in rural areas of the selected districts. The educational status ranged from being illiterate to college graduates. All women clients were housewives. All family planning acceptors belonged to lower, lower middle or middle income groups. ASHAs were women belonging to the village they served and their educational status ranged from completing high school to graduation.

The other stakeholders which included service providers, development partners and decision makers were minimum graduates and had an experience of at least 2 years in implementation or service provision of family planning programs.

2. Uptake of FP methods

All stakeholders unanimously agreed that among limiting family planning methods, female sterilization was the most popular by far. Women generally preferred this method once their family was complete. It was perceived as a simple “onetime” solution, with relatively lesser associated side effects or chance of complications.

Male sterilization, on the other hand, was least popular of all the methods. There is a widely accepted myth in the community that it makes the man “weak” and therefore may impair his ability to work and earn for the family thereafter.

“Why should my husband get NSV... he is the bread-winner of the family... if he becomes weak then what will happen to us” – A woman client who had undergone sterilization

Among spacing methods, condoms, IUCDs and OCPs were the most preferred, although there were many myths or misconceptions linked to IUCDs and OCPs in the community. Uptake of spacing methods has been increasing over the past few years, although many still preferred traditional methods like calendar method or withdrawal method for spacing pregnancies. Injection DMPA and Centchroman pills, which were recently introduced (2017) in the public health system, are yet not as popular due to lack of information about them among general public in the study districts.

3. Factors influencing the decision on uptake of FP method

Factors which emerged as key influencers of client decision to take up an FP method in the two study districts are following:

3.1. Felt need for a small family: Felt need for a small family emerged as the single most important driving factor for uptake of a family planning method in the two study districts. Almost all the clients who had opted for a limiting method stated that they took the decision as they had achieved their desired family size and did not wish to have more children. They cited increased costs associated with managing care and education of children and emphasized that

smaller families are easier to manage with the means available. Participants from other stakeholder groups also identified the felt need for smaller families as the primary motivating factor behind couples' decision to adopt a permanent family planning method.

"Getting sterilization is good forever. It will be good as the number of children will be less. We will be able to feed them well, take good care of them and educate them well." – Female sterilization acceptor

3.2. Health concerns: Almost all the PPIUCD clients, who accepted the method after their delivery, stated that they wanted to adequately space their subsequent pregnancies. They feared that frequent pregnancies would make them "weak" and "sick" and this would also adversely affect the health of their children. ASHAs or their motivators agreed that health concerns around closely spaced pregnancies was an important factor influencing clients to take up spacing methods like IUCDs, pills or condoms.

Majority of men who opted for NSV stated that they did so out of concern for the health of their wives. They stated that they felt their wives were not healthy enough to undergo a surgery (female sterilization procedure) and therefore took the decision to undergo sterilization themselves.

3.3. Motivation by Sahiya/ASHAs: All health service providers, decision makers and development partners noted that motivation of clients by ASHAs played a very important role in uptake of family planning services. Majority of women clients reported that ASHA of her village was one of the primary sources of information on FP methods and that they always trusted her to give the correct information and guidance. ASHAs too stated that motivating clients to take up a method was their primary role with respect to family planning program and they had to follow up several times with some couples to motivate them to opt a method. They also reported the need to sometimes motivate family members of clients for ensuring that they take up the method of their choice.

3.4 Advise by family members, friends or neighbours: Many clients stated that their decision to opt for a family planning method was taken after consulting their partner, mother in law or any other family member who had used the method before. A few clients also mentioned taking advice of their neighbors and friends before opting for the method.

3.5 Myths and misconceptions on methods: It emerged that there were many myths and misconceptions prevalent in the community regarding spacing methods like the IUCD and OC pills, which served as a deterrent to their uptake. With respect to NSV, there is a widely prevalent myth that it makes the man weak or less masculine, and therefore even women don't want their husbands to take it up.

