

Quality of family planning services in UP and Bihar: Learnings and future opportunities



1 Background

India has witnessed an eight-percentage point increase in the modern contraceptive prevalence rate (mCPR), from 48% in 2015-16 (NFHS-4) to 56% in 2019-21 (NFHS-5). In particular, states like Uttar Pradesh (UP) and Bihar have witnessed a significant rise in mCPR from NFHS-4 to NFHS-5 (i.e. 32% to 44% in UP and 23% to 45% in Bihar). However, contraceptive prevalence of effective and newly introduced reversible contraceptive methods remained low (from 0.4% to 1.2% Injectable (Antara) use in UP, and 0.3% to 1.1% Injectable use in Bihar from NFHS-4 to NFHS-5). In addition, the data from state surveys suggested that while 60.9% in UP and 55.0% in Bihar had heard about injectable, correct knowledge about its dosage remained low (21.3% in UP; no reference data for Bihar). Awareness about weekly pill (Chhaya) was even lower (18.3% in UP and 15% in Bihar), as was correct knowledge about its usage among currently married women of reproductive age (CMWRA) (1.4% in UP and 2.0% in Bihar). Furthermore, despite the gains in mCPR in both states, the levels are still far from national average suggesting the challenges with individuals' access and continued use behaviors. For instance, the data from NFHS-5 indicates that frontline health workers (FLWs) reached out to only 25% of female non-users in UP and 20% female non-users of family planning (FP) in Bihar. As per NFHS-5, 54% current users of selected modern contraceptive methods (Sterilization, IUCD, Pill) in UP and 35% in Bihar who started last episode of use within 5 years preceding the survey, were ever informed about possible side effects or problems of that method, what to do if they experience side effects and other family planning methods they could use. Besides the outreach and client's report of method

Key progress in availability of trained Human Resources (HR) and Fixed Day for FP Services in UP (2017-2021)

1

Trained lap/minilap providers increased: from 1 provider for 49,000 Currently Married Women of Reproductive Age 15-49 years (CMWRA) to 45,000 CMWRA

2

Trained Injectable (Antara) /Chhaya providers increased: from 1 provider for 8,000 CMWRA to 4,200 CMWRA

3

Availability of counselors increased: from 1 counselor for 157,000 CMWRA to 72,000 CMWRA

4

Annual number of Fixed Day Services (FDS) increased: from 1 FDS per 5,000 CMWRA to 3,600 CMWRA

information, there is lack of information on quality of care in the provision of FP services, in many large-scale surveys including NFHS. Examining the quality of care is critical to further accelerate progress in FP, as the improved quality not only attracts new contraceptive users, but the effort sustains the existing users (Assaf et al., 2017; Tessema et al., 2016).

This brief provides an overview on the progress made in improving service quality under family planning program using data from individual and facility surveys conducted in both UP and Bihar. This overview is nested within the modified FP quality of care framework by Jain (Jain, A.K., 2017), which focuses on structure (including trained human resources and availability of equipment and methods) and the service giving process (which includes information exchange with clients and interpersonal relations to improve the quality of care in health interventions).

2 How has the program approached to improve the quality of services?

In aligning their goals and objectives with national quality improvement programs like LaQshya (MoHFW, 2017) and Kayakalp (Kayakalp: ND), the state governments of UP and Bihar have made several efforts to improve the availability, quality, and utilization of FP services by improving the availability of trained human resources, providing adequate equipment and supplies, and reaching individuals at their doorstep for service delivery over the last 5 years. The State Quality Assurance Committees (SQACs), the District Quality Assurance Committee (DQACs), and the Quality Team at the First Referral Unit (FRU) under the LaQshya program have also been active in quality assurance. In addition, the Technical Support Units (TSUs) in both states have been providing support like preparing training modules for counselors, facilitation and hand-holding support in providers' training, identification of facility level gaps and guidance to enable the facility to qualify for LaQshya certification. These inputs would have contributed to improvement in the availability and quality of FP services.

3 Methods

We analyzed data from a recent state-wide survey among 12,200 CMWRA from UP and 22,668 CMWRA from Bihar, as well as data from 496 health facilities catering to the surveyed population in UP and 557 health facilities in Bihar.

