EXPANDING THE BASKET OF CHOICE

Empowering Women with New Contraceptive Options in Uttar Pradesh

Roll out of new contraceptives in Uttar Pradesh

2022

THE UTTAR PRADESH TECHNICAL SUPPORT UNIT

The Uttar Pradesh Technical Support Unit (UP TSU) was established in 2013 under a Memorandum of Cooperation signed between the Government of Uttar Pradesh (GoUP) and the Bill & Melinda Gates Foundation (BMGF) to strengthen Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) and nutrition in the state. The University of Manitoba and its India-based partner, the India Health Action Trust (IHAT) are the lead implementing organizations of this initiative. The UP TSU provides techno-managerial support to the GoUP across three platforms; community, facility and health systems. Health systems strengthening includes support to the GoUP at the state level for policy formulation, planning, budgeting, human resource management, monitoring, contracting, procurement, and logistics to improve health outcomes and reduce inequities in the availability, utilisation and quality of services.

Contact Details

Uttar Pradesh Technical Support Unit
India Health Action Trust
404, 4th floor & 505, 5th Floor, Ratan Square
No. 20-A, Vidhan Sabha Marg
Lucknow-226001, Uttar Pradesh, India
Email: ihat.lucknow@ihat.in
Ph: +91-522-4922350 / 4931777

Couples at different life stages require contraceptive choices that best fits their personal circumstances and meets their need. This helps them continue contraceptive use and empowers them to decide on their family size. Offering a basket of contraceptive choices also aligns with best practices of government programs, helps reduce unmet need, increases method continuity, reduces unintended pregnancies and offers protection against some sexually transmitted infections.

As part of the “Mission Parivar Vikas” campaign launched by the Government of India in 2016, the basket of contraceptive choices was expanded with the addition of two new methods: a three-monthly injectable contraceptive called Antara and a non-hormonal oral contraceptive pill called Chhaya. In keeping with the Vision 2030 commitment of Government of Uttar Pradesh (GoUP) to enhance access, availability, quality and the utilisation of Family Planning (FP) services across the 75 districts of the state, Antara and Chhaya were also included.

The Uttar Pradesh Technical Support Unit (UP TSU) is supporting GoUP in rolling out the key interventions of Mission Parivar Vikas in the state, with a focus on introducing, scaling and sustaining new contraceptives. This Implementation Note encapsulates the approach and activities undertaken to introduce new contraceptives within the government program. It also describes how this expanded basket of choice is beginning to make a tangible difference to women’s lives in the state.

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ABBREVIATIONS

ASHA	Accredited Social Health Activist
BMGF	The Bill & Melinda Gates Foundation
CHCs	Community Health Centers
ICDS	Integrated Child Development Services
DCH	District Combined Hospital
DTTU	Delivery Team Topping Up
DWH	District Women's Hospitals
DMPA	depot-medroxyprogesterone acetate
DCGI	Drugs Controller General of India
EC	Emergency Contraceptive
GMSD	Government Medical Store Depot
FOGSI	Federation of Obstetric & Gynecological Societies of India
FP	Family Planning
FP-LMIS	Family Planning. Logistics Management. Information System
FLW	frontline workers
HTSP	Healthy Timing and Spacing of Pregnancy
HMIS	Health Management Information System
HBNC	Home Based Newborn Care
HDC	Home Delivery of Contraceptives
IEC	Information, Education and Communication
IHAT	India Health Action Trust
IFPS	Indo-US bilateral agreement for implementing the Innovations in Family Planning Services
IPM	Informed Push' supply chain models
IPC	Infection prevention and control
LARC	Long-Acting Reversible Contraceptive
mCPR	Modern Contraceptive Prevalence Rate
MEC	Medical Eligibility Criteria
MPA	Medroxy Progesterone Acetate
MPV	Mission Parivar Vikas
MOIC	Medical Officer In-Charge
ACMO	Additional Chief Medical Officer
RCH	Reproductive and Child Health
NFHS	National Family Health Survey
NHM	National Health Mission
OPD	Outpatient Department
PMU	Project Management Unit
RM-NCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
RCOG	Royal College of Obstetricians and Gynaecologists
SC	Sub Centre
SIFPSA	State Innovations in Family Planning Services Agency
SN	Staff Nurses
TFR	Total Fertility Rate
ToT	Training of trainer
UP	Uttar Pradesh
UPHMIS	Uttar Pradesh Health Management Information System
UP TSU	Uttar Pradesh Technical Support Unit
USAID	United States Agency for International Development
VHND	Village Health and Nutrition Day
IVDM	Voluntary Decision Making
WCD	Women and Child Development
WHO	World Health Organization

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01 INTRODUCTION

Current evidence points out that more than **200 million women** in the developing world live with an **unmet need of contraception.**

Family planning (FP) improves health, reduces poverty, increases educational and employment opportunities and empowers women and couples to lead a better quality of life. Universal access to high-quality FP is one of the most significant drivers that can improve women's health and the well-being of her family. Yet, current evidence points out that more than 200 million women in the developing world live with an unmet need of contraception. They are thus unable to avoid unintended pregnancies, despite a personal intention to do so. If this persistent demand for high quality and effective FP services were met, the wins would be astounding: 52 million unintended pregnancies, more than 70,000 maternal deaths and more than a million infant deaths could be averted each year[1].

The expansion of contraceptive options for voluntary FP is critical to address this unmet need, which evolves throughout the reproductive life-course depending on the personal preferences and choices of women and couples. An expanded basket of choice is essential to any successful FP program because it offers women and couples the option to choose a method of

their choice and switch from one method to another if and when desired. Adding one new method to the available method mix can increase contraceptive prevalence by as much as eight percentage points[2]. Addition of one method available to at least half the population correlates with an increase of 4-8 percentage points in total use of the 6 modern methods (Source: Ross J, Stover J. Use of modern contraception increases when more methods become available: Analysis of evidence from 1982-2009.Glob Health SciPract2013;1: 203-12).

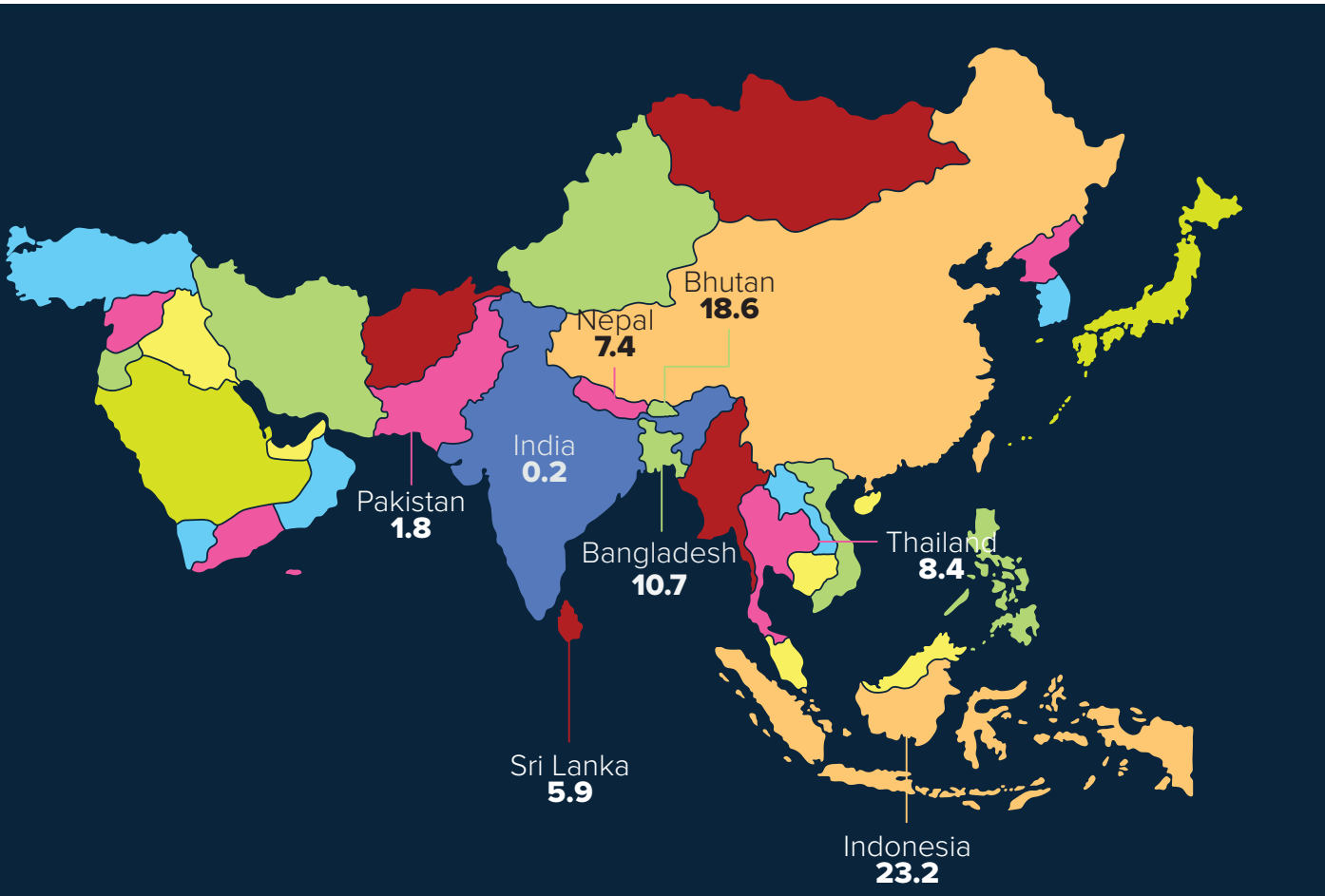
Globally, injectable contraceptives, such as Medroxy Progesterone Acetate (MPA), are one of the preferred FP methods and are widely used as an effective, safe, and acceptable way of spacing between pregnancies and averting unwanted pregnancies. They are not new, and early research trials and efforts to launch them began way back in the 1950s. It was in the early 1990s that injectable contraceptives such as Depo-Provera came into regular use. It is estimated that currently 74 million women worldwide use injectable contraceptives as a method of choice[3]. In some of India's neighboring countries, injectable contraceptives have been offered as part of the government-run family planning program and have contributed to a significant proportion of the contraceptive method mix provided in the country[4].