3.6 Asymmetric information on methods: It was also evident that counselling or information provided to clients on FP methods was inadequate. Although the ASHAs reported giving information to clients on all available choices, majority of the clients denied being informed about other available options during their decision making process. When probed, majority of the clients were not able to elaborate on the expected side effects of the methods they were currently using. However, the clients felt that their information base was sufficient for them to make an informed choice.

3.7 Other factors: Religious norms and preference for a male child also influenced the uptake of FP services. A couple of clients did state that they opted for female sterilization after having a male child, as after that they felt their family was complete. Few ASHAs and service providers pointed out that uptake of female sterilization was very low in tribal areas and Muslim dominated communities, owing to their cultural and religious norms.

3. b. Influence of financial incentives on client's decision to opt for a FP method

All clients, including both women and men, categorically stated that their decision to opt for a family planning method was primarily driven by their felt need to limit or space subsequent births. They said that they would have opted for the method irrespective of whether government provided them with financial incentives or not.

"The government gives us (financial incentive) or not it doesn't matter to us. We have a desire to do NSV, so we go and get it done." – NSV Client.

Many clients did welcome the financial incentives though and said they felt happy about the amount that the government was providing. Most of them stated that they utilized the money to take good care of themselves by eating nutritious food and buying medicines, to help them recuperate from the surgery. A few clients said that the money helped them compensate for their travel expenses, wage losses or expenses incurred in availing these services at the public health facilities.

A couple of clients informed that they were not aware of any financial incentive attached with the method of their choice until after the procedure.

Majority of Sahiyas and service providers echoed the same sentiment that clients would avail FP services irrespective of financial incentives due to their felt need. However, few of them did state that financial incentives may be a primary driver for clients belonging to the lower socio economic strata of the society.

Decision makers and members of development partner agencies however attached more importance to financial incentives for clients and felt that they were important drivers of family planning uptake, especially for those from lower socio economic strata of the society.

"We belong to a district where there is lot of poverty, and I think this incentive people should get"- District level official

Couple of decision makers also suggested increasing the amount of financial incentives for clients, especially those attached with spacing methods, to improve uptake of FP methods in their area.

4. Influence of financial incentives on service provision by ASHAs or motivators

It was evident that financial incentives play a very key role in motivating ASHAs for performing their family planning program related duties. ASHAs are not salaried employees and therefore the financial incentives attached with their different duties are the primary source of income for them.

Majority of the ASHAs clearly stated that financial incentives attached to their FP related work are very important to them. Many of them were able to recall the exact amount they had received as incentives for family planning in the past one year. Few of them also emphasized that the amount given was not commensurate with the 'hard work' they put in and therefore should be increased. Some also expressed displeasure over delays in payment, which they felt was demotivating.

"We do this work and we like doing it. Our incentive money should also be released on-time. We do our work fully but if the amount is paid in time so we will do the work happily. We work everywhere and also want to do a better work, so that we get the cash rewards at a proper time interval" – ASHA, Chatra district.

Participants from other stakeholder groups agreed that financial incentives served as a key motivation factor for Sahiyas to do their work. Some of them agreed with the demands of ASHAs for increasing the amount of financial incentive for them. They also emphasized on ensuring timely payment to them for keeping their motivation levels high.

A couple of service providers and members of development partners did raise concerns on selective promotion of FP methods, which have incentive amounts associated with them, by the ASHAs.

"ASHA is more motivated to give as much information as possible for these methods (attached to incentives)." – Member of Development Partner

5. Influence of financial incentives on service provision by nurses and doctors

It emerged that for doctors, nurses and ANMs, who are salaried employees, the financial incentives served as an extrinsic motivation for carrying out their family planning related work. It was perceived as a 'token of appreciation' from the government for their efforts. Majority stated that the amount was important to them, however they did add, that they would continue to provide their services irrespective of whether they received the incentive amount or not.

Participants from other stakeholder groups (government officials, development partners) agreed that financial incentives were important motivators for the nurses and doctors as well. A few of them also felt that different amount of incentive money for different methods does influence service provision by ANMs and nurses as they tend to 'push' those methods which have incentives associated with them.

