

POLICY BRIEF

This policy brief is based on the external evaluation of a pilot intervention aimed at increasing access to Long Acting Reversible Contraception (LARC) in Ramechhap, a hill district in rural Nepal with lower than average use of family planning services.

The pilot was implemented by the Ministry of Health, with technical support from the Nepal Health Sector Support Programme (NHSSP). The evaluation was conducted by HERD International and Mott MacDonald. DFID and USAID co-financed the pilot and its evaluation as part of their wider support to Family Planning in Nepal.

This policy brief summarises the main findings and policy implications of the evaluation. Policy makers and interested readers are strongly advised to refer to the full evaluation report for important additional detail and context - available at: <http://www.herd.org.np/project/strengthening-nepal-family-planning-programme>

September 2016

Mobilising Visiting Providers to expand access to Long Acting Reversible Contraception in Ramechhap district, Nepal

INDEPENDENT EVALUATION

LARC is an under-utilized contraceptive option in hill and mountain districts (and probably elsewhere in Nepal)

Long Acting Reversible Contraception (LARC) comprises Intra-Uterine Contraceptive Devices (IUCD) and Implants. The advantages of LARC over short term methods of family planning include very high effectiveness, long duration of protection, relatively easy insertion and removal, broad eligibility for women of reproductive age, high acceptability and continuation, limited side effects, and low cost. LARC are therefore a good option for women interested in spacing childbirth. The Nepal Family Planning Programme has included IUCDs and Implants as part of five contraceptives that should be regularly available at all government health facilities up to the level of health post with a birthing centre, where a skilled-birth attendant should be in post.

The reality though is that LARC are not regularly available in many health facilities or these simply deliver a very small number of LARC. This is due to a combination of demand and supply side factors.

- Demand side factors include low awareness of LARC among rural women and limited mobilisation/referral of potential users.
- Supply side barriers include the lack of confidence of many service providers to insert and remove LARC combined with the staff shortages faced by many rural health posts in hill and mountain districts.

What did the pilot intervention attempt to demonstrate?

The pilot attempted to find out if effective information dissemination and community mobilisation combined with a reliable quality service would attract the interest of eligible women to opt for LARC in Ramechhap. Two implementation modalities were tested and evaluated:

- **Modality A** comprised direct provision of LARC by three contracted 'visiting providers' (auxiliary nurse midwives – ANM) in health facilities that do not have a birthing centre (NBC). Since NBCs do not have staff trained in LARC these facilities do not deliver LARC on a regular basis.
- **Modality B** consisted of training (for implant) and coaching (for IUCD) health staff based in health facilities with a birthing centre (BC) in LARC insertion and removal. The training for implant was provided to 12 skilled birth attendants (SBAs)/paramedics of 12 BCs, whereas the coaching on IUCD was delivered to SBAs in 8 BCs in Ramechhap (by the same three visiting providers responsible for modality A). The question being explored in this modality was whether the training and coaching would increase the confidence and competence of SBAs and result in higher LARC provision and uptake in the Birthing Centres.

Pilot implementation and evaluation took place simultaneously (embedded independent evaluation approach) over a period of approximately 8 months.

Summary findings

Significant increase in uptake of LARC for both modalities:

- 1,123 additional LARC users and 4,327 additional CYP.
- Demand for implants was high: 11 times higher than for IUCD.
- Uptake was 5 times higher in the direct provision modality (modality A) in NBCs.
- The pilot confirmed that BCs deliver very few LARC on a regular basis. In 2014 the 8 BCs from Ramechhap delivered just 35 LARC during a period of 8 months.

Both modalities were cost effective.

- Modality A (direct provision) was highly cost effective by the WHO definition and per DALY averted.
- Implants were much more cost effective (8.5 times per DALY averted) than IUCD, mainly because many more implants were inserted than IUCD.
- Implants provide good return on investment: NPR 11.7 (Mod A) and NPR 4.5 (Mod B) for every rupee invested.

High levels of user satisfaction and good service quality.

- In a sample of 76 women interviewed after receiving the LARC service, 90%+ rated service quality and attitude of service providers as good or very good.

Policy implications and recommendations from evaluators

1. **Modality A (direct provision) is worth scaling up** in hill districts (and perhaps also in selected terai or mountain districts) with high unmet need for family planning and with limited supply of LARC from government facilities. It would be more cost-effective and preferable to clients if visiting providers focus on delivery of implants, as IUCD insertion requires hygienic conditions and facility space for vaginal examination that many NBCs cannot offer due to their small size or precarious infrastructure.
2. **LARC campaigns or regular LARC clinics?** The direct provision modality could be provided either through 'campaigns' or through regular and predictable LARC clinics in NBCs throughout the year. The latter option has not been piloted but it is likely to help providers, community mobilisers (FCHVs) and clients better prepare in advance.
3. **Combine supply and demand side efforts.** There is no point in scaling up direct provision of LARC by visiting providers unless an information cum community mobilisation effort is made simultaneously. FCHVs need time to mobilise the different parts of their catchment areas in order to avoid pockets of underserved populations.
4. **Should direct provision focus exclusively on NBCs?** The direct provision modality could probably be extended to cover both BCs and NBCs, particularly in areas where BCs deliver few LARC on a regular basis. This approach would enable coaching of the BC staff by the visiting provider on a day when sufficient numbers of clients are likely to be available, thus overcoming the problem faced during the pilot where there was often an insufficient number of LARC clients in the BC on the day when the coaching would take place.
5. **Modality B achieved lesser results: should it be dropped?** Coaching of BC staff by visiting providers was less cost effective than direct LARC provision mainly because the approach attracted fewer clients. However, regular training and coaching of BC staff remains a priority to optimise the investment made in staffing these facilities. Hence why the approach described above in point 4 looks particularly relevant and promising, so we recommend that it should be piloted.
6. **More performance management is required, particularly in Birthing Centres.** More regular performance management of LARC output in BCs is necessary to ensure that SBAs use their skills and attract clients. The BCs in our study delivered too few LARC for months and months without this information having led to remedial action.
7. **District Health Officers should drive the scale up effort, but need support to do so.** DHOs will need support similar to the one received from NHSSP during the pilot for them to properly plan, oversee and supervise the work of visiting providers and to incorporate the lessons from scale up. DHOs need to place higher attention to proper recording and reporting of family planning to identify low and high performing BCs. Data on FP from the HMIS was found to be very unreliable.

Policy brief prepared following a dissemination workshop held in Kathmandu on 8 July 2016.

HERD International and Mott MacDonald have provided Monitoring and Evaluation services to the Nepal Family Planning Project funded by DFID and USAID.