74 MILLION WOMEN

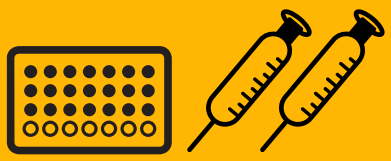
Worldwide use **injectable contraceptives** as a method of choice.

Injectable contraceptive use is 5.9% in Sri Lanka, 7.4% in Nepal, 8.4% in Thailand, 10.7% in Bangladesh and 18.6% in Bhutan[5], as a proportion of the overall FP method mix as compared to 0.2% in India and 0.4% in Uttar Pradesh (UP) (NHFS-4). Experiences from Asia, Africa and South America show that injectable contraceptives can be delivered in non-clinical settings through community-based workers, after appropriate training on counselling, client selection and screening, safe administration of the injection, and follow-up care resulting in higher rates of acceptability and continuation[6].

Figure 1: Map displaying the use of injectable contraceptives by country - 2019



In India, injectable contraceptives were approved by the Drugs Controller General of India (DCGI) in June 1993 for use as an FP method. In 1999, social marketing[7] organizations like DKT-India, Janani and Population Services International made efforts to improve access and availability of injectable contraceptives through their service channels such as franchise clinics, own clinics, and pharmacies.. Women who are counselled about side effects are less likely to discontinue and more likely to become satisfied users and eventually the best advocates for injectable contraceptives. In 2015, the World Health Organisation (WHO), the Royal College of Obstetricians and Gynaecologists (RCOG), London, the Federation of Obstetric & Gynecological Societies of India (FOGSI) and other international bodies also acknowledged the evidence of high acceptability of injectable contraceptives among women in different reproductive life stages including breastfeeding women (starting six weeks after giving birth).



The Government of India launched **Mission Parivar Vikas in 2016-2017** in a campaign mode to substantially improve access to contraceptives and family planning services in **146 high fertility districts.**

Identifying family planning as one of the most crucial interventions to address maternal and infant morbidity and mortality in the country, the Government of India (GoI), launched Mission Parivar Vikas (MPV) in 2016-2017 in a campaign mode to substantially improve access to contraceptives and family planning services in 146 high fertility districts with Total Fertility Rate (TFR) of >3 in seven high-focus states. These districts are in Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh and Assam, which constitute 44% of the country's population. Mission Parivar Vikas brought an enhanced basket of contraceptive choices with the addition of two new methods – a three-monthly injectable contraceptive called Antara and a non-hormonal oral contraceptive pill called Chhaya, which were added to the existing method mix for FP in the public sector in India.

The main objective of the Mission Parivar Vikas family planning initiative is to bring down the TFR to 2.1 by the year 2025. The Ministry of Health and Family Welfare, through its sustained family planning efforts, aims to achieve its goal of increasing modern contraceptive usage and ensuring that 74% of the demand for modern contraceptives is satisfied by 2020, with continued emphasis on delivering assured services, generating demand and bridging supply gaps.[8]

The Government of Uttar Pradesh initiated Mission Parivar Vikas activities in 2017. The Family Planning project within the Uttar Pradesh Technical Support Unit (UP TSU) is an effort to support GoUP to accelerate these efforts. The UP TSU provides techno-managerial support to focus on the unmet need for FP through expanding the basket of choice by introducing two new methods, Chhaya and Antara.

This implementation note details the conceptualization and implementation of a series of activities designed and rolled out since July 2017 to introduce and improve the availability and utilization of these two new contraceptives, Antara and Chhaya, in UP.

02

STRATEGY AND APPROACH

The phased approach enabled the strengthening of systemic processes at multiple levels: **State, division and district** - ensuring availability and quality of service delivery within public health facilities.

Anticipating challenges that could emerge with introducing two new contraceptive methods in the government program, the GoUP decided on a phased approach for the scale-up of this program. The phased approach enabled the strengthening of systemic processes at multiple levels: State, division and district - ensuring availability and quality of service delivery within public health facilities.

Antara and Chhaya were launched in UP on World Population Day in July 2017 (Figure 1). As an evidence-based phased approach, TFR was the criteria used to prioritise districts and the facilities (Table 1). Thus, eight district women hospitals (DWH) and one medical college in districts with TFR>=3.5, 23 DWH in districts with TFR: 3.0-3.4, and 40 DWH in districts with TFR < 3.0 were chosen in Phase 1, 2 and 3, respectively. In Phase 4, from October 2018 onwards, the remaining public sector facilities, including medical colleges, District Hospitals (DHs), Community Health Centers (CHCs), Primary Health Centres (PHCs) and Sub Centers (SCs) of all 75 districts were included.

In early 2020, these contraceptives were also made available at PHCs and SCs that had been converted to Health and Wellness Centres (HWCs). By March 2021, these contraceptives were available across the State of UP, covering 93 DHs, 14 Medical Colleges, 961 CHCs, 2,058 PHCs, and 7,282 SCs; a total of 10,405 facilities across 75 districts.

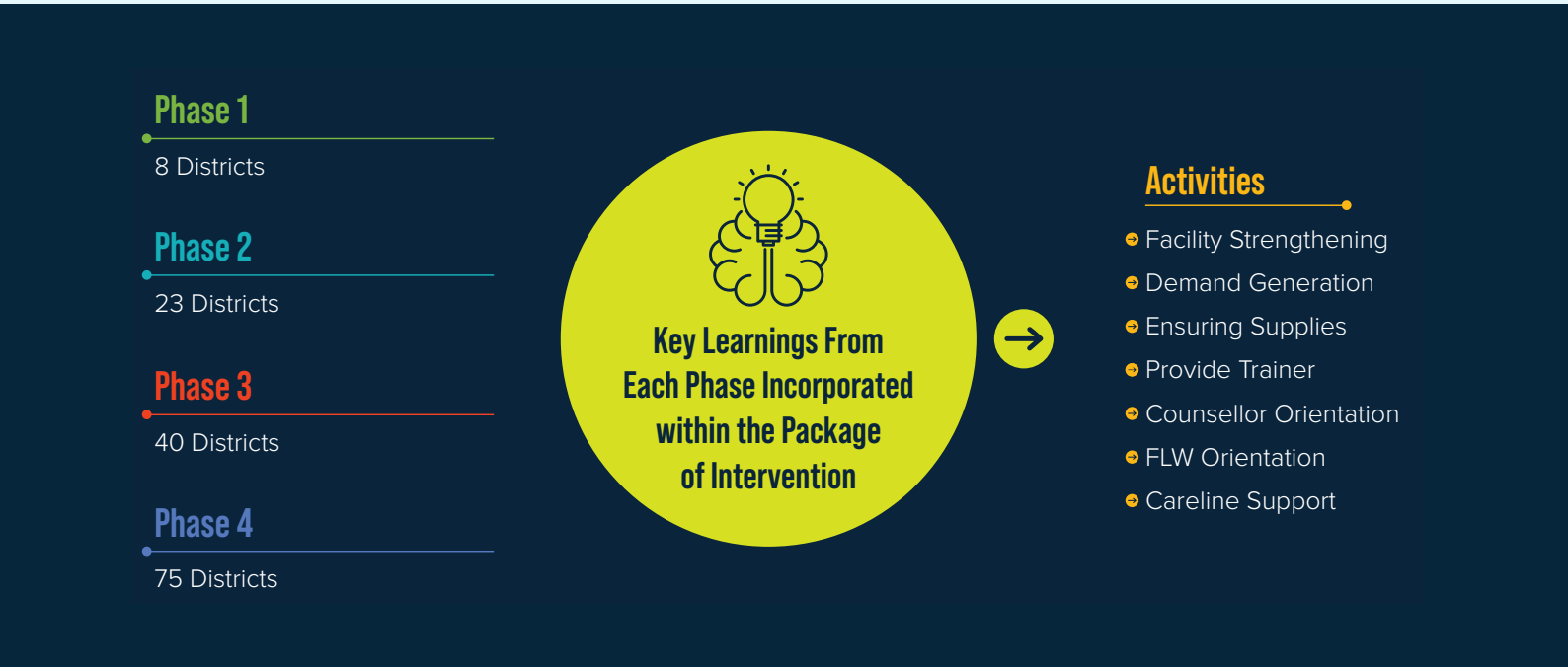
Table 1: Phase wise launch of Antara in UP

Phases of the rollout	# Districts	# Public health facilities	Date of launch
Phase 1	8 districts	8 District Women Hospital + 1 Medical College (in Lucknow)	01 August 2017
Phase 2	23 districts	23 District Women Hospital	06 November 2017
Phase 3	40 districts	40 District Women Hospital	15 February 2018
Phase 4	All 75 districts	22 District Women Hospital /District Combined Hospital (DCH) + 13 Medical colleges + 961 Community Health Centre + 2,058 Primary Health Centers + 7,282 Sub Centers	October 2018 onwards (upto March 2021)

Source: As per HMIS up to March 2021

Key learnings from each phase related to facility strengthening, demand generation, supply chain management, capacity building of service providers, counsellors and frontline workers (FLW), follow-up of clients, the continuation of use, etc., were incorporated within the package of interventions as the program expanded.

