

REQUEST FOR PROPOSAL (RFP)

Evaluation of the Umeed Family Planning Systems-Strengthening Scale-Up Project

Seven districts, Uttar Pradesh

1. Introduction and Purpose of this RFP

Population Foundation of India (PFI) invites proposals from qualified research and evaluation agencies to conduct the evaluation of Umeed family planning systems-strengthening scale-up project, implemented across seven districts of Uttar Pradesh.

This document sets out the background, evaluation questions, design, scope of work, deliverables, timeline, and proposal requirements. Agencies should read the full document before preparing a technical and financial proposal. Where a design parameter is described as indicative, the responding agency should propose refinements supported by its own reasoning, and PFI will confirm the final parameters with the selected agency at inception.

2. Background

2.1 The Umeed project

PFI with support from Mobius Foundation and Government of Uttar Pradesh is implementing Umeed scale up project since February 2024 across 50 implementation blocks in seven districts of Uttar Pradesh to strengthen Family Planning (FP) and Sexual and Reproductive Health (SRH) services. The project strengthens the existing government health system rather than creating parallel delivery structures. The project aims to build responsive and sustainable government systems that strengthen existing FP and SRH programs, improve access, and increase demand for modern contraceptive methods in seven districts of Uttar Pradesh.

The key objectives of the project are as follows:

- **Objective 1:** To enable the expansion of FP and SRH services making clinical services available at sub-block level facilities
- **Objective 2:** To increase FP awareness and uptake by strengthening the capacities of front-line service providers and improve their skills to effectively use Social and Behavior Change Communication (SBCC) tools and job aids
- **Objective 3:** To facilitate an enabling environment through inter-departmental coordination for strengthening family planning services through District Working Group (DWG) and Block Coordination Committees (BCCs) or similar mechanisms. Facilitate adoption and scaling up of this model (Umeed scale-up) in additional blocks/districts of UP and national level.

The full objective-wise results chain, including activities, outputs, and outcomes for each objective, is provided in Annex A and should inform the evaluation team's approach.

2.2 Purpose of evaluation

The proposed evaluation is a systems and service-delivery evaluation. It will assess whether facilities, providers, and convergence and coordination (C&C) mechanisms have shown improvement and contributed to positive results. The core indicators viz. facility readiness, provider competency, method mix, and C&C functioning, will be repeated at the endline making this evaluation as the reference point against which the endline results will be assessed later. Agencies should design instruments and record data in a form that can be repeated without extensive modification at endline.

Projects like Umeed implemented through government systems may generate effects beyond their stated objectives. The evaluation will therefore read family planning service strengthening as a **tracer of wider system performance** and will also record system-level change that the project did not set out to produce.

At the **FP client level**, effects may extend beyond contraceptive method adoption to include informed choice, reproductive agency, satisfaction with counselling and services, and potential social or economic benefits associated with contraceptive use. At the **provider level**, effects may go beyond improved technical competencies to include greater confidence and self-efficacy, job satisfaction, shifts in attitudes towards gender and patriarchal norms, and application of counselling and communication skills beyond family planning services. At the **system level**, strengthened interdepartmental convergence may generate wider effects such as improved coordination and problem-solving, stronger governance processes at block and district levels, and greater recognition of the interdependence of departments in addressing health and development outcomes.

3. Evaluation Questions

The evaluation will answer five questions, each assigned to a stage of the project's results chain:

1. **Interdepartmental convergence (process):** Are DWGs and BCCs producing the C&C results envisaged by the project?
2. **Facility readiness (output):** Has FP service readiness improved since the pre-implementation baseline?
3. **Service delivery (output):** Has the method mix shifted since implementation began, measured against each block's own pre-implementation trend?
4. **Provider competency and practice (outcome):** What level of counselling competency have trained health providers and frontline functionaries reached, disaggregated by cadre (Staff Nurse, ANM, ASHA, CHO, FP Counsellor) and time since training, and does that competency translate into how providers deliver FP counselling to clients?
5. **Quality of counselling (outcome):** What standard of FP counselling do client exit interviews record, and how does it relate to the measured competency of the provider delivering it?

The competency assessment will be adapted from a standardised scale drawn from the **WHO Family Planning and Comprehensive Abortion Care Toolkit for the Primary Health Care Workforce: Competencies** or any other recognised competencies measurement tools. The agency should demonstrate familiarity with such toolkits, or an equivalent standardised instrument, in its technical proposal.

