

EVALUATION REPORT

Expanding the range of family planning services through comprehensive VSC events (VSC+) in Baitadi and Darchula districts Nepal

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HERD International
Mott MacDonald

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Acronyms

ANM	Auxiliary Nurse Midwife
DHO	District Health Office
FCHV	Female Community Health Volunteers
FHD	Family Health Division
FP	Family Planning
HFOMC	Health Facility Operation and Management Committees
HERD	Health Research and Social Development Forum
HMIS	Health Management Information System
IUCD	Intra-uterine contraceptive device
KII	Key Informant interview
LARC	Long Acting Reversible Contraceptives
LSHTM	London School of Hygiene and Tropical Medicine
MCPR	Modern Contraceptive Prevalence Rate
M&E	Monitoring and Evaluation
MM	Mott MacDonald
MoH	Ministry of Health
MSI	Marie Stopes International
NHRC	Nepal Health Research Council
NHSSP	Nepal Health Sector Support Programme
RA	Research Assistant
SBA	Skilled Birth Attendant
SPN	Sunaulo Pariwar Nepal
SRO	Senior Research Officer
VDC	Village Development Committee
WRA	Women of Reproductive Age

1. Summary of key evaluation findings and recommendations

This is the report of the independent evaluation of a pilot intervention to expand the range of family planning services through comprehensive Voluntary Surgical Contraception (VSC) camps in Baitadi and Darchula, two hill districts of the Far-Western Development Region of Nepal.

Voluntary surgical contraception (VSC) camps are the main or only means for the Ministry of Health¹ to deliver sterilisation services to the rural population of Nepal, particularly in remote locations of hill districts. For many of them the sterilisation services delivered from district hospitals – if and where district hospitals deliver these services - remain largely inaccessible due to distance, cost of travel and disruption to normal life. While traditional VSC camps tended to focus on delivering male and female sterilisation services, this pilot intervention and its evaluation aimed to assess if provision of a wider range of family planning services (VSC, LARC, injectable contraceptives, oral contraceptive pills and counselling) delivered through VSC camps expands availability, choice and uptake of family planning services in rural Nepal. Hence the term ‘VSC+’ to refer to this expanded range of services.

Four sites were selected in each district and the pilot intervention was delivered between August and December 2015 in Baitadi and Darchula districts. Two modalities of implementation were adopted in this pilot:

- **Modality A: Service provision by the DHO in Baitadi.** In Baitadi, a trained surgical team from within the district (district hospital) provided comprehensive VSC+ services through the camps. Four sites were selected for implementing camps – one District hospital, one Primary Healthcare Centre (PHCC) and two health posts (HPs). In the district hospital, a fixed day static approach was adopted where VSC+ services were provided by trained providers of the same facility on fixed days throughout the intervention period. This operating team from the district also provided sterilisation and other contraceptives in the three remotely located facilities where these services are not routinely available.
- **Modality B: Service provision by MSI/SPN in Darchula.** In Darchula a trained surgical team from outside the district travelled to the district health facilities to provide comprehensive VSC+ services. The four sites selected were one district hospital, one peripheral hospital, and two HPs. Marie Stopes International/Sunaulo Pariwar Nepal (hereafter MSI/SPN) was contracted by NHSSP to provide the services. The MSI/SPN team brought with them equipment and supplies that are required and unavailable in the service delivery sites.

¹ Until 2016 and throughout the evaluation study the Ministry of Health was referred to as the Ministry of Health and Population (MoHP). We have maintained the latter name and acronym in the references only.

The target population in both modalities were men and women of reproductive age (WRA) residing in the catchment areas of the selected health facilities.

Findings

Findings are briefly presented herein using the six evaluation questions that were defined for this evaluation. Please refer to Chapter 6 for more detail.

Evaluation Question 1 - Does the provision of an expanded range of FP services through comprehensive camps (VSC+) increase the availability, choice and uptake of FP services in rural Nepal?

Regarding availability, all forms of contraception² plus counselling services were offered in all the VSC+ camps of both Baitadi and Darchula, so the availability and choice of family planning services clearly increased both when compared to the traditional VSC camps and also when compared to the range of services offered from those facilities on a regular basis. Most clients (74% in Baitadi and 60% in Darchula) took less than 2 hours to reach the camps, which seems reasonable in the context of rural, hilly Nepal. The large majority of clients in both districts travelled to the health facilities by foot, whether by choice or because of the transport restrictions experienced in Nepal at the time caused by the fuel crisis.