Figure 2: Phase-wise learnings incorporated in the intervention package



UP TSU supported the setting up of a Project Management Unit (PMU) to support the National Health Mission (NHM) in the rollout of MPV in January 2017. The PMU comprised of a six-member team led by a government officer. It was strategically embedded in the State Innovations in Family Planning Services Project Agency (SIFPSA)[9] to oversee the operationalization of the MPV. The PMU coordinated activities between the government and partner agencies, managed activities and processes and accelerated progress. The PMU was active for two years and wound up in December 2018, after gains were consolidated.

03 THE ROLLOUT : MAJOR ACTIVITIES

The new contraceptive rollout primarily focused on three major interventions:

I. Facility Strengthening,

II. Strengthening facility-community linkages for services, and

III. Health System Strengthening at the state level. The focus of these three interventions was to increase the availability, quality, and utilization of FP services to reduce unmet need by expanding the 'basket of choice' of new contraceptive methods.

The **UP TSU** developed a **Training Module, compressed to a duration of 2-3 hours**, making it easily comprehensible for the trainees and customizing it to **encourage active participation** during the training.

FACILITY STRENGTHENING

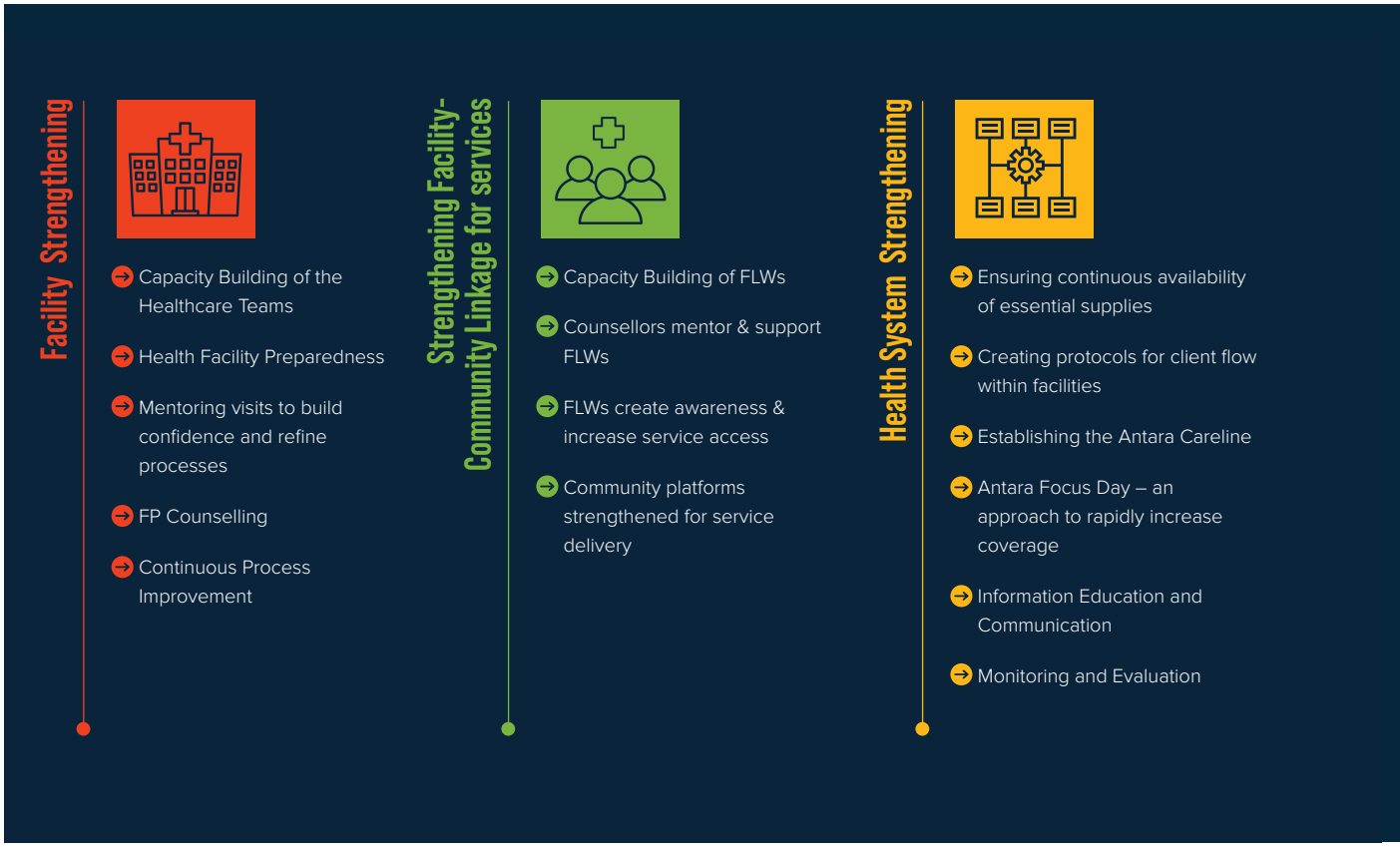
Facility strengthening was aimed at increasing the availability of new contraceptives and improving the quality of services in the public health facilities. Activities under facility strengthening included:

1. Capacity Building of the Healthcare Teams

- **Team Orientation and training to introduce new methods of contraception:** The UP TSU developed a training module,

compressed to a duration of 2-3 hours, making it easily comprehensible for the trainees and customizing it to encourage active participation during the training. Training of trainer (ToT) teams were developed to roll out the module. The ToT teams used the module to train and orient Health Facility teams comprising doctors, staff nurses (SN), pharmacists, storekeepers, counsellors, housekeeping staff, attendants, etc. The content included information on new contraceptives, their advantages and limitations, client selection criteria, site of administration (for injectable contraceptives), bodily changes that could occur, myths and misconceptions, pre and post care, maintenance of stock, reporting and indenting process. Clinical staff subsequently underwent more detailed training on technical content.

Figure 3: Rollout of the New Contraceptives in UP: Focused Approach



2. Health Facility Preparedness

- **Facility Strengthening Visits initiate new-services provision:** UP TSU teams consisting of 2-3 persons visited each health facility for a facility strengthening round over a two-day scheduled visit. Starting with a whole site team orientation to brush up the technical knowledge of the clinical staff, the UP TSU team would then split up to focus on specific roles and skills of the nurses, pharmacists, storekeepers and counsellors. The nurses were re-oriented on maintaining infection prevention practices, especially the safe disposal of needles. The pharmacist and the storekeepers were re-oriented on the storage requirements of new contraceptives, the use of the Family Planning Logistic Management Information System (FP-LMIS), indenting and distribution. The counsellors were mentored on maintaining MPA cards and registers, supporting clients to register on Careline (a telephonic system for registration and follow-up for Antara clients) while brushing up their counselling skills and know-how on the new contraceptives. They were also guided on making their counselling room more client-friendly and how to position all the Information Education Communication (IEC) materials effectively to draw and retain the client's attention.

- **Identify Areas for Service Provisioning:** Facility Teams, guided by the UP TSU, would then identify and prepare the area for service provision. Seating arrangements were made for clients, separately for those waiting for administration of injectables and post-injection observation. Information related to do's and don'ts about the new contraceptives was prominently displayed in the service provisioning area. In addition, posters were displayed to make the area welcoming for clients. The nurses and counsellors were provided with information leaflets for distribution to the clients. Registers and MPA cards were made available in adequate quantities.

3. Mentoring visits to build confidence and refine processes

Facility strengthening rounds in each phase were followed by mentoring visits to reiterate important aspects related to new contraceptives service provisioning, to identify areas that still required improvement, and to draw facility-specific plans with the facility teams that would be followed up in subsequent visits. Common issues emerging from across a wider number of facilities and districts were discussed at the state level. Solutions were identified in consultation with the GoUP team, and directives and guidelines were issued to address the issue across all districts systematically.

→ Revising and Refining Registers

It emerged during interactions with the facility staff that the Antara register was cramped for space to capture client details such as phone numbers. Each sheet of the register was designed to capture the details of 30 clients across 60 columns. There was no provision to capture doses after the 4th dose. There was inconsistency in filling up data due to the ambiguity in column headings. There was no segregation for capturing subsequent doses. This resulted in subsequent doses being captured as new clients. This made it difficult for the data entry operator to count repeat doses leading to incorrect HMIS entries. Therefore, the Antara register was redesigned to provide more space for capturing client details like phone numbers essential for follow-up. Ten small boxes were made to allow for the correct entry of mobile numbers without missing any digits. Another essential modification was to have separate sections for repeat doses. New data columns were added to capture more relevant information related to the client's bank account number, Aadhar number, name and designation of the service provider, Accredited Social Health Activist (ASHA) escorting the client to the facility and details of the incentive received by the client and ASHA. Printed record registers were made available at the facilities, as were MPA cards.

→ The Medical Eligibility Wheel

Another example of feedback received during mentoring rounds that were acted upon is the Medical Eligibility Criteria (MEC) wheel. The facility staff mentioned that the MEC wheel was in English. This made it difficult for the Counsellor to understand and explain to clients. The MEC wheel also did not have information related to Chhaya. Following discussion with the GoUP team at the state level, a Technical Support Group (TSG) was formed to redesign the MEC wheel and include information on Chhaya. The MEC wheel was redesigned, translated into Hindi, printed by the State and distributed to all facilities. Similarly, mentoring visits also elicited the need for easy to understand IEC material, client flow mechanisms, a robust system for follow up and reminders, especially for Antara clients. Uninterrupted supplies, a protocol for the management of excessive bleeding, understanding around incentives, the need for queries to be addressed on a real-time basis were issues about the provider identified and addressed in consultation with the GoUP.

Every mentoring visit at each facility followed the 10 step plan, indicated below:

01

Meet Chief Medical Superintendent/Medical Officer In-Charge and provide brief objective of visit and follow up on the points discussed in the previous visit. At the end of mentoring visit, share visit's observations and areas for improvement.