4. Theoretical Approach: Contribution Analysis

Umeed project operates alongside other actors and pre-existing government systems. A simple before-after comparison cannot isolate the project's effect. The evaluation will therefore use **contribution analysis**, a theory-based method that tests whether the observed pattern of change is consistent with the project's theory of change (Annex -I), after ruling out plausible alternative explanations. This method suits multi-component interventions where a single causal pathway cannot be isolated through a controlled comparison.

The central proposition to be examined: contraceptive uptake rises only where competent providers meet informed demand at a functioning facility, and gains persist only if government systems absorb coordination, supervision, and financing once external support ends.

The selected agency is expected to structure its analysis and final report around this proposition, triangulating findings from facility, provider, client, and coordination data against the results chain in **Annex A**, and explicitly testing alternative explanations for observed change (for example, secular trends, other actors' concurrent activity, or seasonal effects).

5. Scope of Work

The scope of work covers four linked components. The agency is responsible for the full cycle of each component: instrument adaptation, ethics clearance, piloting, primary data collection, data management, analysis, and reporting.

5.1 Component 1: Facility readiness

PFI conducted a Service Availability and Readiness Assessment (SARA-based) facility survey during the initial phase of Umeed scale-up, establishing a baseline using universal sampling of District Hospitals (DHs), Community Health Centres (CHCs), and Primary Health Centres (PHCs) across 50 blocks. The agency will:

- Confirm baseline SARA coverage facility-by-facility before the sample is finalised.
- Administer the SARA-based facility readiness tool at a **sampled facilities** (see Section 8), enabling a paired before-and-after comparison against the matching baseline record. PFI will provide the list of facilities in which baseline SARA assessment was conducted.

5.2 Component 2: Frontline worker and provider competency

The agency will design and administer a structured knowledge and counselling-skills assessment survey among a stratified sample of trained Staff Nurses, ANMs, ASHAs, CHOs, and FP Counsellors, stratified by district, cadre, and training cohort, to test whether competency is retained or declines with time since training. The provider competency-assessment sample will be estimated using Cochran's formula for a single proportion, assuming 95% confidence, 50% expected competency prevalence in the absence of prior estimates, and a 7% margin of error. Based on these assumptions, an indicative sample of approximately **280–300 trained providers** is proposed. The tool also should combine scenario-based vignettes with simulated client interaction, since counselling is a skill rather than recall alone, and should cover method-specific counselling, side-effect information, and eligibility screening. The agency will also

cross-tabulate provider competency scores against that facility's exit-interview ratings, to test whether measured competency predicts client-perceived quality rather than assume that it does.

5.3 Component 3: Client exit interviews

PFI is already conducting client exit interviews in facilities with functional FP counselling corners (FPCC), as part of concurrent monitoring. The agency will:

- Analyse the existing PFI exit-interview responses in depth, in coordination with PFI's monitoring team.
- Supplement this dataset with commissioned primary exit interviews at sampled facilities where FPCCs are functional. Approximately **300 client exit interviews** will be conducted across the 60 sampled CHCs and PHCs. The sample size will be estimated using Cochran's formula for a single proportion, assuming a 95% confidence level, 50% expected prevalence in the absence of prior estimates, and a 7% margin of error. The sample will be adjusted for clustering of clients within facilities using an indicative design effect of 1.3 and for approximately 10% non-response or incomplete interviews. This results in an estimated sample of approximately **280 clients, rounded to 300 for operational feasibility**. FP clients for exit interviews will be adjusted for facility type and client volume. Within facilities, **systematic or consecutive** sampling should be used to minimise selection bias. Tentatively, client exit interviews can be sampled based on the following table:

Facility type	Indicative interviews
Higher-volume CHCs	6–8 clients
Moderate-volume PHCs	4–5 clients
Low-volume PHCs	Minimum feasible number
Overall	~300 clients

- Present exit-interview findings as facility-user experience, not as a district-representative measure of demand or unmet need, since community-level data collection is outside the scope of this assignment.
- Where repeat observations are available from the concurrent monitoring system, examine change in counselling quality over time.

5.4 Component 4: Key informant interviews and document review

The agency will conduct key informant interviews (KIIs) with:

- DWG members and BCC members.
- District and Block officials.
- State-and-district level programme staff.

