PATHWAYS TO SCALE AND SUSTAINABILITY

Increasing Access and Uptake of Family Planning Services by Strengthening Urban Primary Health Centres & Relieving Client Load at Higher Level Facilities

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This first edition of TCIHC's PAthways to Scale and Sustainability focuses on the TCI's guiding principle of 'leveraging existing systems'. Instead of working outside of existing systems, which can lead to duplication, waste and missed opportunities, TCI works within existing government- and community-led systems to harmonize strategies, plans, funding and technical assistance and, therefore, furthers longer term sustainability. Consequently, implementation of proven interventions becomes the new norm in all sub-systems of the health system, including policies and procedures, human resources, financial and managerial practices.

Understanding the Existing Health Service Delivery Framework

With the continued population growth in urban areas especially in poor urban areas, the Government of India (GoI) launched the National Urban Health Mission (NUHM) in 2013 as a sub mission to the National Health Mission. Around this time, the urban poor population mainly depended on district hospitals and 'C' or 'D' type of centres for health services. These 100- to 500- bed hospitals provide basic specialty services, newborn care, psychiatric services, general medicine, including family planning services, rehabilitation services, accident and trauma services, dialysis services and anti-retroviral therapy, etc. As a result, the district hospitals are extremely overburdened with limited medical providers caring for 500-600 patients per speciality per day and delivering on average 700-800 babies per month.

This untenable situation made the government redesign its strategy and introduce urban primary health centres (UPHCs) under NUHM. Under this revised strategy, UPHCs were to provide all kinds of primary health services, including family planning, to 50,000 population in urban areas. However, they focused mainly on immunization and polio drives. Family planning services existed but was limited to short-acting methods, primarily condoms and oral contraceptive pills (OCP). Medical Officers and staff nurses at UPHCs were out of practice in providing long-acting reversible contraceptives (LARCs), such as intrauterine contraceptive device (IUCD), which UPHCs could provide but not immediately post-delivery. IUCD kits had been lying unused at UPHCs. Besides, the government and facility staff did not fully believe that UPHCs could provide LARCs. Due to these challenges with inadequate equipment, lack of trained providers and negative mindsets, UPHCs were not able to provide LARCs in practice.

In 2017, The Challenge Initiative for Healthy Cities (TCIHC) introduced its demand-driven, city-led model in 20 cities of Uttar Pradesh (UP). TCIHC's goal is to facilitate the rapid and sustainable scale-up of high impact approaches (HIAs). These HIAs were adapted from experience of the Urban Health Initiative (UHI), Expanded Access and Quality (EAQ) and Health of the Urban Poor (HUP) projects. From these previous project experiences, TCIHC learned from district officials that increasing demand from the community for family planning services further burdened the district hospitals as they could barely manage their heavy outpatient case load.

As a result, TCIHC worked with city governments to activate UPHCs as a facility of choice for family planning services, adapting the fixed day static (FDS)/family planning day (FPD)/Antral diwas HIA for UPHCs so that UPHCs could provide quality family planning services, including long-acting spacing methods, and communities could access them closer to their doorstep.

Data for FY 2017-18 from Health Management Information System (HMIS) illustrates this situation clearly (refer figure 1). The collective annual family planning (FP) client volume of the 392 urban primary health centres