02

Handholding of counsellor at facility and providing feedback based on the direct observation of counselling sessions. Constantly encourage use of counselling tools, and expand counselling to other areas in the facility where clients come for other services such as OPD, post-natal ward, etc., in order to reduce missed opportunities. Integrate FP counselling on certain designated days such as 9th day clinic for anaemic women, immunization day, etc. to minimize missed opportunities.

03

Where counsellor was not available at facility, discussion with CMS/MOIC to designate/deploy a person for FP counselling, mentor the designated person (mostly staff nurses) on counselling, observe sessions and provide feedback. Discuss missed opportunities and how to minimize them.

04

Meet doctors and reiterate the do's and don'ts including importance of screening of clients using Medical Eligibility Criteria (MEC) wheel.

05

Meet SN & Auxiliary Nurse Midwife (ANM) and discuss and reiterate the process of injection, do's and don'ts, record-keeping, stock maintenance, filling up of MPA cards, post injection counselling, and follow up of clients.

06

Review record keeping to ensure that all relevant information is captured.

07

Interact with store keeper to see how new contraceptives are being warehoused and whether they are in accordance with quality assurance standards. Address queries related to FP-LMIS.

08

Interact with ASHA and ASHA Sanginis at facility to understand their experience with new contraceptives, clarify doubts, misconceptions if any.

09

Interact with clients if available at facility at the time of the mentoring visit and understand their experience related to new contraceptives, services, etc.,

10

For any district level support, meet CMO/Additional Chief Medical Officer ACMO (RCH) of district and discuss the way forward.

The mentoring visit cycles were intensive but essential to focus on family planning and build the facility teams' confidence to provide quality new contraceptive services. It helped improve processes at facilities, regularly address doubts and queries in a friendly, non-threatening way, and develop a connection at the district and state level to advocate for areas that needed attention. This made the rollout more robust and looped in all relevant stakeholders in the government system, thereby enhancing synergies in program implementation. The UP TSU team played a catalytic, facilitative and linking role in this entire process.

4. Counselling – a core component in FP

Training and capacity building for counsellors was a significant aspect of the rollout. Counsellors were trained to improve client centered counselling, provide adequate information to the client to make an informed decision, understand the importance of screening, link clients to appropriate services, minimize 'missed opportunities' for counselling, improve follow-up care to reduce discontinuation and improve sustained use. Counsellors were informed about the link between Healthy Timing and Spacing

of Pregnancy (HTSP) and reduction in maternal mortality and morbidity, trained to identify and reduce missed opportunities during the post-partum and post-abortion period, oriented on MPV and other FP schemes, and provided with job-aids on new contraceptives, Antara and Chhaya and other FP methods. Post-training mentoring was extended to counsellors to strengthen their understanding of quality counselling and new contraceptives through onsite (as part of facility strengthening) and off-site (WhatsApp group) communication.

Figure 4: Continuous Process Improvement

Case studies with questions for counsellors to respond to, frequently asked questions, audio messages, role plays, short films, etc., were shared with counsellors on these WhatsApp groups. This helped in creating a responsive encouraging environment where counsellors could ask and post questions. Responses to individual queries shared on the WhatsApp group helped resolve other counsellors and strengthened the learning process.

5. Continuous Process Improvement

A comprehensive checklist was developed to support the facility teams in improving standardised processes. The checklist covered client registration and referral to FP counsellor, method-specific counselling for new contraceptives, protocols for screening of clients and administration of injectable contraceptives, waste disposal and infection prevention, post-injection instructions, record keeping and storage and display and distribution of appropriate IEC materials in the facility.

Teams visiting the facility for mentoring visits used the checklists to capture information gathered through observation, identify the most prominent gaps, and discuss and develop standard, feasible solutions. The checklist was continuously revised to include new aspects based on the learnings of the previous phase.

The UP TSU also developed a ready reckoner to complement the checklist as a guidance document for the mentoring teams. This ready reckoner covered both clinical and non-clinical aspects. The ready reckoner was also a dynamic document that was periodically upgraded to include the finer fine points missed by facility teams which were important for quality service provisioning. The mentoring teams used the ready reckoner to stress essential points during visits.

Counsellors were trained to **improve client centered counselling,** provide **adequate information to the client** to make an informed decision**, understand the importance of screening, link clients to appropriate services,** minimize 'missed opportunities' for counselling, **improve follow-up care** to reduce discontinuation and improve sustained use.

STRENGTHENING FACILITY-COMMUNITY LINKAGES FOR SERVICES

Front line workers (FLWs) often represent the first and only point of contact with the public health system for rural women. It is imperative that we invest resources in strengthening, training and empowering FLWs to serve communities. When appropriately designed and implemented, FLW programs can increase the use of contraception, mainly where unmet need is high, access is low, and geographic or social barriers to the use of services exist. FLWs are particularly important for reducing inequities in access to services by bringing information, services, and supplies to women and men in the communities where they live and work rather than requiring them to visit health facilities, which may be distant or otherwise inaccessible.

Following activities were conducted to strengthen the facility-community linkages for services through capacity building of FLWs and strengthening community platforms for service delivery.

On an average

40 INJECTABLE CONTRACEPTIVE DOSES PER MONTH

were administered in blocks where FLWs were mentored by counsellors as against 24 doses per month where no counsellors were available available, in 2020-2021

(Source: HMIS)

1. Capacity Building of Frontline workers:

Using the cascade training model, a pool of district-level trainers was created to support the capacity building of FLWs on new contraceptives. In 2017, 13 batches of training at the state level were facilitated—the batches comprised officials from district and block-level selected from all 75 districts. After the ToTs were completed, FLW trainings were rolled out at the district level. By December 2018, as many as 1,76,200 FLWs were trained on FP and oriented on new contraceptives. The training modules also focussed on orienting the FLWs on the importance of HTSP and its impact on maternal and child health. The importance of offering the entire basket of choice was emphasized to assist clients in informed, voluntary decision making.

2. Counsellors mentor and support Frontline workers

Post-district-level trainings, monthly cluster meeting platforms were utilized to roll out capsular modules with FLWs, following a high-frequency low-dose approach to capacity building. Counsellors at facilities took a keen interest in participating in the cluster meetings organized at their facilities. This helped to create a strong connection between FLWs and counsellors. Increased uptake of FP services, including new contraceptives, was evident within the facilities where counsellors created a mentoring relationship with FLWs. In FY 2020-2021, on an average, 40 injectable contraceptive doses per month were administered in blocks where FLWs were mentored by counsellors as against 24 doses per month where no counsellors were available (Source: HMIS)

3. Frontline workers create awareness and increase access of communities for services

The orientation of FLWs supported State's effort in introducing new contraceptives to the communities. FLWs were able to share information about new contraceptives with confidence and allayed the anxieties and concerns of clients. Furthermore, FLWs helped generate demand for new contraceptives by offering to counsel on side effects and removing myths and misconceptions, which is one of the reasons for not using FP services among women. FLWs were also instrumental in connecting Antara clients to Careline for telephonic follow-up.

4. Community platforms strengthen for service delivery

The Village Health and Nutrition Day (VHND) platform was leveraged by FLWs to talk about and distribute IEC material on new contraceptives; Antara and Chhaya. FLWs also helped in improving linkages with facilities for Antara and mobilizing clients for Antara Focus Days. FLWs were oriented on indenting for FP supplies, including Chhaya using the government system of FP-LMIS.

In addition to public health facilities, FLWs also served as a service delivery point for Chhaya. Chhaya was included in the home delivery of contraceptives (HDC) scheme. This strengthened the availability at the community level and community-based distribution. Under the HDC scheme, FLWs distributed Chhaya along with other FP methods (Condoms, Emergency Contraceptive (EC) Pills, Mala-N) right at the doorstep of the clients. By March 2021, more than 2.3 million cycles of Chhaya were distributed.

Health System Strengthening

1. Ensuring continuous availability of essential supplies

Ensuring the continuous availability of new contraceptives at facilities in alignment with the phased rollout was important. The supplies from the Government Medical Store Depot (GMSD) were indented and issued through the FP-LMIS portal. UP TSU provided technical support for supplies estimation so that adequate quantities of new contraceptives could be procured to avoid stock-outs. Following procurement, the stock was distributed across the Chief Medical Store Depots (CMSDs) in the districts and district hospitals to ensure availability at district and block level facilities. Distribution of stock was streamlined, and inter-district transfers were carried out in case of excess demand. UP TSU supported the State in the end-to-end rollout of FP-LMIS for better tracking and management of FP supplies, including new contraceptives.

State TOT on FPLMIS

2. Creating protocols for client flow within facilities:

An effective client flow mechanism was critical for enhancing the utilization and uptake of newly-launched contraceptives at the facility. Client flow was designed for the first and repeat doses of Antara in consensus with the CMS and/or the Medical Officer In-Charge (MOIC) (both with and without the availability of a Counsellor at the facility) [Figure 5].