KII findings should be corroborated against DWG and BCC meeting minutes. Interviews with DWG members and district health officials will also provide insights into the expansion of Umeed activities to non-Umeed blocks, which reportedly occurred during implementation at the request of the district administration. The agency should propose a KII sampling and saturation approach in its technical

proposal, including the criteria it will use to judge that it has reached sufficient coverage of district and block perspectives. The sample should include at least one DWG member from each district and one BCC member from each sampled block. It should also include relevant district- and block-level health officials, as well as at least one Umeed programme staff member at both the state and district levels.

6. Data Sources

Component	Source	Role in Evaluation
Facility readiness	SARA-based survey	Before-after comparison against confirmed baseline
Quality of counselling (client-reported)	Exit interviews (existing PFI data plus agency-administered supplement)	Quality-of-counselling proxy for facility-reaching clients
Provider competency	Structured assessment	Cross-checked against agency administered exit-interview ratings
Convergence and coordination process (DWG and BCC)	Key informant interviews	Evidence for district- and block-level convergence
Coordination record	DWG and BCC minutes (PFI-provided, agency-reviewed)	Corroborates interview findings

7. Evaluation Design

The evaluation will use a **mixed-method design** combining a quantitative facility survey, a structured provider competency assessment, quantitative and qualitative exit-interview data, and qualitative key informant interviews, integrated through contribution analysis. The agency's technical proposal should set out, for each component, the specific instrument, administration mode, quality-assurance procedure, and analysis method it will use, and should explain how findings across components will be triangulated against the results chain in **Annex A** rather than analysed as four separate, unconnected workstreams.

8. Sampling Approach

The evaluation will use a **two-stage stratified sampling design**, to build an analytically credible sample that captures variation in duration of exposure, implementation conditions, facility type, and district context, while retaining the ability to compare sampled facilities with their own baseline where data are available.

8.1 Stage 1: selection of blocks

Blocks will be selected using a stratified criterion-based approach. The final sampling frame will be prepared from project implementation approach, in consultation with the PFI programme team. Within each district, selection will capture variation across three criteria:

- **Rollout cohort and duration of exposure:** an early entrant with the longest period of implementation, alongside a later entrant, to examine whether stronger results associate with longer exposure.

- **Implementation intensity and fidelity:** process indicators¹ that precede the outcomes being evaluated, timing and coverage of provider training, mentoring frequency, BCC functionality, FP-corner establishment, and completion of planned SBCC activities.
- **Geographic and access context:** variation in remoteness, population dispersion, facility accessibility, and other operational conditions, based on administrative or project data rather than field-team judgement.

*The evaluation will be conducted in **18 implementation blocks**: three each in Bahraich, Gonda, Sitapur, Unnao, and Barabanki; two in Balrampur; and one in Shravasti district. The agency should select blocks in consultation with the programme team, covering the variation in project exposure and criterion stated earlier. This approach of selection will preserve district representation and avoid choosing only high-performing or easily accessible blocks. **Jarwal block, within Bahraich, will be excluded from this sampling frame**, since it was covered separately under a stand-alone Jarwal pilot evaluation.*

8.2 Stage 2: selection of facilities within sampled blocks

Facility selection will be based on confirmed programme records rather than an assumed even mix. The programme records show 102 facilities with a functional FP Counselling Corner (FPCC) across the 50 implementation blocks, mostly at CHC/FRU and PHC level. FPCCs have not been established at Health and Wellness Centre (HWC)/Sub-Health Centre (SHC) level, so these facilities fall outside the FPCC-based sample and, where included at all, serve only broader SARA readiness benchmarking, not the counselling-quality strand.

Within each sampled block, the facility sample will draw primarily on facilities with a functional FPCC, applying two criteria:

- Confirmed FPCC functionality.
- Staffing adequacy i.e., at least two of three trained FP Counsellors consistently available at the facility, to ensure sampled corners can generate exit interviews and be linked to a specific provider's competency score.

A facility failing the staffing threshold will be replaced within the same block where a substitute is available. A smaller number of non-FPCC facilities per block will be added for broader SARA benchmarking, consistent with the wider facility mix covered at baseline. District hospitals are excluded from the core sample.

8.3 Sample size

Data collection strand	Indicative sample
Facilities (SARA-based readiness)	~36-40, across all sampled blocks (~All CHCs in sampled blocks and sampled PHCs where FPCC is functional). In Shravasti district, FPCC are not established at the PHC level and thus, will be excluded from the sample.