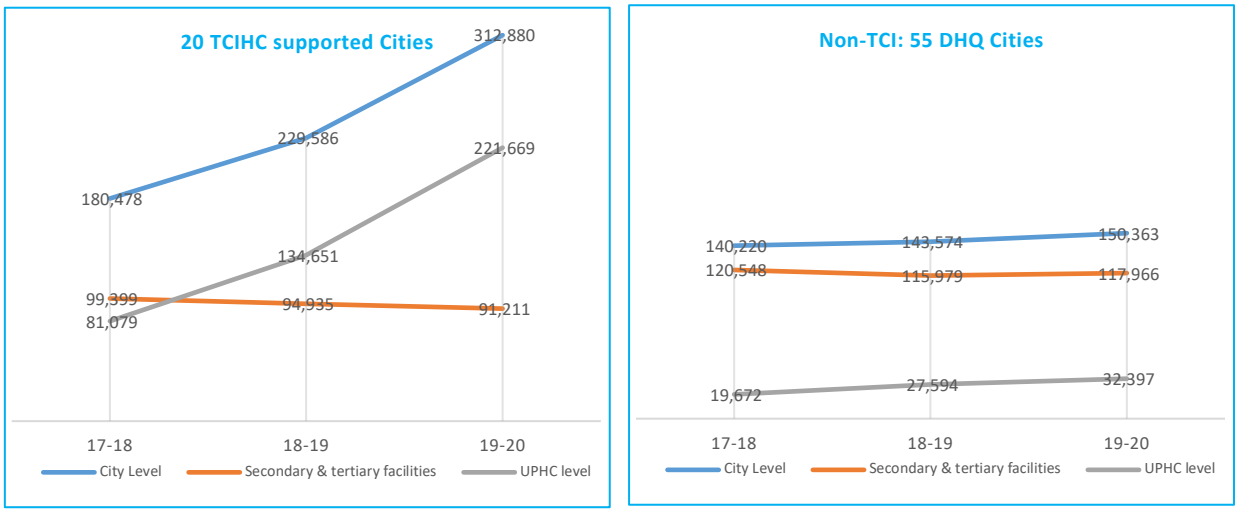

Figure 1: Comparison between TCIHC and non TCIHC cities on Annual Changes in FP client volume (source – HMIS, 2017, 2018, 2019).

(UPHCs) of 20 TCIHC-supported cities was around 81,000 clients (prior to TCIHC support) as compared to 19,000 clients in 55 non-TCIHC cities.

At the same time, the tier-3 facilities (secondary and tertiary) annual FP client volume was almost equivalent to that of the UPHC at 99,000 clients as compared to 120,000 client volume in 55 non-TCIHC cities.

Situation on Method Mix pre-TCIHC

Table 1 with data from HMIS on family planning choices available to the population also brings out a similar picture, where except OCPs and condoms, all the remaining choices were mostly available at secondary and tertiary facility.

Thus, at the time of TCIHC's initiation, there was a clear gap in both demand and supply. Thus, creating congestion at the highest level of service delivery for family planning services, impeding access to family planning services, especially to those who reside in poor urban slums.

Method	Client Volume
Centchroman	2,023
Condom	24,370
EC	2,700
IC	1,871
IUCD	59,382
OCP	25,185
PPIUCD	39,757
NSV	1,060
FST	24,130

Table 1: Method mix in 20 TCIHC cities; HMIS 17-18 (client volume based adjusted CYP methodology)

Applying TCIHC's Business Unusual Approach: Activating Existing Service Delivery Model

With this background in mind, TCIHC started supporting the city government to activate the exiting urban health service delivery model by strengthening capacity of existing demand, supply mechanisms and an enabling environment through technical coaching on HIAs.

On the demand side, TCIHC coached urban ASHAs following a "Lead, Assist and Observe" coaching model to ensure that ASHAs: i). understood the importance of completing and updating the ASHA diary or Urban Health Index Register (UHIR); ii). could identify non-users of family planning; iii). Learned how to prioritize clients based on data and what it revealed about their needs; and iv). Could effectively counsel and refer clients to assured service delivery points.

On the supply side, TCIHC supported the city to dedicate a day for family planning at all UPHCs via its FDS/FPD/Antral diwas HIA. This approach sparked service delivery points to focus on challenges inherent in the system in providing high-quality family planning services to clients. Thus, the system ensured trained providers and staff, availability of supplies and equipment, etc.

TCIHC's intervention in the 20 cities of Uttar Pradesh not only increased the demand for family planning services with informed choice but also established a mechanism for satisfying that demand at the level of the health system, closest to the community. It reduced client mobilization to secondary and tertiary facilities for those who did not require surgically related family planning services, like sterilization.

On the enabling environment side, TCIHC ensured that local governments could effectively budget for FDS and other HIAs in the Program Implementation Plan (PIP) and use data to inform decisions about which HIAs to budget for and implement.

