

implementation story:



Fixed-Day Static Approach: Informed Choice and Family Planning for Urban Poor in India



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AUTHORS

Deepti Mathur, Mukesh Sharma,
Vivek Sharma

CONTACT

deepti@psi.org.in

ORGANIZATION

Population Services International

PARTNERS

National Health Mission,
Governments of Uttar Pradesh,
Madhya Pradesh and Odisha
Urban Primary Health Centres



Background and Context

The urban poor living in India are among the most vulnerable people worldwide, yet they have limited access to voluntary family planning (FP). According to the 2011 Census of India, more than a third (377 million) of India's 1.2 billion people live in urban areas, representing an increase of 100 million people since 2001 (Census, 2014). Urbanization is expected to continue, with approximately 40 percent (550 million) of the population projected to live in urban areas by 2026 (UN, 2018).

Family Planning options in India heavily skew toward female sterilization and women have relatively few options for birth spacing, especially among younger women (ages 15 to 29), including first-time parents. Condoms and oral contraceptive pills are relatively widely available, but longer-acting reversible contraceptives (LARCs)—such as intrauterine devices (IUDs) or injectable contraceptives—are not. LARCs provide critical options for women who do not want to use a short-term or permanent method of FP, but still want to be able to space their births.

In India, LARCs have remained out of the basket of choice of FP at urban primary health centers (UPHCs), as the focus on female sterilization limited the demand and access to spacing methods of FP. Additionally, UPHCs though being closest to urban poor populations had not previously been considered a delivery point for LARCs.

In 2013 India launched the National Urban Health Mission and a new national urban health service delivery model to provide essential primary health care to the urban poor through Urban Health and

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

Mrs. Sana Balaissa, 37, mother of five children and program participant

Nutrition Days (UHND), outreach camps (ORC); UPHCs; and Community Health Centres (CHC) (one for every 2,000, 50,000 and 250,000 people, respectively) (NUHM, Framework for Implementation, 2013).

The new National Urban Health Mission prioritized the hiring and training of accredited social health activists/ASHAs (also known as community health workers) according to guidelines from the government of India (NUHM, 2013). Like other urban health platforms, UPHC staff focused on health priorities such as immunization and polio drives, but not FP. Altogether, UPHCs were poorly positioned to introduce LARCs.

THE HIGH IMPACT PRACTICE

To scale up access and availability of quality FP for the urban poor, Population Services International's The Challenge Initiative for Healthy Cities (PSI-TCIHC) adapted a fixed-day services approach (NHM, 2008), which was demonstrated by the Urban Health Initiative. The approach builds on the fixed day static approach of NHM FDS approach for FP in rural areas and [Family Planning and Immunization Integration](#) High Impact Practice.

The Urban Health Initiative (UHI, 2011) had successfully expanded the provision of permanent and other FP methods for the urban poor through fixed-day service provision in public and private district-level facilities in 11 cities in the state of Uttar Pradesh. Their experience revealed that when FP fixed-day services are regularly organized in a facility, they also tend to enhance the quality and use of routine FP care. PSI-TCIHC sought to build on this successful model to include a broader mix of birth-spacing methods at UPHCs, creating the Fixed-Day Static (FDS) approach.

The FDS approach increases access and availability of high-quality FP, including LARCs, for women of reproductive age (ages 15 to 49), with a specific focus on the needs of young women (ages 15 to 29) residing in urban slums who have typically been overlooked by both UPHCs and other providers. The approach ensures the availability of human resources and supplies for a wide variety of FP methods, including IUD kits, injectables, condoms, oral contraceptive pills, and weekly pills, at UPHCs during widely publicized fixed days and times. ASHAs play a central role in identifying, counseling, and directing women to UPHCs when the availability of FP methods is assured.

FDS is a collaborative effort to support the government in providing health care through the medical-officer-in-charge, staff nurse, and auxiliary nurse midwives posted at UPHCs.

Implementation Story

"Family planning was the last thing on anyone's mind at our urban primary health centers. However, after observing and participating in the special FDS drive in 2018 facilitated . . . by PSI-TCIHC, I saw people coming in for family planning services. From that day onward, we regularly conducted FDS. And from August 2018 onward, we are conducting FDS without the support of PSI-TCIHC team."—Urban health coordinator, Saharanpur

In September 2017, in partnership with select cities in Uttar Pradesh, Madhya Pradesh, and Odisha, with high urban and urban poor populations—PSI-TCIHC¹ sought to scale up access and availability of high-quality FP, expanding choices for urban and poor women.