¹ Training of ASHA, ANM, Counsellor, CHO, Mobile van shows, Health Mela, Wall writing, Mega FDS, other innovations like playing Jingle through Garbage collection vans, Training of supervisory cadre of NRLM/ICDS

Trained providers (competency assessment)	~280-300, stratified by cadre
Client exit interviews (agency-commissioned, supplementing existing PFI data)	~300, per facility depending on the client load
Key Informants Interviews	~30, across all sampled blocks (7 DWG members, 14 BCC members, 9 Umeed project staff (State and Districts))

Provider assessments should be linked to sampled facilities, to support the cross-tabulation described in Section 5.2.

8.3. Inclusion and Exclusive Criteria for respondent selection

Sampling frames for facilities, providers, clients, and coordination body members will be built on the criteria below. The criteria serve two purposes. They ensure that respondents have had enough exposure to what the evaluation measures. They also ensure that the sample captures the groups in which family planning outcomes differ most. The agency may propose refinements at inception, with reasons, and PFI will confirm the final criteria.

Category	Inclusion Criteria	Exclusion Criteria
Health facilities	- Facilities covered by the baseline SARA assessment - Facilities with a confirmed functional FPCC - Facilities with at least two of three trained FP Counsellors consistently available	- District hospitals, from the core sample - Facilities where the FPCC became functional less than three months before fieldwork, since exposure is too short to assess - HWC and SHC level facilities from the counselling strand, retaining them only for broader SARA benchmarking
Healthcare providers	- Providers trained under Umeed who completed the full training (two rounds comprise of first training and refresher) package for their cadre, confirmed against project training records - Providers who completed training at least three months before fieldwork - Providers currently posted at a sampled facility and delivering family planning services in their current role	- Providers who attended an orientation or a single session rather than the full package. - Providers trained at least once in less than three months before fieldwork - Providers on long leave, under transfer orders, or not posted at the facility during fieldwork - Providers transferred into a sampled facility who were trained elsewhere, unless training records confirm the full Umeed package.
FP clients	- Currently married women who received family planning counselling or a family planning service at a sampled facility on the day of interview - Stratification by age, in two groups: under 25 years, and 25	- Clients who received neither counselling nor a family planning service during that visit from family planning counselling corner - Clients under 18 years, unless the ethics approval covers

	years and above and by parity, in three groups: zero parity, low parity meaning one or two living children, and higher parity meaning three or more. • A small purposive group of male clients and accompanying partners, where present, so that counselling on male methods and partner involvement can be assessed	minors and includes a consent and safeguarding protocol approved • Clients unable to give informed consent or unwilling to be interviewed in a private setting. • Repeat interviews with the same client within the fieldwork period.
DWG and BCC members	• Members in post for at least 6 months at the time of interview • Members who attended at least one recorded meeting in the preceding 12 months • At least one member from a department other than health in each sampled district, drawn from ICDS, Education, Panchayati Raj, NRLM or the district administration	• Members nominated but never recorded in attendance • Members in post for less than six months

9. Timeline and Deliverables

The evaluation is expected to be completed within **four months of contract signing**, including approximately three to four weeks of primary data collection. PFI intends to onboard the research agency no later than the **first week of October 2026**. The proposed evaluation timeline has therefore been developed on the assumption that the evaluation will commence from this date.

#	Deliverable	Key contents / outputs expected	Indicative timeline
1	Inception Report and Final Evaluation Protocol	Refined evaluation methodology and contribution analysis framework; evaluation matrix linking questions, indicators, data sources and methods; final block, facility and respondent sampling strategy; confirmed sampling frames; fieldwork plan; QA plan; ethics and safeguarding protocol; detailed work plan.	By 3rd week of Oct 2026
2	Final Data Collection Tools and Field Protocols	Final SARA-based facility tool; provider competency assessment including vignettes/simulated interaction; client exit interview tool; KII guides; informed-consent forms; Hindi translations; enumerator manuals/SOPs; digital data collection forms, where applicable. All tools to be designed so core measures can be repeated at endline.	By 3rd week of Oct 2026
3	Ethics Clearance and Pilot Report	IRB/ethics approval; documentation of pilot testing; pilot findings; revisions made to tools and protocols;	By mid/end of Nov 2026