Business Unusual Leads to Unrealized Gains

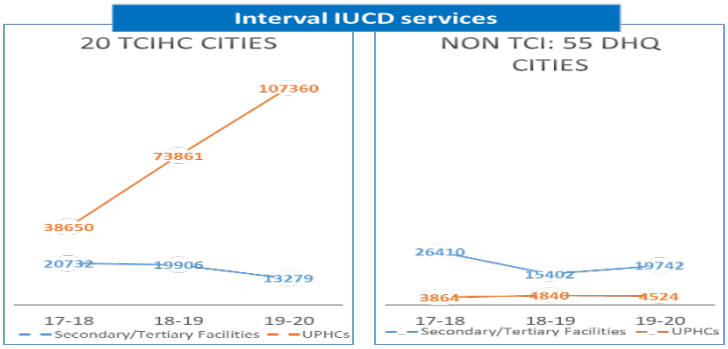

Figure 2: Comparison between TCIHC and non TCIHC cities with regards to IUCD services (source – HMIS).

These efforts not only led to increases in annual client volume and improvements in method mix but also the decongestion of district level facilities. For the 20 TCIHC supported cities, interval IUCD uptake at UPHCs increased by more than 230% from approximately 33,000 in 2017-18 to over 100,000 in 2019-2020, according to HIMIS (see Figure 2). At the same time, the uptake of interval IUCD declined 54% from 20,000 to 13,000 at secondary facilities. In the 55 non-TCIHC supported cities UPHCs, the IUCD uptake moved by only 700 points from 3864 to 4524 clients by 2019-20; and at the secondary facility, it declined by 37% (26,000 in 2017-18 to 19,000 clients in 2019-20). This was a demonstration to the government as to how the system could effectively work in the three-tiered manner as envisaged by the GOI.

"Availability of FP services at UPHC level has not only increased the overall demand of family planning services but now clients prefer to visit UPHCs rather than Urban Community Health Centres (UCHC) for services like interval IUCD and ANTRA, reason behind this is easy availability of quality FP services in their vicinity."

- Dr. Rashmi, MS, UCHC, Indira Nagar, Lucknow, UP

"I am happy that I can avail family planning services of my choice from nearby Zakir colony UPHC. Because a few months back when I visited the district hospital for the same, I had to return without availing services due to high client load. Even the district hospital is quite far from my place. Now whenever I meet any woman in my area interested in family planning, I tell her about our nearby facility."

- Zahida Parveen 24-year-old mother of three, Moradabad UP

Impact on Short-Term Methods

Similar trends to IUCD are seen for condoms, OCPs and centchromans in the 20 TCIHC supported cities where uptake has more than doubled at UPHCs and has also increased but not significantly at secondary facility with the exception of centchroman, as its uptake is visibly high at secondary facilities as well. In non-TCIHC supported cities, centrchroman increased popularity and acceptability added to the outpatient department (OPD) load and

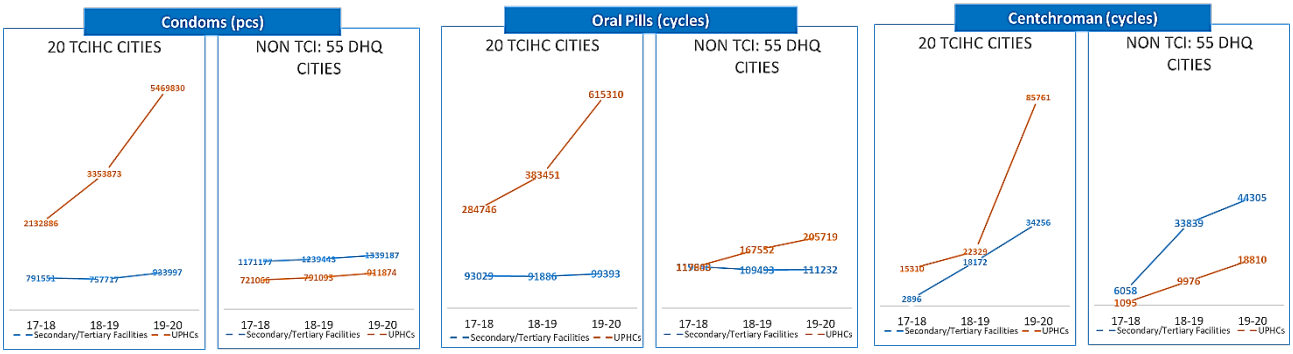

Figure 3: Comparison between TCIHC and non TCIHC cities with regards to Condoms, OCPs and Centchroman (source – HMIS)