The introduction of FDS involved not only establishing systems to ensure the availability of high-quality care, but also surmounting initial resistance among city-level decision makers who felt such care would not be feasible at UPHCs. PSI-TCIHC, in coordination with city governments, therefore selected a few "ready-to-start" UPHC facilities to



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1. TCIHC builds on the demonstrated success of the Bill & Melinda Gates Foundation's Urban Reproductive Health Initiative, Expand Access and Quality to Broaden Method Choice, and USAID's Health of the Urban Poor. It is scaling up these proven solutions for voluntary FP for the urban poor population. It is an unusual approach for providing lifesaving reproductive health and FP information and health care to individuals, families, and communities.

demonstrate their ability to provide high-quality FP for clients once a week on a fixed day. Because the National Urban Health Mission was new, PSI-TCIHC also rigorously advocated for budget allocations, equipment purchase approvals, and government trainings for UPHCs.

Implementation of the FDS approach revealed that ASHAs had competing priorities and struggled to identify and prioritize FP clients from their multiple registers. PSI-TCIHC coached them on informed choice counseling and how to prioritize households and clients during home visits, devising a list of potential clients for follow-up, called an “FP due list.” They were also coached to estimate FP need based on their lists and to note it for auxiliary nurse midwives to ensure timely procurement from the state and strengthen supply chain management.

To demonstrate the feasibility of the FDS approach at UPHCs, select facilities were equipped in one of three ways:

- For UPHCs with the required infrastructure, clinicians, and other human resources, and existing links with ASHAs for community mobilization for FDS days, ASHAs were coached on household and client prioritization, and they spread the word about FDS at UPHCs during their household visits.
- UPHCs with poor infrastructure and no provider but available supplies were equipped with a provider from an adjoining facility and linked with ASHAs for community mobilization.
- UPHCs with human resources but no supplies such as IUD kits, and boilers (for sterilizing medical instruments) sourced it from the district facilities.

Over time, as UPHCs institutionalized regular FDS days and served increasing numbers of clients, they started procuring equipment for themselves using the budgets secured as part of PSI-TCIHC’s advocacy efforts. For example, by 2018 all 513 UPHCs in 31 cities supported by PSI-TCIHC had sufficient IUD kits and boilers in place.

According to the program management information system, FDS demonstrations at four facilities in Varanasi and Firozabad, cities in Uttar Pradesh, resulted in LARCs contributing between 61 percent to 95 percent of all FP methods during the month measured. As a result of their successes, UPHC medical officers in charge took more interest in the FDS approach. PSI-TCIHC made its data visible and UPHC medical officers in charge became advocates of FDS as a means to increase access to information and voluntary FP on both fixed days and routine days.

PSI-TCIHC also presented FDS results to city chief medical officers and state-level district magistrates at various review meetings and platforms, including district health society meetings. Eventually, the dramatic increase in FP care at the UPHCs convinced city and state government leaders to incorporate the FDS approach at UPHCs in all urban areas across Uttar Pradesh, Madhya Pradesh, and Odisha. Today 513 of 517 UPHCs in these states are implementing the FDS approach, a benefit of using data for decision making.

The four implementation steps detailed below were key to the success of the FDS approach and its steps including facility preparedness and screening of clients before providing an FP method build on the World Health Organization (WHO)’s [Family Planning: A Global Handbook for Providers](#) (WHO, Family Planning: A Global Handbook for Providers, 2018) and the [Medical Eligibility Criteria Wheel for Contraceptive Use](#) (WHO, Medical Eligibility Criteria Wheel, 2015) to provide informed choice counseling on a variety of FP methods.

- **Scheduling:** The city chief medical officer directs all UPHCs and adjoining facilities to develop an FDS calendar. The city selects the FDS day so it does not conflict with any other priority health days or events, such as local markets or immunization days. The day is then selected and followed by all facilities in the catchment area. The FDS day is widely publicized door-to-door by ASHAs who are connected to a specific UPHC, covering a catchment area of 2,000 people and visiting approximately 15 to 20 households daily. ASHAs refer clients to UPHCs for spacing methods and to higher-level district or medical college facilities for permanent methods.