Did the uptake of family planning increase? By increase in uptake we refer to the additional family planning services that were taken up in the camps and that would have *probably* not been taken up in the absence of the VSC+ camps. We did not attempt to measure the additionality of VSC+ camps in a rigorous manner because neither the methodology nor the available HMIS data allowed for that type of comparison. When we compared the uptake of sterilisations in VSC+ camps with HMIS data on uptake of sterilisation during VSC camps held in previous years we concluded that the numbers of camp users remained roughly similar, although the analysis was inconclusive (see Tables 3.4 and 4.5 and related comments in the findings chapters).

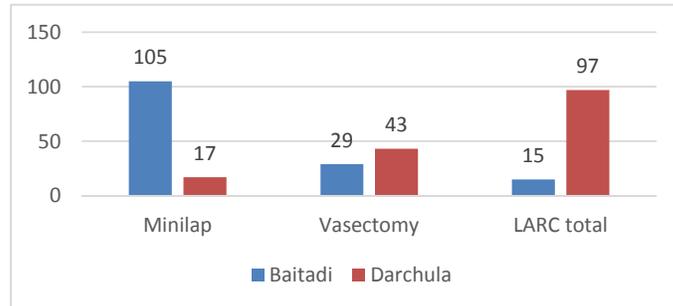
In any case, the uptake of family planning clearly increased as a result of the VSC+ camps, particularly for LARC and sterilisation services. Importantly though, the camps attracted a small proportion of new users, as estimated through exit client interviews – a proxy indicator, as records kept during the camps did not include this information or incompletely so. Specifically, 87% of interviewed clients in Baitadi (21/24) and 90% in Darchula (36/40) reported to have switched family planning methods on the day of the camp, usually from a short term to a longer term method or from a reversible to a permanent method.

Total uptake of family planning services was roughly similar in Baitadi and Darchula where 150 and 169 clients respectively took up services offered at the camps. The average number of clients per camp was 12.4 (Baitadi) and 10.5 (Darchula). As shown in the figure below, while the total uptake of family planning services (LARC and sterilisation combined) for both modalities was quite similar, the majority of clients under modality A (Baitadi) opted for sterilisation (90%), whereas under modality B a larger proportion opted for LARC (58%).

² Condoms, oral contraception pills, injectable Depo-Provera, Long Acting Reversible Contraception (implants and IUCD) and sterilisation.

This difference in uptake by type of service is explained mainly by the modest uptake of LARC in Baitadi and by the surprisingly low uptake of Minilap in Darchula.

Figure 1.1: Comparison of uptake of family planning in Baitadi and Darchula



The reasons for the differences in the choices made by users remain unknown and unexplained by this evaluation. The low uptake of Minilap in Darchula could be linked to provider-induced counselling of women to take LARC rather than Minilap due to the perceived difficulty of referring any women suffering from post-surgical complications to the district hospital in Khalanga (that had been damaged by the 2013 floods) or to Dhangadhi (a secondary referral facility), both of which are located a considerable distance from the camp sites. According to service providers these factors (distance and referral service availability) affected greatly Minilap provision in the Hikila and Latinath camp sites (see discussion in 4.1.5 for more details). In any case, provider behaviour seems to have been the main reason for lower uptake of Minilap, which biased the supply in favour of LARC (particularly implants) with lower risks of complications. To be clear, we do not think that the differences found respond to intrinsic differences between modalities A and B (public versus private provision) but by the specific characteristics of Darchula district that influenced provider behaviour in a particular manner.

The differences in the composition of demand i.e. the relative weight of LARC versus sterilisations under each modality have had a profound effect in the cost effectiveness and cost benefit analysis that will be discussed later when responding to evaluation question 6 (the costing analysis).

Evaluation question 2 - Were the users of VSC+ camps able to choose the FP service/commodity of their choice? Was the choice properly informed through counselling?

The increased availability of family planning services enabled men and women attending the camps to exercise their choice. The exit interviews conducted among a sample of clients (men and women) who had received either sterilisation or LARC showed that all of them had received the family planning service of their choice. Likewise, all the camp users interviewed had received counselling and most of them had been counselled both before and after receiving the service. The privacy and confidentiality of counselling could not be always guaranteed due to lack of adequate space in some facilities, a few of which had been damaged by floods (in Darchula).

Evaluation question 3 - What is the perspective of beneficiaries/clients about quality of services provided through the camps?