The public health facilities (CHC and above) were assessed for their FP service readiness and three key indicators were used. This includes:

1. availability of contraceptive methods;
2. availability of equipment;
3. availability of infection prevention (IP) materials.

In addition, CMWRA data was used to assess their correct knowledge and usage of new modern spacing methods (all women), and quality of care/counselling received on sterilization, injectable, Intrauterine Contraceptive Devices (IUCDs), and pills (for those who started using these methods since January 2018).

4 What have we learned?

Some of the key learnings emerged from the existing data sources are presented below.

Expanded coverage of service provisioning

- The FP programs have increased the basket of choice for contraceptive methods and ensured their availability across all facilities in both states. In UP, facility assessment data showed substantial expansion in the availability of new contraceptives over past three years at Community Health Centre (CHCs) and above [Figure 1A]. On average, the number of methods available in each facility has also increased, from three in 2018 to five in 2021. About 66% of facilities had more than five methods available at the time of the study. Similarly in Bihar, availability of FP commodities and newly introduced contraceptives like Centchroman (availability increased from 76% in 2019 to 85% facilities in 2021) has improved during past three years (Table 2).
- The availability of essential equipment for sterilization and IUCDs improved between 2018 and 2021 across all levels of facilities in UP. Out of 12 essential equipment, the average number of equipment available for IUCDs in all facilities increased from seven in 2018 to nine in 2021 and has remained more or less the same as far as LAP services are concerned [Table 1].
- In Bihar, during 2017-2021, IUCD kit availability increased (IUCD 380A- 74% to 91% and IUCD 375- 36% to 92%) across all levels of facilities. Sterilization services provided by empaneled government doctors have also shown increase in last 2 years in both L2 (L2 includes CHC, PHC and RH; 48% in 2019 to 50% in 2021) and L3 (L3 includes DH and SDH; 63% in 2019 to 71% in 2021) facilities. (Table 2)
- The availability of basic infection prevention (IP) materials has increased by 15 percentage points in UP, from 18% in 2018 to 33% in 2021 [Table 1].

Assaf, S., et al., 2017. <https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-017-2287-z.pdf>

Tessema, G.A., et al., 2016. <https://doi.org/10.1371/journal.pone.0165627>

Jain, A.K. (2017) Quality of Care in the Context of Rights-Based Family Planning, Policy Brief, Population Council, New York.

MoHFW, 2017: https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCH_MH_Guidelines/LaQshya-Guidelines.pdf

Kayakalp, ND: https://nhm.gov.in/images/pdf/in-focus/Implementation_Guidebook_for_Kayakalp.pdf

Table 1: Level of facility readiness by availability of type of method, availability of trained provider, availability of equipment, availability of commodities, and availability of IP material in UP