- Facility preparation:** District Quality Assurance Committee (NHM, Quality Standards for Urban Primary Health Centres, 2015) members visit facilities one or two days before the FDS day. Based on the estimated client load, facilities are equipped with FP supplies (e.g., IUDs, injectable contraceptives, oral contraceptive pills, weekly pills, and condoms); equipment; IUD insertion kits; infection prevention kits; human resources; reporting forms; and information, education and communication materials. Additionally, arrangements are made to smooth the flow of clients from registration to counseling and then to examination and care. Preparations are ensured for nearby accredited private facilities and district women’s hospitals so they can offer permanent methods to clients referred by ASHAs or UPHCs.
- Coaching and mentoring:** The PSI-TCIHC team coached ASHAs through a “low-dose frequent coaching” model, meeting each worker once a month for 12 months in person. Skills training included (1) informed choice counseling and referrals, (2) devising an “FP due list” of prioritized households for FP based on records and household visits, (3) using communication materials during counseling, (4) responding to questions about FP methods, and (5) linking the community with FDS. One PSI-TCIHC member visited 10 households with each ASHA once every month for a year. In 12 months, 6,000 ASHAs were coached across 31 cities in three states.
- Community mobilization:** ASHAs and other frontline health workers publicize FDS days in the community during their routine household visits and on FDS days where they reach out to eligible households near the selected UPHCs.

This approach has helped the government maximize its use of limited human resources and increase the provision of FP. The October 2017 demonstration sparked FDS adoption by 95 percent of the facilities. Based on data from 31 program cities, PSI-TCIHC found that when a facility adopted the FDS approach, it increased the quality and use of FP care during routine days as well.

PSI-TCIHC conducted two rounds of population-based surveys, which found that the modern contraceptive prevalence rate among currently married women (ages 15 to 49) in poor areas of cities increased significantly from 49.8 percent in Round 1 (September 2018) to 53.7 percent in Round 2 (September 2019).

Furthermore, UPHC Health Management Information System (HMIS) (NHM, HMIS, 2019) data show that the PSI-TCIHC program contributed a 168 percent increase in annual FP client volume as of March 2020 (compared with baseline), or 175,671 more clients accessing FP care (see Figure 1). The UPHC proportion of FP clients is around 67 percent of the total annual FP client volume at the city level.

HMIS trends also show a rapid increase of short-acting reversible methods, including injectable contraceptives, and an increase in IUD use (see Figure 2).

Furthermore, FDS increased the number of IUD and injectable clients in the facility as suggested by the program management information system, which shows that about three-fourths of IUD and injectable clients receive these methods on an FDS day.

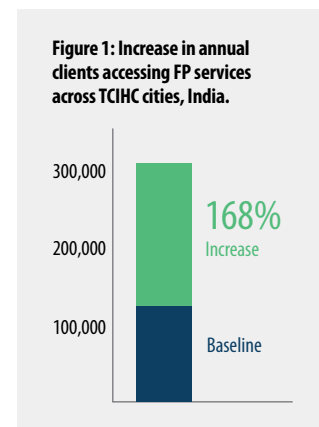


Figure 2: Increase in Annual Client Volume at UPHC level in TCIHC supported cities, Sept.2017-Feb.2020.

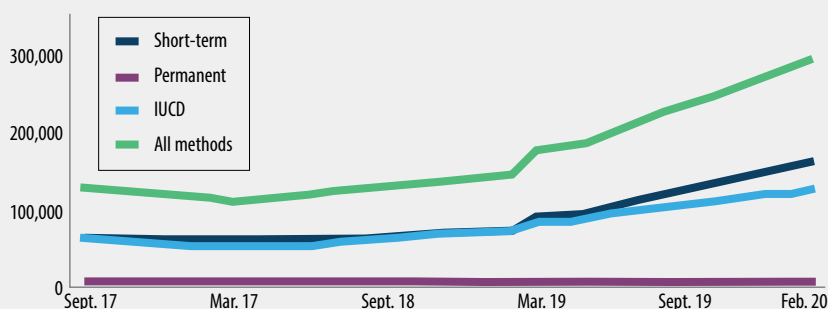


Figure 2 represents the increase in annual FP client volume. To prevent overestimation of short-term methods, HMIS data have been adjusted using standard couple-year protection, which is the total estimated protection provided by contraceptives in a one-year period. To account for seasonal variations, the data represent a 12-month average for short-acting methods and rolling sums for long-term and permanent methods. An increase in the trend therefore means that the latest month outperforms the same month from the last year.