		final approved instruments ready for field deployment.	
4	Fieldwork Completion and Quality Assurance Report	Completion of approximately 36-40 facility assessments, 280–300 provider assessments, 300 client exit interviews and approximately 30 KIIs*; fieldwork tracking; response rates; deviations from planned sample; replacements; supervision and data-quality checks; documentation of field challenges and corrective actions.	By 3rd week of Dec 2026
5	Cleaned and Documented Evaluation Database	Cleaned quantitative datasets for all survey components; variable labels/codebooks/data dictionaries; anonymised analysis-ready files; facility–provider linkage file where required; cleaned existing PFI exit-interview dataset used in analysis; documentation of data cleaning and missing-data treatment.	By 1st week of Jan 2027
6	Qualitative Dataset and Analysis	Complete KII transcripts in Hindi and English; anonymised transcripts, Audio Recordings; qualitative coding framework/codebook; coded dataset or coding outputs; document-review matrix covering DWG/BCC minutes and other programme records.	By 1st week of Jan 2027
7	Statistical and Integrated Analysis Outputs	Quantitative analysis plan and statistical outputs; paired baseline–evaluation SARA analysis; provider competency analysis by cadre and time since training; exit-interview analysis; competency–client experience cross-tabulation; method-mix analysis; analysis of existing monitoring data; tables and figures supporting major findings.	By 1st week of Jan 2027
8	Contribution Analysis and Triangulation Matrix	Evidence matrix mapping findings against the Umeed results chain; assessment of the central contribution proposition; triangulation across facility, provider, client, and C&C evidence; examination of alternative explanations; documentation of intended and unintended outcomes.	By 1st week of Jan 2027
9	Draft Evaluation Report and Validation Presentation	Full draft report covering methodology, findings by evaluation question, contribution analysis, wider/unintended effects, limitations, conclusions and recommendations; executive summary; presentation of findings to PFI; documentation of key validation feedback.	By mid-Jan 2027
10	Final Evaluation documents	Final evaluation report incorporating PFI feedback; executive summary; final presentation deck; final tables/figures and annexes; final cleaned datasets,	By 3rd week of Jan 2027

		codebooks, tools, transcripts, coding framework and analysis files; clear documentation to enable replication of core measures at the planned endline.	
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*KII: DWG member, BCC member, District and Block Health Officials, State and District Programme team.

All deliverables will be subject to PFI's review and written approval. The agency will incorporate PFI's comments within mutually agreed turnaround times before the corresponding deliverable is considered final and the associated payment tranche is released. Also the agency is expected to adhere the timelines and the whole assignment needs to be completed by **end-January 2027**. Kindly note that the proposed timelines are non-negotiable.

10. Roles and Responsibilities

10.1 PFI will provide

- Baseline SARA facility readiness data, for the paired before-after comparison.
- Project related information required to prepare the block and facility sampling frame.
- Introductions and administrative facilitation with CMOs, DWGs, and BCCs in the seven districts.
- Obtain the permission to conduct evaluation from district officials.
- Operational support in arranging the field interviews at facility level.
- Access to the existing client exit-interview dataset collected through concurrent monitoring.
- Copies of DWG and BCC MoMs for review.
- Technical review and written feedback on instruments, the inception report, and draft deliverables, within agreed turnaround times.

10.2 The agency will provide

- A technical evaluation team meeting.
- Adaptation, translation, and piloting of all data collection instruments.
- All ethics review and clearance required for human-subject data collection, including informed consent procedures for providers, clients, and key informants.
- Primary data collection across all four components, including recruitment, training, and supervision of field staff.
- Data management, cleaning, and quality assurance.
- Quantitative and qualitative analysis, including the contribution analysis narrative.
- Transcripts of in-depth interviews both in English and Hindi
- A coding framework for qualitative data analysis and data analysis plan for quantitative aspect of the evaluation.
- The inception report, draft report, final report, and presentation materials specified in **Section 9**.

11. Ethical and Data Protection Requirements

- The agency will obtain institutional ethics review (IRB) clearance before fieldwork begins and should factor the time required for this clearance into its proposed work plan.
- The agency will obtain written informed consent from all providers, clients, and key informants, in a language and format they understand, and will explain that participation is voluntary and non-participation carries no consequence for service access or employment.
- The agency will protect client confidentiality throughout exit interviews, including private interview settings that do not compromise a client's privacy at the facility.
- The agency will store all personally identifiable data securely, restrict access to the named research team, and anonymised data before analysis and reporting, retaining a separate, secured facility-provider linkage file only where required for the competency cross-tabulation in Section 5.2.