Figure 5: Client Flow for Antara (First and Repeat Dose)

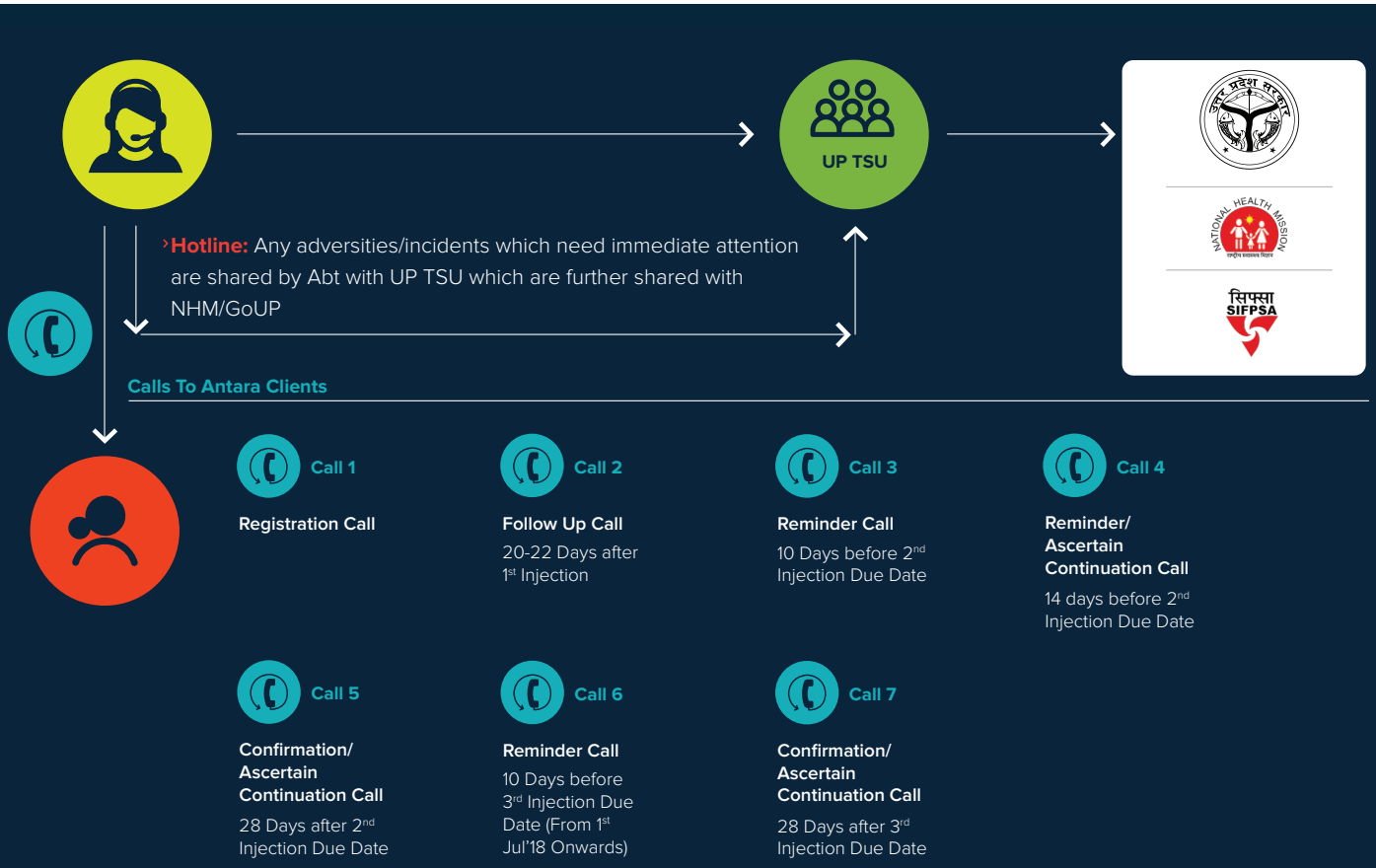
3. Establishing the Antara Careline

Although injectable contraceptives are an effective method of contraception, women may experience significant bodily changes (including menstrual changes such as prolonged spotting, heavy bleeding and amenorrhoea) once they start using this method. A majority of users experience these symptoms due to hormonal changes and may require counselling for support. Follow-up support is needed more strongly during the initial few doses as this is when different bodily changes are experienced. A gap in counselling and non-addressal of issues that the woman may be experiencing can easily lead to premature discontinuation. Since the beginning of the rollout, the GoUP recognized the significance of counselling being available to the client not only at the time of administration of the injectable contraceptive but also intermittently in the time period between two doses. This support can help with long-term compliance and improve the continuation rate of using an injectable contraceptive.

Careline is a **telephone-based comprehensive counselling process with algorithms developed and counsellors trained** to focus specifically on follow up support to Antara users.

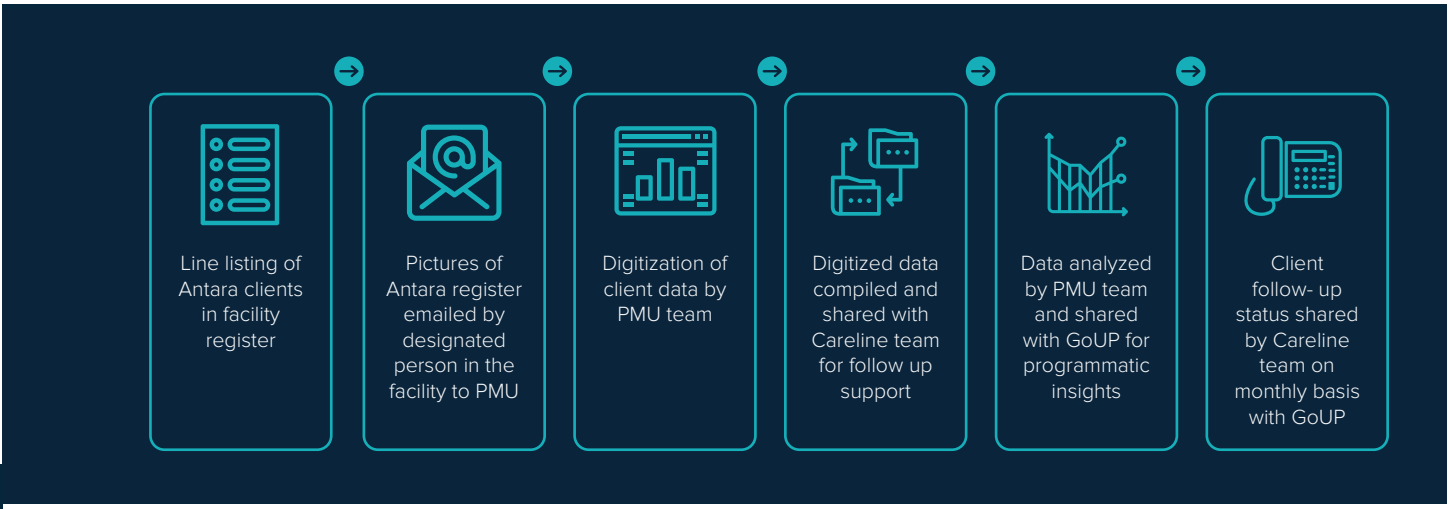
While the facility staff, including counsellors and staff nurses, were trained on counselling clients to accept new contraceptives, in case of clients accepting Antara, it was observed that the majority of clients would not reach out to the facility teams in-between doses when they began to experience bodily changes at home. Therefore, GoUP, with support from UP TSU and Abt Associates, established a Careline for telephonic counselling and follow-up support to help bridge this gap. Careline is a telephone-based comprehensive counselling process with algorithms developed and counsellors trained to focus specifically on follow up support to Antara users. Follow up with clients up to the third dose was done by the Careline counsellors. This included seven outbound calls over a period of six months to Antara users (Figure 3) to support the client to manage bodily changes and to remind her to come back for subsequent doses.

Figure 6: Careline Call Algorithm for Antara Clients



For effective outbound calls, UP TSU helped GoUP set up a system (Figure 4) of clientwise data collection from facilities, digitized by the PMU team and shared with the Careline team to make outbound calls to Antara acceptors. The system was designed to reach client information to the Careline on a weekly basis to enable the Careline counsellors to reach out to the Antara acceptors within 15-20 days of the first dose taken. Though this was an intensive and time-consuming process, this was essential in the initial phase of the rollout to extend the counselling support proactively to the maximum number of Antara acceptors and to minimize the development of a negative perception that could emerge as women start to experience bodily changes around 15-20 days post administration of the dose. A call received around the time of bodily changes would be comforting, supporting and reassuring to the women, who would then be able to ask questions and address queries to the counsellors who were proactively calling them up. The mechanism of reminders built through these outbound calls also encouraged the women to come back for subsequent doses well in time, giving them a reminder strategically just 7-10 days before their date for the next dose.