burden on the district facility and added to congestion at this point, clearly signalling that UPHCs of these cities are not relieving the client load burden on high order facilities (see Figure 3).

Introduction of Injectable Contraceptive at UPHC Level

With medical officers and staff nurses being trained on Antara, its introduction into the method mix took off. There is a clear jump (see Figure 4) in uptake of injectable contraceptive at secondary and tertiary facilities at 284% (2197 in 2017-18 to 8450 in 2019-20). When Antara became available at UPHCs, its uptake increased exponentially from 57 doses in 2017-18 to 30,566 in 2019-20. Similarly, in 55 non-TCIHC supported cities, the uptake of injectable improved from 17 to 3000 at UPHCs and from 5800 in secondary and tertiary facilities to 7000. Interestingly, this increase in second dose is again exponential at UPHCs as compared to 55 non-TCIHC supported cities.

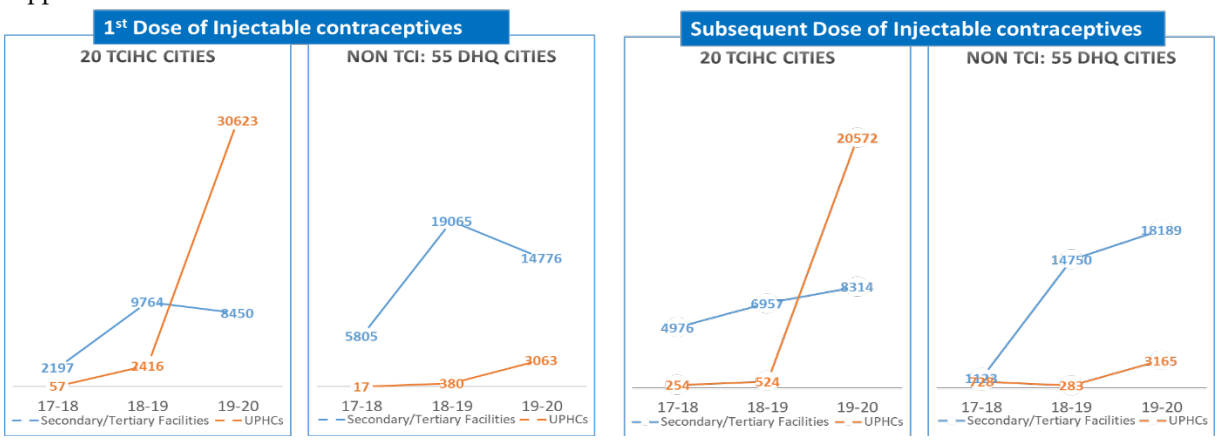

Figure 4: Comparison between TCIHC and non TCIHC cities with regards to injectable contraceptive (source – HMIS)

All of these efforts demonstrate how strengthening UPHCs for family planning service delivery not only ensures doorstep services to the poor urban community, but also relieves the client load burden from higher order facilities where family planning clients were going in the absence of UPHCs not properly equipped for family planning service provision.

These points also establish that when demand is bifurcated at various supply delivery points it increases optimal utilization of resources. The community opts for the services closest to their doorstep, which saves time and effort on their part and saves resources and time of higher order facilities and decongests them and allows them to focus on complex higher order services for which they were created. Moreover, distribution of demand allows all supply delivery points to give quality services as they are not overburdened. Moreover, service providers are able to take the time they need for quality counselling, which leads to improved client and provider satisfaction.