6. Perspectives on discontinuing financial incentives

6.1 Discontinuing client incentives

There were mixed opinions on discontinuing financial incentives for clients. While all clients stated that they would have opted for the method irrespective of whether financial incentives were attached to them or not, some of them did emphasize that the incentive amount was also important for them. Few clients said that although the amount does not matter to them, but it may be important for the poorer clients.

Among the ASHAs, majority felt that discontinuing financial incentives for clients will adversely impact FP uptake to some extent, as there is a section of clients for whom incentive money is an important motivating factor. Remaining ASHAs, on the other hand felt that owing to the strong felt need for FP methods, discontinuing financial incentives for clients would not have any adverse effect.

Majority participants from the other stakeholder groups concurred that discontinuing incentives will adversely impact uptake of family planning services especially among the poorer sections or among those living in remote locations. Government officials particularly were not in favor of discontinuing client incentives in one go. A government official stated that one needs to first study the impact by discontinuing incentives in a few districts and then come to a conclusion.

"A pilot project needs to be conducted to see what the effect in the region is once it is withdrawn and then compare it with other region. If all are withdrawn all of a sudden then there will be problem" – A government official, Jharkhand

6.2. Discontinuing incentives for ASHAs and service providers

Almost all Sahiyas clearly stated that financial incentives were their primary motivation to work. Many stated that unlike other service providers, they were not salaried employees and entirely depended on these financial incentives to run their families. Few also put forward their demand to increase the amount of incentives for them as it was not commensurate with the amount of effort they were putting in

"We are working for the money only, either it is less or more. If we don't get money how will we work?" – ASHA

Nurses, doctors, government officials and development partners, all echoed the same sentiment and opined that FP services would be impacted majorly if incentives for ASHAs were scrapped. ASHAs played a key role in motivating clients and any step which de-motivates them would have major implication on the FP program.

ANMS, Nurses and doctors stated that discontinuing incentives for them would not affect the services that they provide as they were being paid (salary) to give their services.

Government officials and development partners though expressed their concern that scrapping incentives for service providers may adversely affect their motivation levels especially of nurses and junior doctors and therefore may have an adverse effect on the program. They emphasized that service providers

receive financial incentives for their work across many health programs like maternal health, immunization etc. and scrapping incentives in the family planning program may demotivate them from actively giving services for the program.

"The doctor and the assistant get motivated when they get incentive because there is a series of incentives in all programs. Like in maternal health (MH) caesarean section, the doctor, nurse and even the 4th grade gets incentive. So if you give in some program and not in some, it will demotivate people" - A district level government health official.

7. Perspectives on replacing financial incentives with non-monetary incentives

7.1. For clients

Many clients stated that they would be fine with any non-monetary incentive which the government offers them in place of cash like food items, clothes etc. Some did convey that they would prefer cash incentives as it would give them the freedom to buy things as per their needs. ASHAs too had a mixed opinion on the issue. Many of them felt that clients will appreciate non-monetary incentives more as they would get it right after accepting a method and would not have to wait like in case of financial incentives. A few of them stated that clients use the incentive amount for purchasing nutritious food items to help them recuperate better after surgery and therefore replacing financial incentives with nutritious food items would be a better option as payment of financial incentives does get delayed sometimes. A few ASHAs did however feel that financial incentives were better off as they gave clients the freedom of using it in their own desired way.

Service providers, government officials and development partners were more inclined towards continuing with financial incentives as non-monetary incentives may not meet every client's requirement. They also raised the issue of increased chance of corruption with disbursement of non-monetary items. Some government officials also pointed out the logistical challenges in distribution of non-financial incentives, which they felt would be a major barrier.

7.2. For ASHAs and service providers

For ASHAs, there was agreement among most respondents on the need for financial incentives, as they were not salaried and these financial incentives were their only source of income.

For ANMs, nurses and doctors, there were mixed opinions. While many service providers themselves stated that the 'token of appreciation', either monetary or non-monetary, would motivate them, government officials and development partners were more inclined on continuing with the financial incentives. They felt that non-financial incentives like certificates or rewards for good performance could be supplemented with monetary incentives. However, they were not in favor of completely scrapping monetary incentives as they felt it was important for their continued motivation.