Items	Year	DH n = 66	FRU CHC n = 48	CHC n = 175	Total mean score/percentage N = 289
¹ Mean number of FP methods (minimum–maximum)	2018	4.4 (0–6)	3.3 (2–4)	3.1 (0–6)	3.5 (0–6)
	2021	5.1 (0–6)	4.6 (0–6)	4.6 (0–6)	4.7 (0–6)
² Mean number of methods per facility for which provider is trained (minimum–maximum)	2018	2.5 (0–3)	2.3 (1–3)	1.8 (0–3)	2.1 (0–3)
	2021	2.8 (0–3)	2.5 (0–3)	2.3 (1–3)	2.4 (0–3)
Mean availability of essential equipment					
Sterilization (Mini-LAP) (minimum–maximum)	2018	7.1 (0–11)	4.0 (0–11)	1.4 (0–11)	3.2 (0–11)
	2021	8.4 (0–11)	4.8 (0–11)	2.2 (0–11)	4.1 (0–11)
Sterilization (LAP) (minimum–maximum)	2018	7.1 (0–12)	7.2 (0–12)	3.3 (0–12)	4.8 (0–12)
	2021	7.9 (0–12)	7.1 (0–12)	3.7 (0–12)	5.2 (0–12)
IUCD/post-partum IUCD (PPIUCD) (mean) (minimum–maximum)	2018	8.7 (0–12)	8.6 (1–12)	7.0 (0–12)	7.6 (0–12)
	2021	10.4 (0–12)	10.1 (0–12)	8.9 (0–12)	9.5 (0–12)
³ Mean availability of IP materials (minimum–maximum)	2018	4.0 (1–5)	3.2 (1–5)	1.9 (0–5)	2.6 (0–5)
	2021	4.2 (0–5)	3.7 (0–5)	2.3 (0–5)	2.9 (0–5)
Percentage of facilities having all IP materials	2018	43.9	18.8	8.6	18.3
	2021	62.1	43.8	18.9	32.9
Percentage of facilities with available commodities					
Condoms	2018	68.2	70.8	76.0	73.4
	2021	87.9	64.6	77.1	77.5
Emergency Contraceptive Pill (ECP)	2018	51.5	54.2	61.1	57.8
	2021	80.3	66.7	73.1	73.7
Oral Contraceptive Pill (OCP)	2018	56.1	60.4	69.1	64.7
	2021	80.3	64.6	71.4	72.3
Injectable (Antara)	2018	68.2	0.0	2.3	17.0
	2021	87.9	72.9	76.0	78.2
Centchroman (Chhaya)	2018	66.7	0.0	1.7	16.3
	2021	71.2	60.4	61.7	63.7
IUCD-375/380-A	2018	65.2	79.2	72.6	72.0
	2021	90.9	66.7	80.0	80.3
⁴ Percentage of facilities with 5+ methods available	2018	54.5	0	1.1	13.2
	2021	78.8	60.4	62.3	65.7
Percentage of facilities having a Quality Assurance Committee	2018	–	–	–	–
	2021	95.5	89.6	78.3	84.1
Percentage of facilities having a Quality Improvement Plan	2018	–	–	–	–
	2021	95.5	89.6	78.3	84.1

2018: Facility mapping data from UPTSU; 2021: Facility assessment data from FP survey.

¹ Mean number of FP methods (includes sterilization, IUCD/PPIUCD insertion, injectable [Antara], OCP, Chhaya, and condoms) available at the facility.

² Mean number of methods per facility for which the provider is trained (health facilities at least having providers trained in sterilization, IUCD/PPIUCD insertion, and newer contraceptives: injectable [Antara] and weekly pills [Chhaya]).

³ Mean availability of IP materials includes handwashing equipment, bleach, gloves, facemasks, and soap.

⁴ None of the FRU-CHC has 5 or more methods available in 2018, however about 50% facilities has 4 FP methods available.

Table 2: Level of facility readiness by availability of functional FP Operation Theatre (OT), availability of trained provider, availability of designated FP corner, and availability of commodities, in Bihar

Year	2019			2021					
Facility type	No. of facilities assessed	No. of facilities with functional FP OT (% among facility type)		No. of facilities assessed	No. of facilities with functional FP OT (% among facility type)				
PHC	369	300 (81%)		238	191 (80%)				
CHC	46	40 (87%)		180	170 (94%)				
RH	62	47 (76%)		59	52 (88%)				
SDH	39	21 (54%)		44	25 (57%)				
DH	36	1 (3%)		36	2 (6%)				
Female sterilization services provided by:									
	% L2 facilities			% L3 facilities					
	2019	2021		2019	2021				
	(N = 477)	(N = 477)		(N = 75)	(N = 80)				
Empaneled providers (among government doctors)	48%	50%		63%	71%				
Accredited private providers with own set-up	22%	28%		8%	6%				
Accredited private providers using government set-up	8%	8%		3%	3%				
Female sterilization services provided by (number of providers among the facilities that reported giving FP services):									
	No. of providers in L2		No. of providers in L3						
	2019	2021	2019	2021					
Empaneled providers (among government doctors)	280	274	155	161					
Accredited private providers with own set-up	142	142	8	8					
Accredited private providers using government set-up	43	43	2	2					
% of facilities with designated FP corner:									
	2019			2021					
L2 facilities	78%			81%					
L3 facilities	89%			90%					
% of facilities (PHC and above by L2 and L3) with available commodities in Bihar:									
	2017			2019			2021		
	Overall	L2%	L3%	Overall	L2%	L3%	Overall	L2%	L3%
	N = 550	N = 476	N = 74	N = 552	N = 477	N = 75	N = 557	N = 477	N = 80
OCP	53%	57%	31%	74%	77%	55%	79%	79%	79%
Centchroman (Chhaya)				76%	79%	55%	85%	85%	83%
ECP	48%	50%	35%	24%	24%	23%	77%	78%	71%
Condom	64%	67%	41%	48%	50%	33%	90%	92%	83%
IUCD – 380A	74%	74%	72%	63%	64%	56%	91%	92%	86%
IUCD – 375	36%	35%	43%	76%	77%	68%	92%	92%	89%

