Ipas DEVELOPMENT FOUNDATION

BUILDING A RESILIENT FAMILY PLANNING PROGRAM IN INDIA

Lessons from navigating the impact of COVID-19 on FP: Case studies from Rajasthan and Madhya Pradesh

The COVID-19 pandemic impacted the health systems of countries across the globe, including India's, and disrupted access to Family Planning (FP) information and services. Based on estimates from 2020, in the best-case scenario, the pandemic was expected to disrupt contraceptive use for about 24.55 million couples in India, which would consequently result in 1.94 million unintended pregnancies.[1] An analysis of data from the Health Management Information System (HMIS) indicates that there was a 43% decline in Injectable contraceptives, 50% decline in intrauterine contraceptive devices (IUCDs), 21% decline in oral contraceptives, and 59% decline in weekly contraceptive pills (Centchroman) between April to June 2020, compared to the same period in 2019.[2] This was also the period that was marked by stringent lockdowns involving restrictions in movement of both people and goods, thereby impacting supply chains of commodities and limiting access to FP services.

In April 2020, the Ministry of Health and Family Welfare (MoHFW) rolled out guidelines which declared FP services as essential to be provided during COVID-19.[3] While these guidelines were in place, in 2021, with the advent of the second wave in India came additional consequences of a higher number of COVID-19 cases and increased deaths. This resulted in reduced delivery of essential services, including FP services. Subsequently, in October 2021, MoHFW released guidelines on providing FP services during and post the pandemic which included protocols for sterilization, IUCD, Antara Injectable services, and distribution of condoms and pills. These guidelines also placed emphasis on strengthening self-care efforts for FP and provided directions for FP programme management and ensuring commodity security. Specifically, newer strategies such as tele-consultations for screening clients for first dose Antara Injectable were adopted into national guidelines for FP.[4]

While these adaptations to the FP program were made at the national level, there were also strategies deployed across different states in India to continue providing FP services during the pandemic. However, there is limited evidence/documentation of these strategies that emerged from the state health system's response to the impact of COVID-19 on FP. It is critical to understand these health system responses and draw out learnings which have the potential of informing and building a more resilient FP program that can withstand disasters.

In alignment with the objective of providing learnings for building back better from the impact of the pandemic, Ipas Development Foundation (IDF) adopted an exploratory qualitative research design using in-depth interviews (IDIs) with FP program stakeholders in Rajasthan and Madhya Pradesh. A purposive sampling technique was used to identify respondents across different levels of the health system (state, district, facility, and community) responsible for executing the FP program at these levels. A total of 49 IDIs were completed – 24 in Rajasthan and 25 in Madhya Pradesh.

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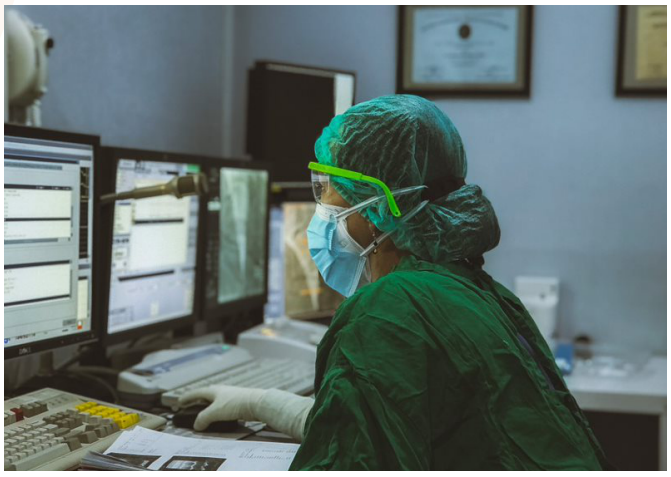
[1] *V.S. Chandrashekar, Sagar A. Impact of COVID 19 on India's Family Planning Program. India: Foundation for Reproductive Health Services India, 2020*

[2] *Singh, S., Muttreja, P. (2022). Family Planning in India during the COVID-19 Pandemic. In: Pachauri, S., Pachauri, A. (eds) Health Dimensions of COVID-19 in India and Beyond.*

[3] *Ministry of Health and Family Welfare. Enabling Delivery of Essential Health Services during the COVID 19 Outbreak: Guidance note. India: MoHFW, Govt. of India, 2020.*

[4] *Ministry of Health and Family Welfare. Guidelines for provision of Family Planning services during and post COVID-19 Pandemic India: MoHFW, Govt. of India, 2021.*

The findings from the study in both states indicate an impact on FP service availability and accessibility during the initial period of the pandemic when there were lockdowns resulting in the suspension of FP services. While the declaration of FP services as essential had been made, the translation into implementation at the ground level was reportedly delayed as the entire system was geared towards tackling the impact of the pandemic. This diversion of resources towards COVID-19 management also occurred during the first few months of the second wave in India which again affected FP service availability during that time. Specifically, facility-based FP services including sterilization and IUCD services were impacted since mobility was restricted, hampering clients' access to facilities; alongside, facilities were instructed to deal only with emergency cases which resulted in a reduction of FP services. Given the diversion of the workforce towards COVID-19 management, there was limited client-provider interaction time, impacting FP counselling as well. Overall, during the pandemic, it was the feasibility of services that shaped the choice of contraceptives available to clients. Temporary short-acting methods that could reach the doorstep of clients were being made available more easily than methods that required clients to visit facilities.