"It will impact, but not their pro-activeness as monetary would. Though "recognition" matters but it doesn't give a push like money" – Member of a development partner on whether non-monetary incentives would motivate service providers.

8. Issues with disbursement of financial incentives

Delay in payment of incentives was reported by some clients and ASHAs. Many participants emphasized on the need to ensure early payment of incentives, especially for the ASHAs and the clients, for keeping their motivation levels high.

ASHAs highlighted the importance of timely payment to the clients stating that delays adversely affect their relationship with their clients who then tend to lose their trust in them. This, they said hampers their work as people in her area start doubting her intentions and words.

"So then sometimes beneficiary starts talking and doubting us, asking what is the reason that Sahiya (ASHA) is not making us get our incentives." – ASHA

Government officials acknowledged that delays do happen in certain cases when the clients do not have a bank account or the documentation isn't complete from their end. They however did point out that such instances are now reducing as more and more clients are getting their bank accounts opened. They stated that the primary reason for this delay is at the client level (documentation issues), temporary unavailability of funds and lack of human resources.

Discussion

In this study, we described the uptake of various FP methods, factors influencing uptake of FP methods and the role of FI in family planning services in Jharkhand state of India, through qualitative interviews with acceptors of FP methods linked with FI, various cadre of health care providers, government health officials and development partners. The key themes emerged from our study are: female sterilization is the most popular limiting method; FI are not a primary factor influencing uptake of FP methods however FI are welcomed by clients; FI were important for lower socio economic group of the society; FI are important motivators for Sahiyas / ASHAs; FI amount offered to Sahiyas /ASHAs for FP methods is low; possibility of biased counselling by Sahiyas / ASHAs; negative implications of discontinuing FI for Sahiyas / ASHAs to FP program; no implications of discontinuing FI for other health providers; Sahiyas / ASHAs were in favour of FI; other group of service providers were in favour of non FI; delays in timely payment of FI.

Our study revealed that female sterilization is the most popular limiting method, this corroborates with the results from nationally representative study conducted in 2015 -16 where female sterilization was used by 36% of currently married women in India [20]. This popularity could be due to convenience, free provisioning at public health centres, and provision of compensation [21], myths around temporary FP methods [22]. In our study women were against their husband undergoing vasectomy, due myth that would make them weak. However, a study conducted in Punjab state of India revealed that the main concern of the men was that if they get it done and their partners conceives then it would bring a bad name to the woman as well as to the family [23]. This difference

might be due to primarily two reasons: differences in state and population interviewed. The participants in the study conducted in Punjab state were graduates and postgraduates; while in our study we had mixed population in terms of educational level. Moreover, these two states differ by socio-demographic characteristics, education, infrastructure and overall development. Our result is in consistency with other studies conducted across India, that highlighted various myths and misconceptions around NSV, including fear of surgical procedure; fear of post-operative weakness, inability to function sexually, failure of NSV and lack of knowledge related to NSV [24-28]. Similarities between our results and results of these studies shows that myths and misconceptions around male sterilization did not change over the years, implying these misconceptions are deep-rooted in the communities that requires innovative approaches to address it.

As per clients in our study, FI did not act a motivator for accepting FP method. This result is in line with qualitative study conducted in West Bengal, where female family planning acceptors noted that they would opt for sterilization procedure even in the absence of FI; however, all respondents emphasized the need of having at least one son for the family progression and care provider to them during the old age [29]. A review conducted by Heil and colleagues [10] concluded that FP behaviours, like other behaviours, are sensitive to incentives and recommended that future research is needed as there is a lack of evidence based on rigorous studies. Additionally, a study conducted in Mexico [30] on the effect of large conditional cash transfer program concluded that cash transfer was positively associated with uptake of modern FP methods by adolescent and young adult women.