Figure 7: Data Flow from Facility to Careline for Outbound Calls



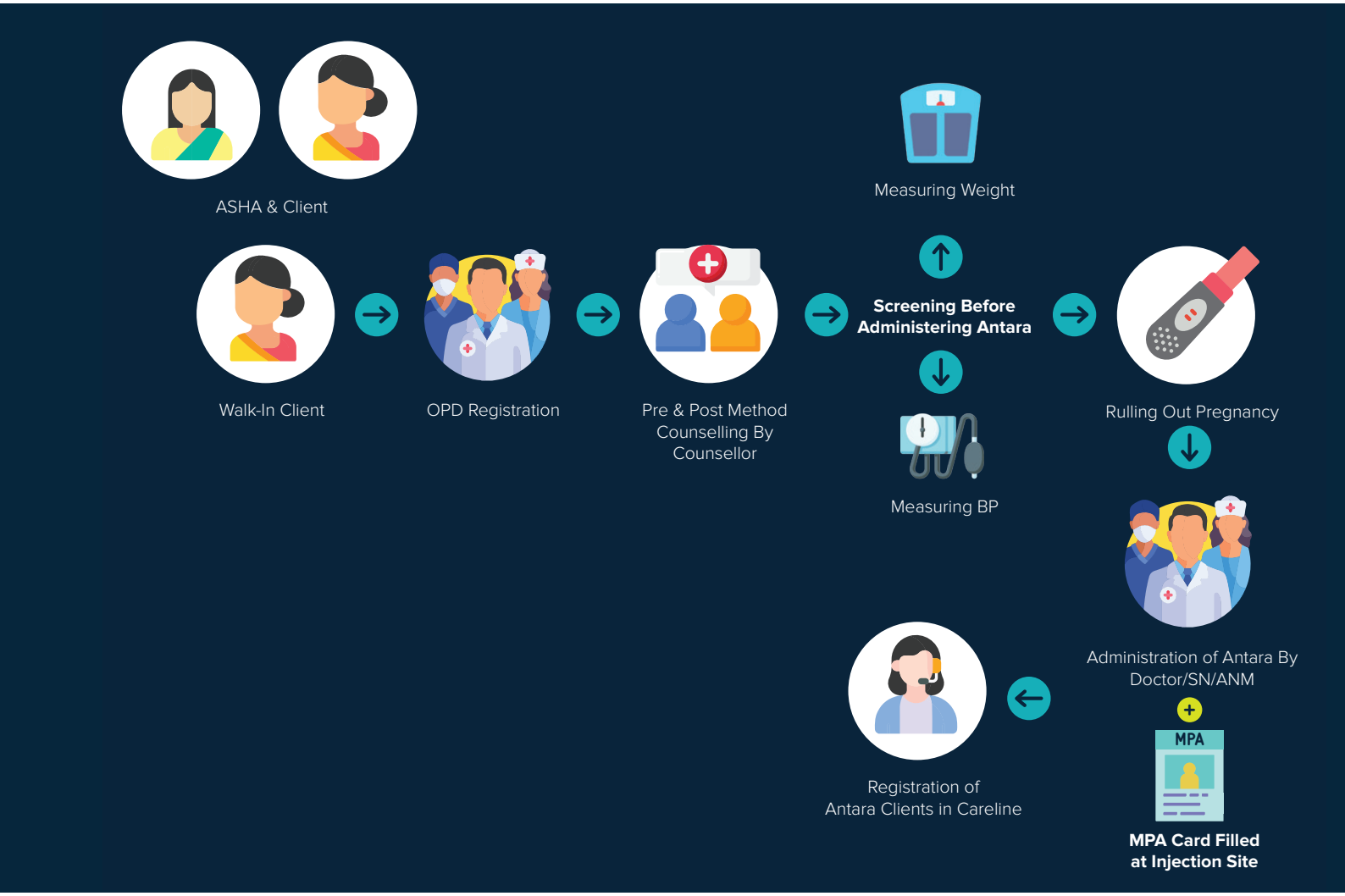
Over the years, as the number of Antara acceptors increased and services started being provided through a more significant number of facilities, an inbound call facility was added as a feature to the Careline. From January 2019 onwards, a toll-free number (1800 103 3044) was made available for the clients to make inbound calls. Women accepting Antara as a method of choice at facilities were encouraged by counsellors and staff nurses to register themselves at the Careline. Once registered, follow up, and reminder processes would start. Women who had not registered immediately after the first dose was then followed up by the ASHAs to eventually get themselves registered at the Careline. The inbound functionality also gave Antara users the ease and convenience to share their doubts and seek support and information as per their convenience. Careline data shows that of the users registered, 65-70% continued to the second dose, and 55-60% continued to the third dose. The effective support provided through the Careline prompted the State to consider setting up a state call centre for family planning.

4. Antara Focus Day – an approach to rapidly increase coverage

To scale up the availability of Antara, a pilot intervention for an Antara Focus Day was implemented. Each district fixed a day in a week as "Antara Focus Day" to provide the necessary services related to Antara injectables to the beneficiaries. The objective of Antara Focus Day was to create a reliable platform for services where availability of providers and commodities was ensured; FLWs were informed so that they could mobilize clients wanting Antara and accompany them to facilities for services. It was also to test whether creating assurance around spacing methods similar to fixed-day services for permanent methods would lead to an increase in the adoption of spacing methods. This was also in response to the feedback received through Careline that some clients had missed their second or third doses due to the unavailability of services at facilities when they reached the facility for their scheduled doses. While some of them managed to go back to the facility on other days, some completely dropped out due to uncertainty of the availability on other days as well. The approach, as described in detail below, was implemented for four months across all 75 districts.

In discussion with district officials, letters related to the initiative were issued, and one day in a week per district was designated. Communication was sent out to the facility in-charges and FLWs. Local media was roped in to create awareness about the day and also share interesting and positive stories and experiences post organisation of the day. Figure 5 illustrates the movement within the facility during the Antara Focus Day.

Figure 8: Client Flow During the Antara Focus Day



The following arrangements were stressed with the facility teams prior to the Antara Focus Days:

01 Availability of trained service providers (doctors and staff nurses) at the site as the first dose had to be administered under the supervision of a trained medical doctor.

02 Preparing the counselling room wherever available with all the relevant information related to FP and Antara, keeping the basket of choice with all methods clearly displayed in the basket, leaflets and IEC material where clients could access them, and organize the room or area so that it is welcoming to the clients. If counsellors were not available, staff nurses were to be made available for counselling

03 Availability of adequate quantities of commodities

04 Reminder to FLWs about Antara Focus Days at cluster meetings. Encourage pre-registration of probable Antara clients by ASHAs at least a couple of days prior to the Antara Focus Day

05 Registration of client with the Careline preferably before they leave the facility so that they could come under the follow up process

06 Mandatorily give the leaflet with toll-free Antara Careline number to the women post administration of injection. Display IEC with Antara Careline number at the site of administration of injectable contraceptive

07 Keep adequate quantities of registers and MPA cards available. Stress the need of capturing correct information in the

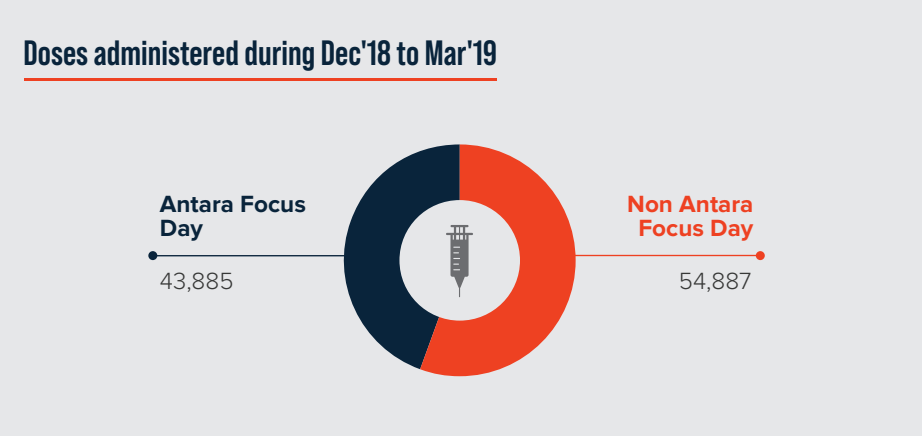
08 Reporting on HMIS

98,762 DOSES

of **Antara were administered** between December 2018 and March 2019.

These focussed days at district and block levels created an enabling environment for users and led to improved uptake of Antara (Table 2 and Figure 6). Table 2 shows how Antara uptake increased at the district level during the Antara Focus Day. According to program monitoring and HMIS data in Table 2, a total of 98,762 doses of Antara were administered between December 2018 and March 2019, out of which 44% (43,885) of Antara doses were contributed by Antara administered during Antara Focus Days (Figure 9 & 10). Therefore, creating and communicating assurance of service availability on 15% of days in a month contributed to almost 50% of total uptake.

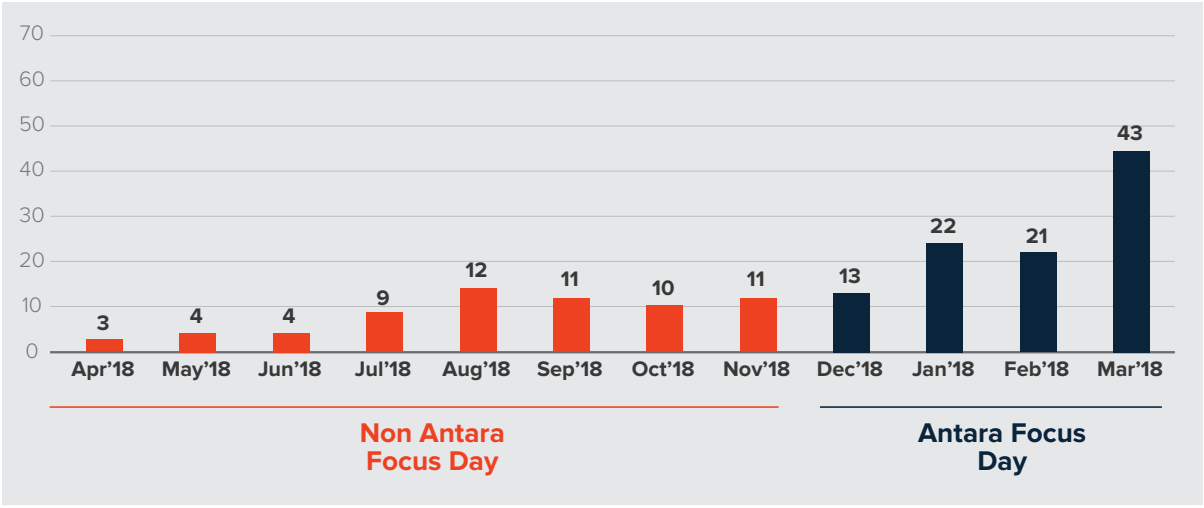
Figure 9: Status of Antara doses administered



Source: Program monitoring data & HMIS data

According to HMIS data, the average number of Antara doses administered per district was significantly higher in the period December 2018 to March 2019 when Antara Focus Days were organized in comparison to the months when Antara Focus Days were not organized at the facilities from the time-period April 2018 to November 2018 (Figure 10). The uptake of Antara per month improved significantly with the start of the Antara Focus Days.