12. Proposal Submission Requirements

Interested agencies should submit the following as separate technical and financial documents:

12.1 Technical proposal

- Understanding of the assignment and the evaluation questions in Section 3.
- Proposed methodology for each component in Section 5, including any refinements to the indicative design.
- Proposed approach to contribution analysis and triangulation against the results chain in Annex A.
- Work plan and timeline against the milestones in Section 9.
- Team composition and CVs, against the requirements in Section 10.2.
- Quality assurance and ethics plan.

12.2 Financial proposal

- Itemised budget against the cost categories, in Indian Rupees, excluding GST, with GST shown separately.
- Cost breakdown by deliverable/milestone, aligned to the payment schedule the agency proposes.

13. General Terms and Conditions

- PFI requires the agency to uphold and demonstrate best practices in Safeguarding and Child protection. Agency will confirm that it will comply with PFI's Safeguarding and Child protection policy requirements.
- The evaluations will follow the UNEG Norms and Standards for evaluation (<http://www.uneval.org/document/detail/1914>) as well as the ethical guidelines (<http://www.uneval.org/document/detail/2866>) and UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation (<http://www.uneval.org/document/detail/980>).
- The Agency will coordinate with PFI's authorised personnel for this project for all related activities under this assignment.

- iv. The end-deliverables should be approved by authorised personnel of PFI for release of payments.
- v. All work/ reports developed/prepared under this assignment are the intellectual property of the office of PFI and cannot be used, published, copied, or otherwise disseminated without written approval from PFI. The agency would never share and use the data for any other purpose.

14. Eligibility Criteria

- i. The agency should have experience in conducting impact evaluation of public-health interventions, including but not limited to family planning and sexual and reproductive health.
- ii. The agency / proposed team should have prior experience conducting surveys and qualitative research in the areas of family planning and sexual and reproductive health.
- iii. The agency should have experience in gathering and systematising both quantitative and qualitative data.
- iv. The proposed team should be gender-balanced and culturally diverse.

The contract will be awarded to the successful bidder following completion of all evaluation including negotiation, if necessary. The successful bidder will have to sign a contract with the PFI to undertake the assignment.

15. Requirement to Apply:

Detailed technical and financial proposal separately, along with company profile and team biodata, should be submitted by **30/09/2026** to louis.augustine@populationfoundation.in.

In case you have any queries before submitting the proposal, you may write to Ms. Shilpa Nair at shilpa.nair@populationfoundation.in before the last date.

Annexes

Annex A: Objective-wise results chain (activities, outputs, outcomes, and key assumptions for each of Umeed's three objectives), provided as a supporting document to this RFP.

Objective 1: Expanding FP service availability

Level	Result	Mechanism	Key assumption
Activities	- Facility mapping - Training nurses/ANMs/ASHAs - Establishing FP corners and equipping HWCs with SBCC materials. - Periodic facility mentoring visits	- Training builds competency - Equipped corners remove a physical and logistical barrier to same-day access	- Trainers reach the intended staff - Facilities have the physical space and staff time to operate a dedicated FP area
Outputs	Trained providers retain and apply skills	Training translates into changed counselling skills and	Staff turnover among trained ANMs/ASHAs is low enough that trained capacity is

	- FP corners operational - Basket of for family planning methods available during VHSND - PPFP/PPIUCD offered at delivery points	knowledge only if supervision and mentoring reinforce it	retained at the facility over the project period
Immediate outcome	Clients experience shorter waiting times, wider method choice, and functioning stock at the point of care	Availability and competency jointly remove the two most common reasons for discontinuation and non-uptake: stock-outs and poor counselling	- Contraceptive supply from state/central government (FP-LMIS) continues at adequate volume - The periodic reviews address distribution, not production, of supplies
Intermediate outcome	Increased initiation and continuation of Family Planning methods	Removing supply and competency barriers converts latent demand into uptake, conditional on the client actually wanting to space or limit births	- The unmet need identified in NFHS-5 (17.9%-27.6% across the seven districts) reflects genuine demand rather than sustained preference for larger families - Similarly, the latest state-level NFHS-6 (2023–24) data showed a decline in mCPR, from 44.5% to 33.2%.
Contribution to impact	Movement toward higher mCPR and lower unmet need	-	-