"I used to refer clients to district hospital for all kinds of services, mostly for delivery, female sterilization, Copper T, Antara. But UPHCs of my area started providing many services. Due to which, I refer women to UPHCs for family planning services as well. The doctors and staff nurse at the UPHC counsel and provide suitable advice on family planning. Women who thought they wanted female sterilization but were unsure are now taking long-term spacing methods from these UPHCs. Most women choose IUCD. Before few choose Antara because we had to take them to the district hospital but now, they get this at UPHC. As a result, my time and client's time both are saved. I had to spend more money to travel to district hospital. Due to UPHCs providing family planning services, I along with my area are both benefitting."

- Indra Devi, ASHA at Kaushalaya Nagar UPHC, Firozabad

Case of Lucknow

In Lucknow, the family planning client volume is either decreasing or stagnant at secondary & tertiary facilities. However, the opposite is the case at the UPHC level, where there is a significant increase due to the expanded availability of family planning methods at the UPHC (see Figure 5).

In Lucknow, the method mix increased due to informed choice at UPHCs and overall increase in client volume shows reduced dependency on sterilization services (see Figure 6). Also, services only offered at secondary facilities, such as PPIUCD and female sterilization, remained either stagnant or decreased.

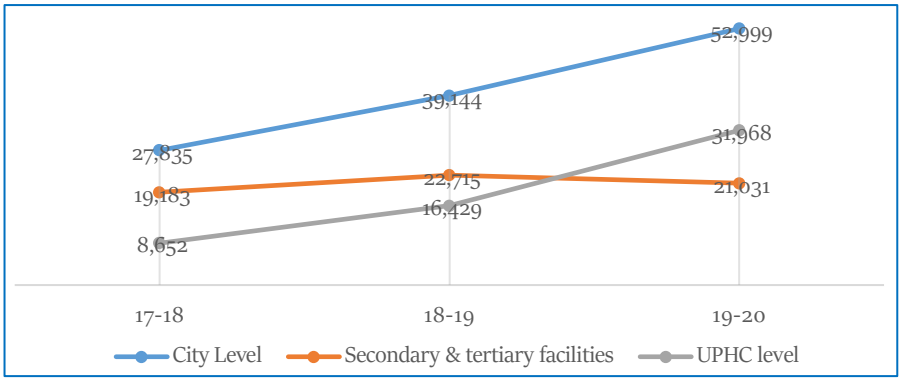

Figure 5: Lucknow: Annual changes in FP client volume (source-HMIS)

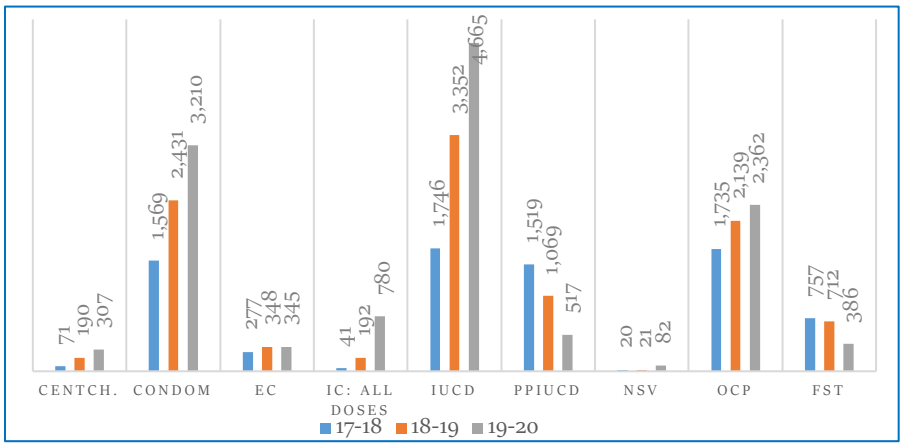

Figure 6: Lucknow: Method wise FP client volume (source-HMIS, CYP adjusted Methodology)

Interview with Dr Anup, ACMO, Lucknow on the significance of these changes.