While there was a system-level impact of the pandemic on FP, there were also shifts reported in provider and community behaviour, both marked by fear of COVID-19. For providers, this translated into hesitancy in delivering services, which was largely allayed by the time of the second wave (by which time healthcare workers had been vaccinated). In Rajasthan, for the community, this fear reportedly affected the family planning behaviours of some people who shifted towards temporary methods (as opposed to their earlier preferred permanent methods). This was not just due to the non-availability of permanent methods but also because they feared that the fatal nature of COVID-19 would affect their living children and therefore they wanted the option of future conception by using temporary methods. In Madhya Pradesh, the fear among the community also translated into a mistrust with the health system with reports of frontline workers being driven away by the community at the time of household visits.

While the perceived impact was evident, there were also practices that the health system adopted during this period that helped navigate the pandemic. Emulating the MoHFW guidelines were two practices reported to have been implemented in both Rajasthan and Madhya Pradesh – one was linking the distribution of contraceptives (condoms and pills) with COVID-19 doorstep surveys and the other was limiting the cases of Fixed Day Static (FDS) services to 10 (from the earlier limit of 30) during peak COVID-19 periods. Aside from these, there were other area-specific strategies adopted that have larger learnings for the system. There was a move towards decentralizing decision-making to lower levels of the health system wherein district and facility officials were encouraged to take decisions regarding the implementation of FP services based on the situation at hand. In some areas, officials set up a referral mechanism to direct clients of sterilization towards green zone facilities in cases of their current areas being red zones. There were also alternate methods of supplying FP commodities being leveraged when supply was restricted. In Rajasthan, vehicles supplying COVID-19 vaccines and samples were used to deliver FP commodities and in places where there were stockouts, there were mechanisms in place for health facilities to procure commodities through local manufacturers/private sellers. Additionally, services were being made available with the support of the Border Security Force (BSF) in one of the districts through medical

vans equipped to provide FP services. In Madhya Pradesh, private vehicle support was being provided to clients who required to reach a facility for accessing FP services. Technology was also being heavily leveraged to increase access to FP services during COVID-19 (tele-consultations for Injectable contraceptive first dose). Besides the integration of technology into service delivery, there was the adoption of it into program management as well wherein video conferences, and WhatsApp groups became the platforms for program planning.

Based on the findings from the states, some lessons have been drawn out that have the potential of further strengthening the FP program and making FP disaster-proof. These are also complementary strategies to India's FP2030 vision of building a more resilient health system for achieving universal access to reproductive health; they include:

Reaching the client vs. the client reaching the system: Findings from the study demonstrate how the health system made efforts in **bringing FP services closer to the community** at a time when the ability of clients to reach the system was severely restricted. This was done by continuing doorstep delivery of condoms and pills as well as decentralizing the provision of Antara Injectable services through tele-consultation of the first dose. With the FP2030 vision of expanding the basket of choice and the ongoing capacity building of **Health and Wellness Centres (HWCs), there exists a great opportunity to reach the last mile** that must be further tapped into.

Continuing accelerated adoption of technology: COVID-19 accelerated the adoption of technology into multiple areas of the FP program including planning and delivery of FP services. The **platform e-Sanjeevani** is being used for tele-consultations with doctors for provision of FP services to the community and on the supply side, the Family Planning Logistics Management Information System **(FP-LMIS)** is used for commodity management. With these digital initiatives in place, there is both decentralization of services as well as decentralization of management processes. This **pace of technology adoption needs to be maintained and implemented** moving forward as well to build a more resilient FP program.

Decentralizing power and decision-making: The findings demonstrate that in some areas where staff at the district and facility levels of the health system were given the autonomy to make decisions regarding FP service provision that were in accordance with the situation at hand (i.e., the pandemic), were reportedly able to navigate service delivery more effectively. Therefore, it is **important to empower ground-level staff to take decisions that they feel would be best suited to the needs of their communities since they are the first responders to disasters in a community**.

Pre-emptively building confidence of health workers: While one aspect of pandemic management is ensuring decentralized decision-making, there is also the aspect of addressing the individual fears among the health workforce. As was heard from providers themselves, it was only by the time of the second wave that the initial fears were allayed as health workers had been vaccinated. It is **important to therefore introduce interventions (both medical and behavioural) to address hesitancy among the workforce** early on in disaster situations as they would be the main actors responsible for providing all health services, including FP.

Building trust between the system and the community: One of the consequences of the pandemic was the displacement of public trust in the health system. Frontline workers attempted to rebuild this trust through the duration of the pandemic by themselves modelling COVID-appropriate behaviour and giving their own examples of being vaccinated to encourage community members to do the same. Trust in the health system is a critical factor for success of any programme, including that of FP and this becomes even more critical during disaster situations. Therefore, it is **important to build public trust through accurate messaging and effective actions since disaster preparedness can only be achieved through communities and systems working together**.

Maintaining and managing commodities stock: The respondents of the study recognized the importance of maintaining a buffer stock in case of any adverse events. This has been adopted as a strategy at the national level as well and has been an important learning from the impact of the pandemic. This **should continue to be implemented for ensuring uninterrupted access to contraceptives**.

Identifying opportunities for intersectoral convergence: One of the innovative ways in which commodities were being supplied was through intersectoral convergence (wherein BSF was involved in delivery of FP services). This is a strong example of how associated workforces can come together to strengthen FP services. Another way in which strengthening can be achieved is through **greater task sharing of FP services between Anganwadi Workers (AWWs) and ASHAs** as well as through **greater engagement of the Panchayati Raj Institutions (PRIs)**. Intersectoral convergence is a critical way of ensuring access to family planning services, particularly in disaster situations.

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