However, studies conducted in India [24, 25, 31] concluded that FI are one of motivational factors for men to accept vasectomy along with word of mouth. Our results in line with the study conducted in Andhra Pradesh state of India where FI were not significantly associated with acceptance of NSV [32].

In our study the felt need for a small family, health concerns, motivation by Sahiyas/ASHAs, advice by family members, friends and neighbours', religious norms and son preference were emerged as a key factors for uptake of FP methods. Similar results were found by Scott and colleagues in Uttar Pradesh, India where respondents mentioned a desire to limit number of children and educate children well [25] as a primary reason for accepting FP methods. However, despite of a clear preference for small families, the desire for male children may result in increased family size, with women continuing to bear children until either they give birth to a son or until some adverse event occurs [25,29]. Furthermore, studies found that certain religious norms also prevented acceptance of sterilization services [25]. The majority of men in our study opted for NSV because the concern related to the health of their wives. Similar results were shown by Shattuck and colleagues who cited concern for women's health (desire to avoid pregnancies, births, and contraceptive side effects) along with desire to limit births, limited financial resources and dissatisfaction with other FP methods as reasons for acceptance of NSV globally [27].

The results of studies exploring the role of conditional cash transfer in increasing institutional deliveries [33, 34] revealed that FI is not a key motivating factor to access institutional delivery; rather support from community workers, growing individual perception of the importance of "safe" and "easy" delivery was an enabling factor to access institutional delivery services. Similarly, a study conducted in Turkey and Latin America [35] emphasized that beliefs around traditional and modern biomedical practices, sociocultural norms, gender relations, and the quotidian experience of poverty in many dimensions play role in health seeking behaviour rather than conditional cash transfer.

Although some of the respondents in our study welcomed FI and used it for covering travel expenses and getting nutritious food after surgery, some of the clients were also in favour of getting non FI like clothes, food items; however, providers expressed concerns with replacing FI with non FI as it may not meet every clients' needs and will have some logistical challenges. Opposite to our results randomized experiment conducted in Ecuador reported that respondents were in favour of FI over vouchers, food items due to autonomy that comes with FI [36].

The government officials and development partners in our study emphasized the importance of FI for lower socio economic group of the society. The impact evaluation of large conditional cash transfer program aiming at increasing institutional delivery in India found improved rates of institutional deliveries, however poorest women didn't benefit from the program [37]. On the other hand, an evaluation of cash transfer programs in Latin America found that cash transfer programs are effective in improving preventive health care, and raising household consumption among poor households [38].

Our study found that FI were major motivator for Sahiyas /ASHAs, the similar findings were highlighted by another qualitative study conducted with ASHAs and their families in two districts of India [39]. Likewise, FI were identified as a major motivating factor in a study conducted in five states in India [40]. On the other hand, Dieleman and colleagues [41] concluded that FI are important, however they are not sufficient to motivate health care provider to perform better. Furthermore, according to the study conducted by Tripathy et al. factors such as interpersonal relations, family support, skill and career development opportunities contribute to the motivation of community health workers [42]. In contrary, incentives did not affect motivation of health workers in Afghanistan [43].

Our studied revealed the issues around the low rate of incentives for ASHAs/ Sahiyas and delayed payment. These results corroborate with studies conducted across India where low rates of FI relative to the level of efforts required to complete their responsibilities, magnified by delayed and incomplete payments was cause of dissatisfaction among ASHAs and their families [39, 40, 44-47].

Our study highlighted the possibility of coercion by ASHAs/ Saahyas where ASHAs may have been promoting family planning methods that were linked to higher incentives. This was evident as many acceptors of FP method in our study mentioned that they were only informed about the method they had adopted during their interaction with ASHA/ Sahiyas. While ASHAs/Sahiyas, stated having briefed clients about different FP methods, however, they also highlighted IUCD and sterilization as the major FP methods which were linked with higher incentives. Government officials and development partners were also concerned about the possibility of coercion or biased counselling because of differential incentives related to FP services. A study conducted in Bangladesh revealed that even though FI is successful in increasing FP use, there is a potential for coercion as FP motivators received FI for referring clients for sterilization [48]. Furthermore, it was noted that FP motivators while referring clients for sterilization targeted low income group of society who might be more susceptible to coercion [49]. A study conducted in India concluded that [39] ASHAs may have been prioritizing and promoting services linked to higher incentives such as sterilization.