1. In 2017-18, Lucknow's service delivery points were limited to 8 CHCs and 1medical college. Now, it has expanded to 52 UPHCs. What is the result of this change?
   - *There is a rise in service uptake of clients because services have reached near their door and their waiting time has also reduced.*
2. How has this impacted community demand for family planning?
   - *Women in slums go to work daily and it's hard for them to go to the hospital and wait in long lines for FP methods. Because if they skip one day of work, they are not able to feed their family a meal.*
3. *Has this reduced client load for primary FP services at secondary and tertiary facilities?*
   - *If we see the data from HMIS it shows growth in all the facilities and you will also realise that growth in primary facilities is high for family planning and client load for primary family planning services like condom, pill, antara, IUCD has reduced at secondary or tertiary level facilities.*
4. *Has this resulted in fulfilling client demand for FP at doorstep?*
   - *Definitely yes. Now, it's easy for ASHAs and ANMs to mobilize clients to facility [UPHC] for family planning methods, like IUCD, Antara, etc. Now, clients have less travel time as well as waiting time.*
5. Do you think increased family planning service uptake at UPHC has increased overall access of services in the city?
   - *With increases in uptake of family planning services at the UPHCs, you not only see increases in service uptake in urban areas, but also urban service utilization; it has a big share in comparison to that of rural.*
6. Do you see any additional benefits from increased service delivery points for family planning?
   - *Yes, with increases in FP uptake, you see decreases in unwanted child, unwanted abortions, and with spacing methods, we may be able to slow down the speed of population growth in our country.*

Case of Moradabad

The story is similar for Moradabad where family planning client volume is either decreasing or stagnant at secondary & tertiary facilities. From this city, Dr G.S. Mortalia, ACMO and Nodal for FP shared, *"that the government introduced injectable contraceptive (Antara) to the basket of choice, and for urban, it was available only at the district women hospital (DWH). Through the efforts of TCIHC, Antara was rolled out across all UPHCs, which made it possible for clients to avail injectable contraceptive at their nearest UPHC. This also made it easy for ASHAs to follow-up these clients. The result of these efforts is such that those who took first dose from DWH could take the subsequent dose at their nearest UPHC. As a result, waiting time for other clients has reduced at DWH."*

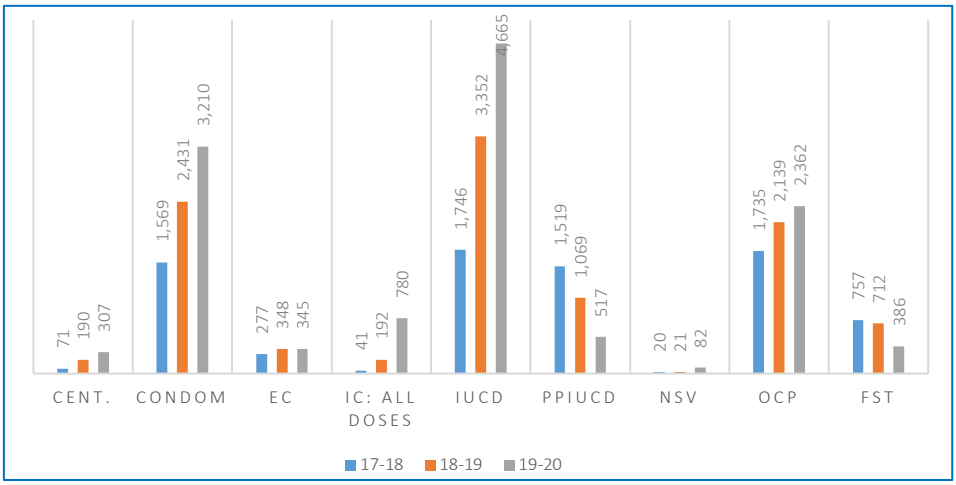

Figure 7: Moradabad: Method wise FP client volume (source – HMIS, client volume: CYP adjusted methodology)

Case of Firozabad

Like other cities, the method mix (see Figure 8) is increasing in Firozabad due to informed choice at UPHCs, which has resulted in a reduction on sterilization services because they are no longer the primary option after condoms and pills. In addition, there is an overall increase in client volume. However, services, like PPIUCD, that can only be offered in secondary and tertiary facilities continue to show an increase in uptake (see Figure 9).