Objective 2: Demand generation through FLWs and SBCC

Level	Result	Mechanism	Key assumption
Activities	- Training frontline workers on counselling, myth-busting, and referral - SBCC package development and dissemination through DWG and BCC meetings - Gender and patriarchy content integrated into FLW training - Recognition mechanism for FP champions	Trained, motivated frontline workers are more likely to raise FP proactively during home visits and other settings	ASHAs and ANMs have the time, within existing workload, to add FP counselling and home visits without displacing other duties
Outputs	- FLWs deliver counselling that providing information and knowledge regarding Side effects - community exposure to SBCC content	Messaging that addresses specific, named barriers (side effects, myths, patriarchal norms) is more persuasive than generic awareness messaging	- Households have some exposure to WhatsApp or in-person FLW contact - Reach is not undermined by low connectivity or FLW absenteeism

Immediate outcome	- Increased accurate knowledge of FLWs and FP counsellors - Reduced fear of side effects among FP clients - Some shift in normative acceptance of spacing	Knowledge change precedes and enables behaviour change, but does not guarantee it	Gatekeepers (husbands, mothers-in-law) are reached or at least not actively working against the message.
Intermediate outcome	- Increased FP counselling initiation by FLW and FP counsellor at facility level - Reduced discontinuation attributable to misinformation	Demand-side change only converts to uptake if supply-side pathway has also succeeded	- Supply-side availability improves on a similar timeline - A demand surge against an unprepared facility could suppress rather than support uptake
Contribution to impact	Movement toward higher mCPR and lower unmet need, with improved informed choice rather than uptake driven by targets	-	-

Objective 3: District Working Group (DWG) and Block Coordination Committee (BCC) and enabling environment

Level	Result	Mechanism	Key assumption
Activities	- DWG and BCC constitution - District/block coordination meetings - HMIS/FP-LMIS monitoring and periodic review	A standing, DM/CMO-chaired multi-sectoral body creates a recurring forum where supply, training, and communication gaps are raised and assigned to the department with authority to act	The DM/CMO chairs meetings with enough regularity and seniority to make DWG decisions binding across departments
Outputs	- DWG meetings held on schedule - Supply gaps identified and referred	Regular convening substitutes for the absence of a single agency with authority over training, supply, and communication simultaneously	Departments represented on the DWG (Health, WCD, Education, PRI etc.) send staff with decision authority, not just attendance
Immediate outcome	Faster resolution of stock-outs and local level challenges staffing gaps	Coordination reduces the time between a gap being identified and a government department acting on it	Government resources (PIP funds, staff deployment) are not constrained by state-level aspects e.g., hiring freeze or fiscal aspects, during the project period

Intermediate outcome	Government ownership of the model sufficient to sustain FP corners, after PFI's direct involvement ends, and to replicate the model in additional blocks/districts	Demonstrated results plus institutionalised process are what make continuation possible without continued NGO funding	Administrative leadership in these districts remains stable enough over the project horizon for best practices to persist
Contribution to impact	Sustainability of the best practices beyond the project period.	-	-

- Annex B: [Family planning and comprehensive abortion care toolkit for the primary health care workforce.](#)

Interested agencies may obtain further information or get clarification about RFP from Population Foundation of India's State office by writing to louis.augustine@populationfoundation.in and with copy to shilpa.nair@populationfoundation.in

It shall be Bidder's responsibility to ensure that your proposal reaches us on or before the given timelines. Quotations received after the submission deadline for whatever the reason maybe, may not be considered for evaluation. Any delay in bidder's response shall not be used as a reason for extending the deadline for submission, unless PFI determines that such an extension is necessary and communicates a new deadline to the proposers.

General Information about RFQ Timeline and

S. No	Description	Information
1	RFP Issued by	Population Foundation of India, Lucknow
2	Project	Evaluation of the Umeed Family Planning System-Strengthening scale-up Project (Seven districts-Uttar Pradesh)
3	Response to RFP to be sent to	louis.augustine@populationfoundation.in
4	Date of RFP	September 21, 2026
5	Date of sending and responding queries	September 26, 2026
6	Last date for submitting the final proposals	September 30, 2026 EOD
7	Final date of Delivery	Four months from the date of signing the contract

In the quotations received from the shortlisted agencies, the designated committee at Population Foundation of India, Lucknow shall review all quotations for printing and will decide accordingly.