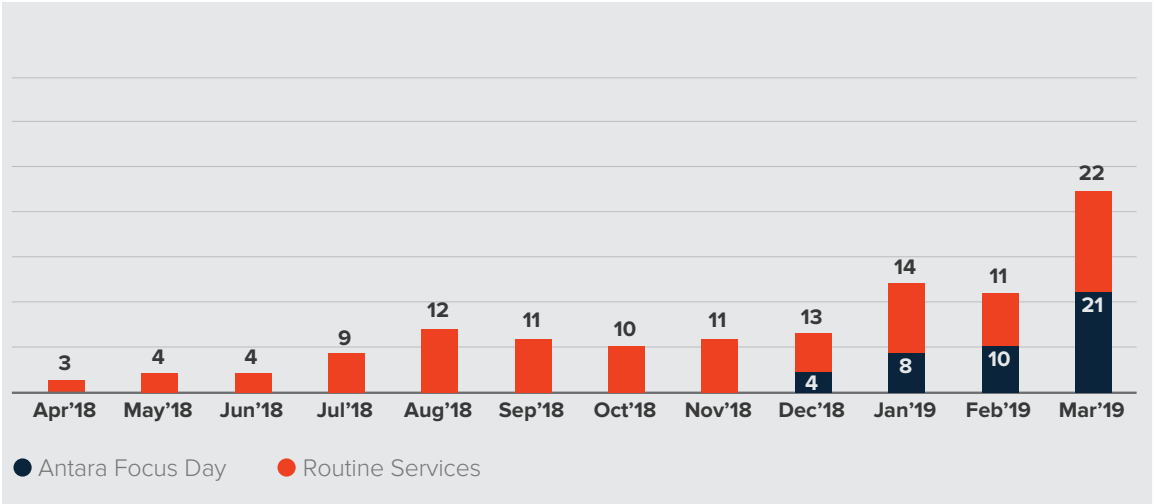
Figure 10: Average doses per month administered in the State in 2018-19



Source: HMIS data

The contribution of doses administered on Antara Focus Days was 30% in December 2018 and rose to close to 50% by March 2019 (Figure 11).

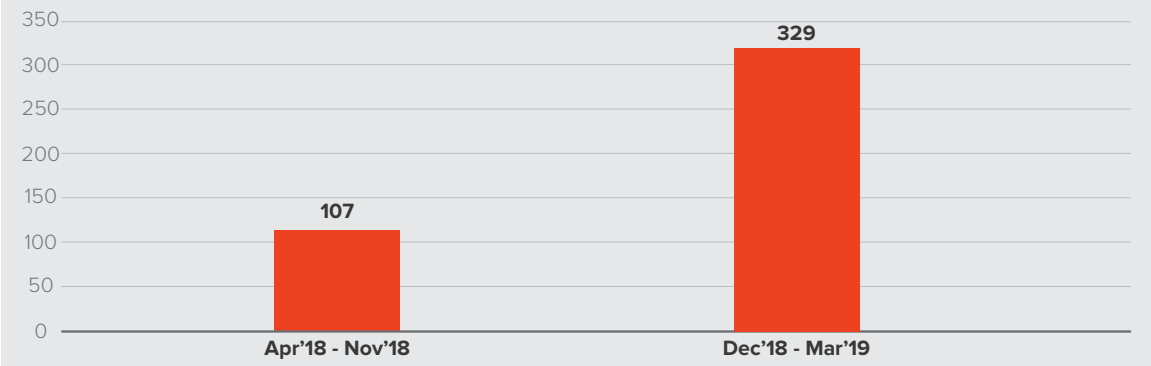
Figure 11: Antara doses administered during Antara Focus Days and routine services in 2018-19



Source: HMIS

The average doses administered per district per month also went up by 200% (from 107 to 329 doses) across all districts during the months when Antara Focus Days were organised compared to average doses administered per district per month before Antara Focus Days were introduced (Figure 12).

Figure 12: Increase in average doses of Antara during months with Antara Focus Days vs rest of the year



Source: HMIS data

Learnings from Antara Focus Days were shared with GoUP. 'Antaraal Diwas' emerged as a statewide strategy based on the learnings presented where GoUP decided to focus on all spacing methods using the pathways adopted for Antara Focus Days. 'Antaraal Diwas' (Antaraal means spacing) focused on creating assured services for all spacing methods in addition to injectable contraceptives.

5. Information Education and Communication

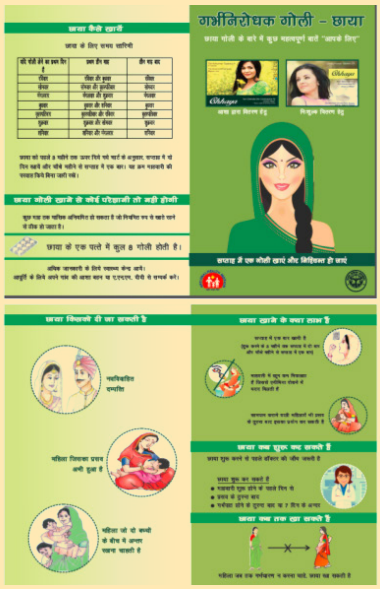
IEC activities play an important role in increasing awareness at the community and facility levels. Creating awareness becomes important when a new method is introduced. IEC activities were systematically planned and rolled out across the State. The focus of the IEC activities was to put out simple, accurate information without technical jargon, with attractive images to capture the attention of clients. Consistent sets of images were used so that people would associate those images with new contraceptives. IEC material was prominently positioned where people congregate, especially within outpatient departments (OPD) and waiting areas of public sector health care facilities.

Figure 13: IEC Material displayed at the Healthcare Facilities

Antara and Chhaya Leaflet & Posters

→ Antara Leaflet

→ Chhaya Leaflet



→ Facility Poster

Mass media was tapped through radio spots and cinema spots. Radio jingles and audio bytes with messages on new contraceptives were developed and played during promotional campaigns such as 'Saarthi Vahaans' (awareness-on-wheels campaigns using designed vehicles for creating awareness at the community level) and 'Saas Bahu Sammelans' (meetings organized at the community level to bring mothers-in-law and daughters-in-law together to discuss FP). Infection prevention and control (IPC) tool kits and promotional materials were developed and given to FLWs for use during VHND. UP TSU supported the State in designing job aids such as the ASHA handbook, facilitator guides, Antara and Chhaya leaflets, facility posters, an MPA card with Careline stickers, an expanded basket-of-choice poster and the Nayi Pahal Kit leaflet for service providers, frontline workers and the clients.

A short film made on the rollout of new contraceptives can be viewed here:

Roll-out of new injectable contraceptives in Uttar Pradesh (English)
https://www.youtube.com/watch?v=T9jVUCqSvSQ&t=15s

Roll-out of new injectable contraceptives in Uttar Pradesh (Hindi)
https://www.youtube.com/watch?app=desktop&v=eHAEteGI2EQ

6. Monitoring and Evaluation

A well thought-out and implemented monitoring and evaluation (M&E) system provides information to measure and track progress and success, data to guide strategic planning, and refine program implementation. The M&E system also helps to allocate and re-allocate resources for optimum use. UP TSU supported the GoUP in strengthening government data systems to monitor the rollout of new contraceptives. In addition, program data captured by UP TSU helped provide early indications that aided strategic decision making.

The UP TSU provided techno-managerial support for data collection, analyses, interpretation and dissemination for optimum utilization of the results for decision making. Some of the areas in which support was provided to the State are:

01 A data collection and collation mechanism for injectable clients' telephone numbers from all facilities to be shared with Antara Careline on a weekly basis so that timely telephonic counselling could be offered to the clients. This support was provided in the initial period of the rollout as it was important to understand the clients experiences with the new method and address any concerns.

02 Antara register was redesigned for better capture of client data. A provision for recording the 5th and 6th dose was added to the register. Facility staff were oriented on capturing the client information in the register.

03 To monitor the availability of supplies, FP-LMIS was strengthened with periodic stock correction exercises to ensure the correctness of contraceptive availability data.

04 To monitor the trainings of the doctors and staff nurses, the training data was captured from all districts and new contraceptive training data was updated on the UP Human Resource Management System "Manav Sampada".

05 Facility-strengthening checklist data was captured and analysed to identify the gaps and areas which needed system-level improvements.

06 Various rounds of data validation, correction and updation were carried out to ensure that correct service update data is reflected on HMIS and UPHMIS.

07 Data related to new contraceptives was regularly analysed. The methods used and findings were shared with NHM at various state and district platforms to provide updates on the progress and highlight areas that needed attention.

08 District specific indicators from survey data (NFHS) were analysed to identify geographies that needed higher focus.

Administration of Antara dose at the Health Facility

1

The client is accompanied by ASHA to the health facility if Antara injectable is chosen as a method of choice.

2

The couple is counselled on importance of FP and FP methods.

3

Client screening is done through the MEC wheel.

4

Weight of the client is checked before administering the Antara dose.

5

BP of the client is measured before administering the Antara dose.

6

Antara dose administered to the client after found suitable in screening.

7

MPA card is filled and handed over to the client.

8

The client is informed about the schedule of the next dose of Antara.

Learnings and Key Results

Facility strengthening, alongwith community interventions are essential when new contraceptive methods are introduced into a program. The whole site facility team orientation and subsequent mentoring created a common understanding among all cadres of healthcare staff on new methods and an enabling environment for all members to share correct information and optimize services. The mentoring visits helped create a strong rapport with UP TSU teams, giving facility teams the confidence to reach out post mentoring for any challenges or queries they faced in relation to new contraceptives service provisioning. Multiple rounds of facility visits also ensured timely identification and addressing issues that need highlighting to the GoUP team at the state level. This accelerated systemic improvements, strengthening the overall program around new contraceptives and family planning. This was further supported by training the FLWs on new contraceptives and connecting them to the Careline so that women accepting new contraceptives also had the required support available at the community level. This also helped link women back to the facilities in case any further follow-up was required.