LESSONS LEARNED

If FDS days are regularly scheduled at a facility, the client volume on FDS days increases, in addition to the quality and use of FP care on routine days.

FDS at UPHCs ensures the availability of high-quality FP care, including long-acting methods, on a fixed day and time known to the community. Thus, on FDS days eligible clients are guaranteed care, whereas on routine days staff may be on leave or a particular supply may be unavailable.

FDS should be linked with outreach or community mobilization through ASHAs.

If FDS is demonstrated at a “ready-to-start” facility, quick results can help advocate with the government to scale it up across the entire city or state.

FDS is a single approach that makes the facility and many other aspects ready for FP, such as demand generation through ASHAs and convergence between UPHCs, District Quality Assurance Committees, district-level facilities, and medical colleges.

Regularity of FDS must be ensured and must be operationalized by a chief medical officer of the city to sustain the approach.

Including FDS as a regular agenda item for discussion at District Quality Assurance Committee meetings, District Health Society meetings, and monthly meetings of medical officers in charge convened by the chief medical officer ensures high-quality FP at UPHCs.

Data should be captured through the government HMIS and showcased in government forums to facilitate critical decisions among leadership.

Creating a client prioritization list or “FP due list” can help ASHAs counsel clients during household visits, mobilize for FDS days, and elevate FP among competing priorities.

If FDS is regularly available at a facility, it strengthens not only FP but also enhances overall quality for other health care.

recommendations

01 Select and set **one day a week** when assured high-quality FP will be provided at UPHCs.

02 **Equip UPHCs** with trained human resources, equipment, and supplies for FDS days.

03 **Coach ASHAs** on how to prepare a client prioritization “FP due list.”

04 **Publicize FDS days** through ASHAs as widely as possible.

05 **Mobilize communities** on FDS days.

06 **Develop WHO guidelines on FDS** as a means to ensure high-quality voluntary FP, including LARCs at UPHCs, helping ensure FP availability at primary health facilities and reducing the client load at secondary and tertiary level facilities.

REFERENCES

Census. (2014). Population Enumeration Data- Final. India: Commissioner, Office of the Registrar General and Census.

High-Impact Practices in Family Planning (HIP). (2013). Family Planning and Immunization Integration: Reaching postpartum women with family planning services. Available from: <http://www.fphighimpactpractices.org/briefs/family-planning-and-immunization-integration>.

National Health Mission (NHM). (2008). Retrieved from https://nhm.gov.in/images/pdf/guidelines/nhm-guidelines/family-planning/fixd_day_static_guidelines.pdf

NHM. (2015, October). Quality Standards for Urban Primary Health Centres.

NHM. (2019). HMIS. Retrieved from <https://hmis.nhp.gov.in>

Srivastava, R.K et al. (2012, September). Trends and Differentials in Fertility and Family Planning Indicators of EAG States in India. National Institute of Health and Family Welfare. Retrieved from http://www.nihfw.org/Doc/Policy_unit/Trends%20and%20Differentials%20in%20Fertility%20and%20Family%20Planning%20Indicators%20of%20EAG%20States%20in%20India.%20September%202012.pdf

National Urban Health Mission (NUHM). (2013). Retrieved from https://nhm.gov.in/images/pdf/NUHM/Implementation_Framework_NUHM.pdf

NUHM. (2013). Framework for Implementation. Retrieved from <https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=295&lid=158>

Urban Health Initiative (UHI). (2011). Urban Health Initiative. Retrieved from <https://www.fhi360.org/projects/urban-health-initiative-uhi>

United Nations. (2018). Revision of World Urbanisation Prospects, UN DESA. Retrieved from United Nations: <https://www.un.org/development/desa/publications/2018-revision-of-world-urbanization-prospects.html>

World Health Organization (WHO). (2015). Medical Eligibility Criteria Wheel. Retrieved from https://www.who.int/reproductivehealth/publications/family_planning/mec-wheel-5th/en/

WHO. (2018). Family Planning: A Global Handbook for Providers. Retrieved from <https://www.who.int/reproductivehealth/publications/fp-global-handbook/en/>