Figure 1A: Percent public health facilities that had newly introduced contraceptive methods in UP, 2018 and 2021

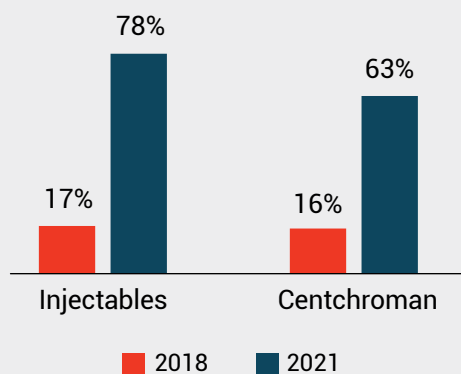
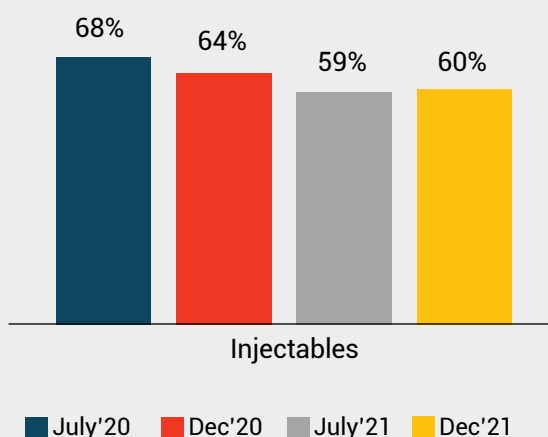


Figure 1B. Public health facilities (Primary Health Centers and above) where newly introduced contraceptive methods were available in Bihar during 2020 to 2021