Between August 2017 to March 2021, 867000 Antara doses and 2.3 million cycles of Chhaya were accepted by couples (Table 2). More than 10,000 facilities across the State were offering new contraceptives as of March 2021. More than 28,000 service providers have been oriented on new contraceptives till March 2021. (source: HMIS).

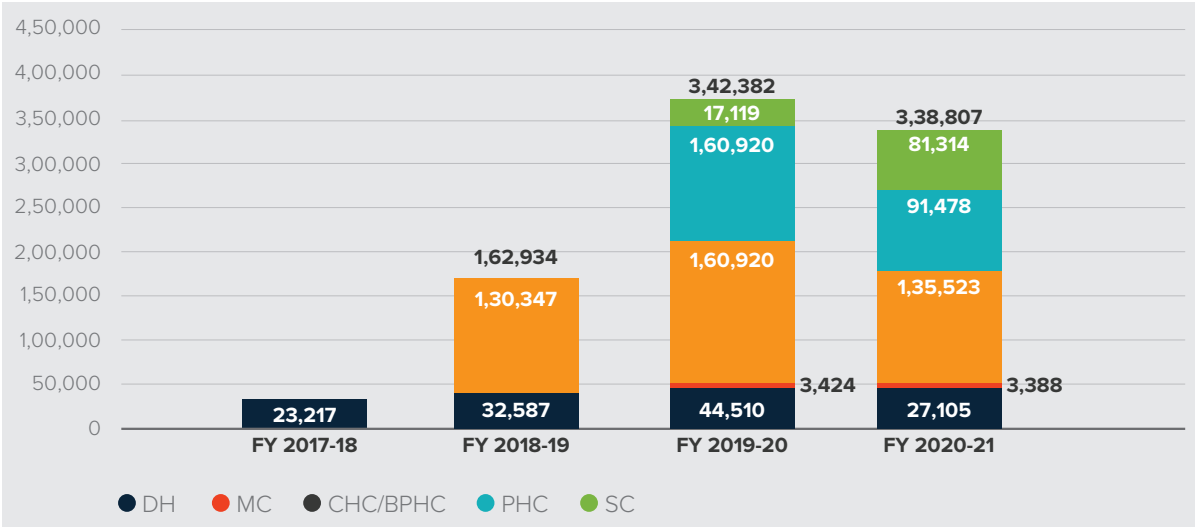
Table 2: Year wise doses uptake of new contraceptives

New Contraceptives	2017-18	2018-19	2019-20	2020-21	Total
Total Antara Doses	23,217	1,62,934	3,42,382	3,38,807	**8,67,340**
Total Chhaya Strips	2,12,948	2,63,438	6,93,530	12,01,168	**23,71,084**

Figures 14 Indicates the Antara doses administered by facility type. There is a gradual increase in Antara uptake over the years. In FY 2020-21, 24% of total Antara doses were administered through sub centre.

Figure 15 shows the increase in usage of Antara and Chhaya as compared to other services. There is tremendous increase in Antara and Chhaya compared to other method.

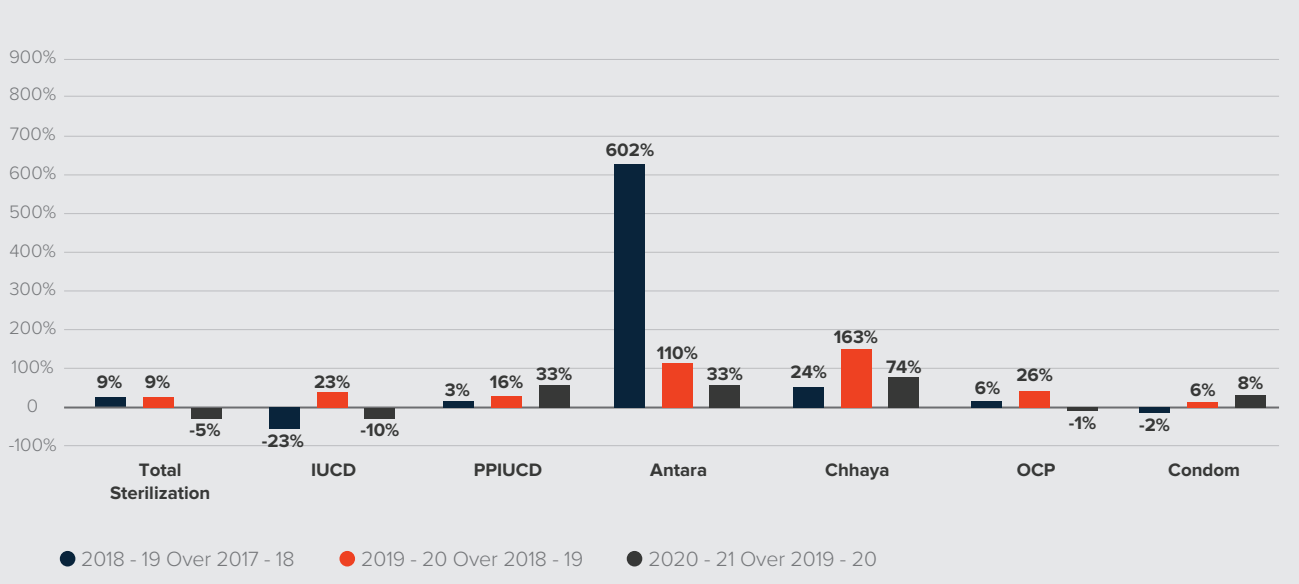
Figure 14: Antara doses administered by facility type



Between August 2017 to March 2021,

8,67,000 ANTARA DOSES AND 2.3 MILLION CYCLES OF CHHAYA WERE ACCEPTED BY COUPLES.

Figure 15: Increase in Antara and Chhaya compared to other services



WAY FORWARD

The focus going forward will be to bring new contraceptives closer to the community making the methods available till the SC level (~20,000+ facilities with a focus on Health and Wellness Centres). Improving the quality of care across all levels of facilities will continue to be an important area of focus. Work towards strengthening counselling for voluntary and improved decision making and strengthening the provision of accurate information to clients will be carried out. A gender and equity perspective would be integrated into the training modules and training packages for health care providers. The Antaraal Diwas (Spacing Days) approach will be sustained to create assured services for all spacing methods.

A statewide integrated call centre will be strengthened to offer information and counselling on all family planning methods and referral linkages for services. The algorithms and counselling module used by Careline will be transitioned to the integrated call centre. A feedback system from clients to understand their experiences of accessing information and services from all available platforms will be discussed with GoUP. The client data captured by the call centre will be periodically analysed for programmatic and behavioral insights.

Uninterrupted supplies of contraceptives will be ensured to the last mile by minimizing stock-outs. Innovative supply chain models such as the informed-push model[10], FP kits for FLWs, etc., would be scaled up. 360^0 campaigns for social and behavior change will be designed and implemented to increase demand for family planning methods, including new contraceptives. Engagement with private sector pharmacies would be explored to improve post-abortion and post-partum family planning.

The integrated programming approach will be piloted and gradually adopted across service delivery platforms to reduce missed opportunities. Integration at the community level will entail offering FP services and counselling during all Village Health and Nutrition Days sessions. Immunization days, Home Based Newborn Care (HBNC) visits, community-based events used by Integrated Child Development Services (ICDS) scheme of Women and Child Development (WCD) department, with a continued focus on Antara Diwas.

Integration at the facility level will entail integration of FP counselling women in the OPD during antenatal check-ups, women in the post-natal ward, and women coming for immunization of their children. Mentoring will support the use of strategically designed, field-tested communication materials and job aids by doctors, nurses and counsellors.

The overall aim is to **reduce unmet need, improve Modern Contraceptive Prevalence Rate (mCPR), improve client satisfaction to optimum levels, and improve acceptability and continuation of family planning methods** to meet these goals.

The overall aim is to reduce unmet need, improve Modern Contraceptive Prevalence Rate (mCPR), improve client satisfaction to optimum levels, and improve acceptability and continuation of family planning methods to meet these goals.

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6. Reference manual for injectable contraceptive (DMPA), March 2016, Family planning division, MoHFW, GoI

7. Social marketing may broadly be defined as the application of marketing techniques to socialproblems. It covers a wide variety of disciplines including health education, advertising, economics, business management, scientific research, systems analysis, community organization, psychology and epidemiology. Social marketing aims to persuade or motivate people to adopt specific courses of action or behaviour which are generally accepted as being beneficial. It is “the design, implementation and control of programmes seeking to increase the acceptability of a social idea or practice in a target group(s)” (Kotler 1975)

8. Ministry of Health and Family Welfare, Government of India, Press Information Bureau. Health Ministry Launches Two New Contraceptives. September 5, 2017 https://pib.gov.in/newsite/PrintRelease.aspx?relid=170537 (accessed on February 10, 2020)

9. State Innovations in Family Planning Services Project Agency (SIFPSA) has been a joint venture of the Government of India, USAID and Government of Uttar Pradesh under Indo-US bilateral agreement for implementing the Innovations in Family Planning Services (IFPS) project in the State.

10. ‘Informed Push’ supply chain models (IPM): commodities are distributed to health clinics on a predetermined delivery schedule without first requiring an initiating order from clinics. This is also referred to as ‘vendor managed inventory system,’ ‘direct delivery,’ ‘direct distribution,’ and ‘Delivery Team Topping Up (DTTU) systems.’

Contact Details

India Health Action Trust

No.8, “VK Commerce”,
3rd Main Road,
KSSIDC Industrial Estate, Rajajinagar,
Bengaluru – 560 010,
Karnataka, India
+91-80-23409698
Email: contactus@ihat.in
Website: https://www.ihat.in

Uttar Pradesh Technical Support Unit

India Health Action Trust
404, 4th Floor,
Ratan Square No. 20-A,
Vidhan Sabha Marg,
Lucknow-226001, Uttar Pradesh, India
Phone: +91-522-4922350 / 4931777

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