Moreover, it is important to emphasize that a review on performance based incentives in community based FP programs showed that differential amount of FI has a potential to steer clients towards one method, thus breaching the principle of informed choice [50].

Additionally, several studies have mentioned coercion as violation of free and informed choice [44,45]. On the other hand, ASHAs may have been focusing on sections of the community that are easier to persuade, leaving behind more vulnerable group of population [44].

Our study found that FI were not important to other cadre of health care providers. But existing literature has mixed evidence on this, thus a study conducted among government employed medical officers in three states of India, found FI as one of the motivator along with job security, opportunities for promotion, working condition [51]. Another qualitative study conducted in two states of India among various cadre of health workers found that FI had limited motivating factor, especially when the amount of FI is nominal [52]. On the contrary a study conducted among health care workers in Pacific and Asian countries concluded that FI is an important motivating factor, especially in countries where salaries of health workers are low [53]. Our study results and other similar studies imply the need to reconsider other ways of motivating various health cadres taking into account Indian health care system.

Given that India's FP program has evolved and made several gains over the past few decades, and the fact that FI for both FP clients and service providers still constitute a major part of resources invested in India's FP program [54], there is a need for more in-depth understanding of the role FI play in enhancing the provision and uptake of FP services in current context. India spent 85% of its total family planning expenditure on female sterilization, 2% on spacing methods and 13% on family planning-related activities such as procurement of equipment, transportation, Information Education and Communication (IEC) and staff expenses in 2016-17 [55]. Moreover, 93% and 87% of the total budget for terminal and spacing methods respectively went toward incentives payment in 2016-17 [54,55].

Strengths and limitations

To best of our knowledge, our study is the first study which explores the perspective of male and female clients, Sahiyas, service providers, decision makers at the district and state levels and development partners; thus exploring an opportunity to understand the role of FI in family planning from various stakeholders' experiences. Second, this study is a part of a larger program whose focus was to incentivize the quality. Therefore, we had the professional relationships with the different stakeholders at each level, that helped us in getting more candid results. Third, we have followed a case study approach in which we interviewed the same Sahiyas associated with the clients helping us in understanding the link between the counselling and informed choice among clients. This helped in triangulation of data and enabled us to gain insights in the decision-making process of the clients and identify the key factors within the service provision system, which influenced their decision.

Our study had few limitations as well. Firstly, we did not interview women and men who had not accepted family planning methods despite counselling from ASHA/ Sahiyas and their perceptions on incentives. Secondly, due to limited number of men who had undergone vasectomy in the last 2 years, we could include only 4 men in our study who had undergone vasectomy.

Recommendations

Our major recommendations from this study are the following: firstly, incentive act as a major work motivator for ASHAs/ Sahiyas, thus they should be continued incentivizing for motivating people to get FP services. However, there is an urgent need to discuss the effect of different amount of incentive provided to the motivators and service providers for different FP methods. Our study highlighted that possibility of coercion around FP services, which can partially explain the popularity of female sterilization as ASHA is paid more for this services and lack of information about other temporary FP methods. Equal incentive for adopting all FP methods can help in preventing the skewed FP uptake towards specific methods. This could also be achieved by timely identification and appropriate action against promotion of services linked with higher FI by regular review and feedback meetings between ASHAs and their supervisors ensuring the quality services to more vulnerable group of population.

Secondly, our study also highlighted that there is felt need for FP services among clients irrespective of incentive money. However, FP incentive holds importance specifically to clients from lower socio economic strata who use this money mostly to buy food or medicine. Thus, there is a possibility of continuing client incentive only for the clients from lower socioeconomic groups or those eligible as beneficiaries under Ayushman Bharat Scheme. This is a flagship scheme of Gol with the vision to achieve Universal Health coverage specifically for poor and vulnerable population by providing free health insurance up to 5 lakhs INR.