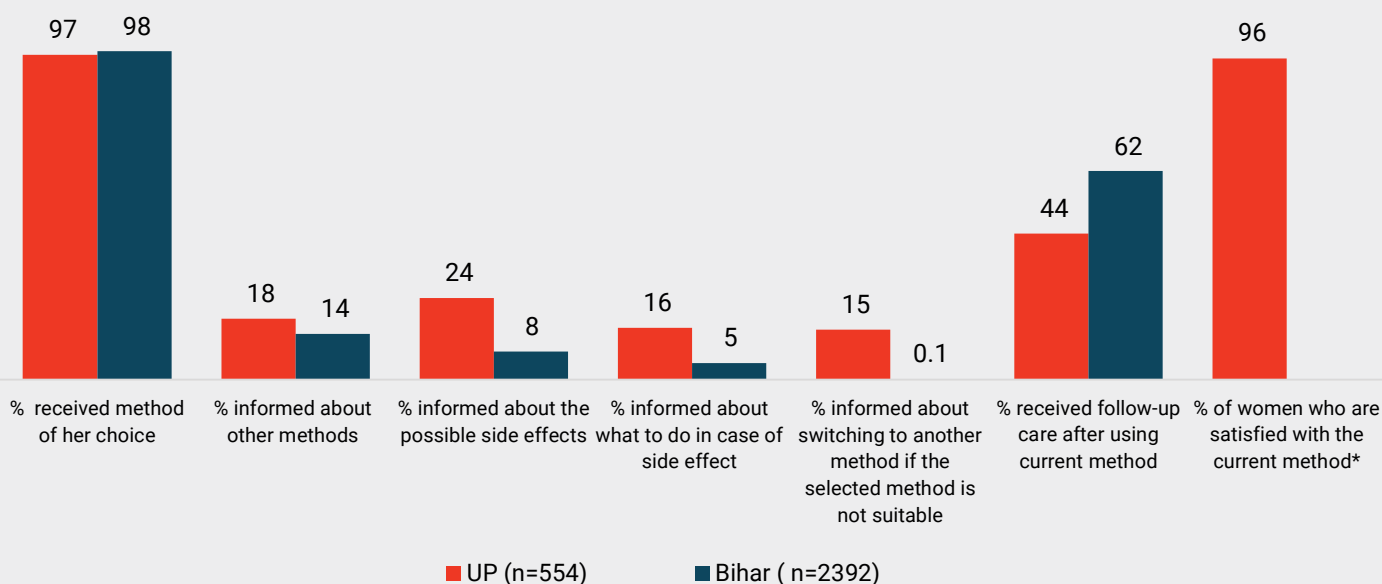
Source- FP fortnight assessment by TSU



Quality of facility-level FP counseling remains a concern

- About 20% of the facility providers counselled women on Chhaya and Antara.
- After adopting a method like sterilization/IUCDs/injectable/pills, only about two-fifths of women in UP and two-thirds of women in Bihar had a follow-up visit to the facility [Figure 2].
- Additional in-depth analysis of data suggests a slightly higher proportion of women who had received their methods from a medical college/district hospital (DH) or from a private hospital reported going for follow-up visits than women who received from primary healthcare centers (PHCs)/other places in UP.
- 24% of women in UP and 8% women in Bihar reported receiving information on side effects and 16% of women in UP and 5% of women in Bihar had been informed about what to do in case of side-effects. Only 5% of women in UP and less than 1% in Bihar were informed about switching to another effective method during their interaction with the provider.

Figure 2: Women who received quality of care/counseling, by provider, at the time of receiving an FP method from facility during 2018 onwards in UP and Bihar (%)



Source: CMWRA survey conducted in UP and Bihar

5 What are the opportunities to improve quality of care?

The opportunities to improve the quality of care include perspectives of person-centered care, continuum of care, technical quality, and going beyond the medicine/method.

- A. Enhancing person-centered care can include involving patients in shared decision-making with health care providers. To do so, providers should enhance their skill to ensure client-centered counseling (such as assessing the need for contraception; suggesting suitable methods; and informing about side-effects and management, as well as when and how to choose an alternative method if unsatisfied with the current method) to support women in adopting a method of their choice.
- Programs should follow this with tracking of individuals (either by establishing unitized tracking or setting up a call center) to ensure method uptake, early detection and timely management of side effects, continuity, and lower risk of discontinuation.
 - Along with person-centered care, ensuring regular monitoring of the same becomes important. Improvements in person-centered care may be correlated with increased adherence to modern FP methods, shorter labors, better ability to cope with pain, decreased incidence of operative births, increased incidence of spontaneous vaginal delivery, increased maternal satisfaction, and less anxiety.
 - Programs should also focus on ongoing capacity building, as this can greatly enhance the ability
- B. As there is a well-established relationship between FP use and other maternal and newborn health outcomes, providers should give care across the continuum. As the evidence have shown higher likelihood of complication among women who adopted sterilization or IUCD compared to other methods, the quality of care aspects should also include follow-up in the community to ensure continuity of complication management as suggested by the provider as well as to identify if a new complication have been developed as a result of method use.
- C. Improving the technical quality of routine and emergency clinical interventions according to defined standards is essential to ensure quality. There needs to be investment from government to improve the capacity of the health-system workforce at different levels (facility and community) and to provide correct and comprehensive information to women in the community. To improve the technical quality, existing state-level, district-level, and sub-district-level committees (SQACs, DQACs, District Health Society (DHS), and Monthly MOIC Review Meetings (MMRMs)) can be roped in by programs for continuous understanding of skills improvement areas of various cadres and other systemic and programmatic gaps.



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