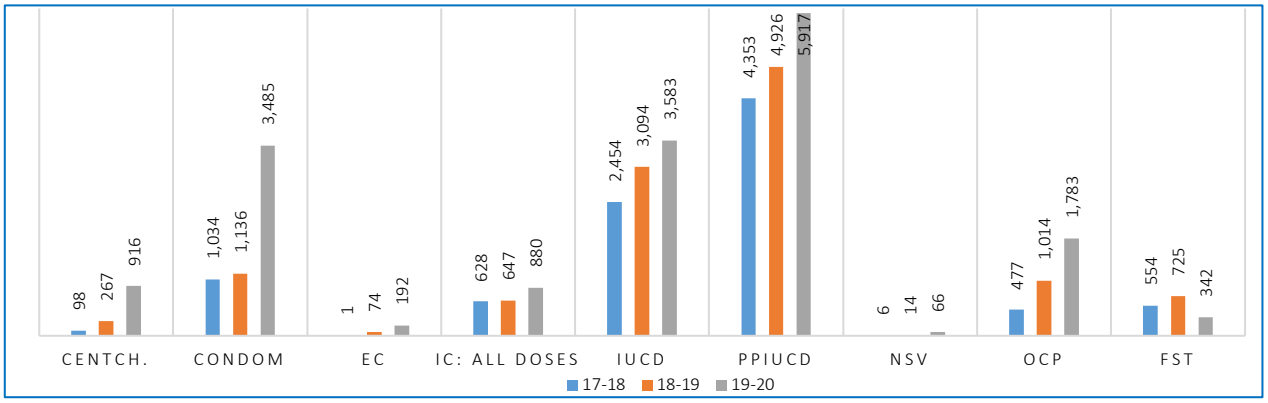

Figure 8: Firozabad Method wise FP client volume (source – HMIS).

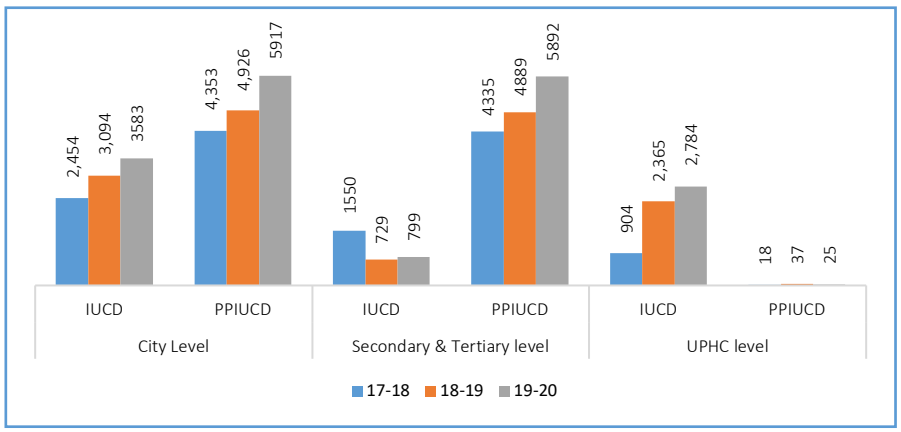

Figure 9: Firozabad IUCD and PPIUCD uptake (source – HMIS).

The Significance of These Changes

By expanding method mix and its availability at UPHCs (specifically IUCD and Antara), women and men have more options which reduces the dependency of family planning services on sterilization and leads to an increase in annual total client volume as observed in TCIHC supported cities compared to non-TCIHC supported cities. Second. the decongestion of services enhances the capacity of service delivery points and boosts the confidence and skills of providers to provide for quality services.

Equipping UPHCs for quality family planning service delivery makes services available to the community at their doorstep, which enables the urban primary health care structure to operate per the vision of GoI. This step enables the three-tiered structure and segregates demand to the most appropriate service delivery point where demand can be satisfied. This step has decongested higher order facilities and UPHCs have emerged as promising service delivery points where quality services are provided, and new initiatives can be layered on.