Thirdly, our study also called attention to fact that since senior doctors considered incentives as only token amount for appreciation, their incentives can be discontinued and the same amount can be used to incentivize the whole team involved in provision of services or for betterment of the health facility.

Fourth, a pilot can be undertaken in a district or relatively smaller administrative area to see the effect of discontinuity of FI and replacement with non-FI, specifically for senior doctors and clients living above line of poverty, on FP services.

Fifth, it is crucial to address myth and misconceptions around IUCD, OCP and male sterilization. This could be achieved by couple counselling or Gender Role Models. Furthermore, considering low popularity and myth associated with male sterilization, men who have undergone sterilization can be made Gender Role Models to motivate and improve male involvement in FP by solving their queries. Our study also showed that men considered it inappropriate to discuss FP options with ASHA /Sahiyas.

Additionally, it is imperative to ensure timely payments of incentives to both the providers and clients. Taking into account IT penetration across India, online / application based system should be considered for real time entry of incentivized services and amount to be paid for each of these services delivered. This will also facilitate easy tracking by ASHAs about their expected incentives in given period.

Finally, although our findings and recommendations are India specific, they can be useful to consider in other country context for incentive based program planning and implementation.

Conclusion

While FI were not motivating factor for clients for accepting FP method, it was welcomed by clients and was used covering travel expenses and for buying nutritious food. FI were important motivating factor for Sahiyas /ASHAs as they not salaried employees; also dissatisfaction with remuneration amount that was not commensurate with the workload, delays in payments were concerns expressed by ASHAs/ Sahiyas. However, FI were not important for other group of health care providers. Future research will be required to explore the effect of FI on whether ASHAs /Sahiyas promote FP methods linked with higher FI; whether ASHAs/Sahiyas target specific groups of the community, hereby leaving the most vulnerable population; discontinuity of incentives for senior doctors & clients from better socio economic status and replacement of FI with non FI for FP services.

Abbreviations

ANM-Auxiliary Nurse Midwife, ASHA-Accredited Social Health Activists, BMGF-Bill and Melinda Gates Foundation, TFR-total fertility rate, CHW-Community Health Workers, ECP-Emergency Contraceptive Pill, FI-Financial Incentive, FP-Family Planning, GOI-Government of India, IDI-In Depth Interview, INR-Indian National Rupee, IRB-Institutional Review Board, JSY- Janani Suraksha Yojana, KII- Key Informant Interviews, LHV-local health volunteers, LMIC-Low and middle-income countries, MPV- Mission Parivar Vikas, NSV-Non-Scalpel Vasectomy, OCP-Oral Contraceptive Pills, P4P-Pay for performance, PAIUCD-Post Abortion intra uterine device, PAS-Post abortion sterilization, PPIUCD-Post-Partum intra uterine device, PPS-Postpartum sterilization, QFP-Quality in Family planning SDG- sustainable development goals, USD-United States Dollar.

Declarations

Ethics approval

The ethical approval was obtained from the Institutional Review Board (IRB) of Johns Hopkins School of Public Health, USA as well as Sigma IRB, New Delhi, India- which is the local ethics committee.

Consent for publication

Informed consent was taken from all the participants of the study.

Availability of data and material

Data are available from Jhpiego's internal institutional data access committee for researchers who meet the criteria for access to data. Data is under the custody of lead author. Any request for data sharing may be sent to lead author at his email address: 'kamlesh.lalchandani@jhpiego.org'. Data will be shared to interested researchers subject to approval from Jhpiego ICO

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

AS and KL contributed to the concept and design of the study. AS, GU and AG were involved in study database creation, checking, and analysis, and AG, GU, AS, AM helped draft the manuscript. All the authors contributed in finalizing the manuscript. KL is the guarantor for the project. All authors had full access to all of the data (including statistical reports and tables) in the study and can take responsibility for the integrity of the data and the accuracy of the data analysis. All authors read and approved the final manuscript.

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