The exit interviews showed high levels of satisfaction with the services received. Specifically, all respondents rated the quality of the service and the behaviour of service providers to be either good or very good. As to waiting times for the service, 83% of interviewed clients in Baitadi (20/24) and 47% in Darchula (19/40) reported that either they did not have to wait to receive the service or that the waiting time was reasonable.

Ten clients in each of Baitadi and Darchula were interviewed one month after receiving the service. None of them reported any major complications but 8 out of 10 clients in each district reported minor side effects and discomfort on the days following surgery or insertion.

Observations notes from research assistants show that all family planning commodities were generally available during the camps, with no stock outs being reported. Likewise the camps included all the required equipment and human resources, although a shortage of beds/stretchers was reported in Darchula where some patients had to lie on the floor after the procedure. There was generally good cooperation between service providers and government staff based in the facilities.

Evaluation question 4 - Were the advocacy activities by FCHVs and HFOMC effective in raising awareness of comprehensive FP services on offer and to generate demand among men and women of reproductive age?

The evaluation methods did not allow for a proper assessment of the effectiveness of information dissemination approaches used for the camps, as this would have required a population based survey that was discarded for cost, time and other reasons. We could only assess the effectiveness of dissemination indirectly by asking clients interviewed how they became aware of the VSC+ camps.

There were some differences between both districts even though the reported approach to information dissemination in both districts was in principle the same, namely FM Radio, FCHVs, health facility staff/service providers, HFOMC and posters. Please note that the samples are not representative so percentages shown below should be interpreted carefully. Percentages of respondents may exceed 100% because respondents were allowed to mention more than one source.

In Baitadi, 29% of clients interviewed reported to have learnt about the camp through the FCHV, 25% from the health facility staff and 16% from the FM radio. Surprisingly, 45% of interviewees said they were not aware the camps would deliver other contraceptives in addition to sterilisation at the time of arriving to the camp, which suggests that the information dissemination was not as effective as it might have been and that most clients in Baitadi attended the camp for the specific purpose of being sterilised. The small number of clients who learnt through the FM radio (4/24) is also surprisingly low and may be linked to the language in which the messages were disseminated (Nepali) while the local language is Doteli, but we do not really know.

In Darchula the proportion of people who learnt about the camps by source was quite different to Baitadi. 97% of interviewed clients had heard about the camp through the local

radio and 42% reported to have also heard about the camps from friends. Only 10% said to have heard about the camp from the FCHV and 5% from the health facility staff or service provider (MSI/SPN).

No clients in Baitadi and only one in Darchula reported to have heard about the camp from the HFOMC.

Evaluation question 6 - What are the main costs incurred in the proposed approach? What are the incremental costs incurred when compared with the traditional VSC camps)? Are there any significant differences in the cost of the approach between the two models being tested in Baitadi and Darchula respectively?

We present deliberately the conclusions for question 6 before question 5 as it makes more sense.

The total cost of implementing the pilots was estimated at NPR 7.01 million (US\$ 68,350) over the evaluation period. This figure covers all camp-related costs, including NHSSP supervision costs. The share of modality A in the total costs was 49.8% and 50.2% for modality B. Therefore both modalities costed roughly the same. It was the difference in the proportions of uptake by type of service – LARC versus sterilisations - that determined the differences in the cost effectiveness, cost benefit and scalability of each of the two modalities. This is because sterilisations have a much higher CYP than LARC. The overall investment in the pilot resulted in provision of FP services to 316 users³, providing 3,082 couple years of protection (CYP): 1,800 CYPs for modality A and 1,283 CYPs for modality B.

It is safe to assume that the differences in the proportion of type of services under each modality were largely determined by contextual realities affecting each modality (distance, effectiveness of mobilisation, messages delivered through counselling, availability of referral services in case of complications in Darchula, etc) rather than by the modality of implementation as such. In other words, the same modalities applied to other districts would have most likely achieved a different composition of LARC and sterilisation uptake that would have offered different results in terms of cost effectiveness, cost benefit, cost per LARC/sterilisation and scalability costs.

Both modalities were found to be highly cost-effective (see how this was calculated in chapter 5), although modality A was slightly more cost-effective than modality B because more sterilisations were delivered than LARC.

When comparing the cost effectiveness of the previous model (VSC camps offering only sterilisation services) with the comprehensive VSC+ camps it was found that adding LARCs to the VSC camps is highly cost effective, as the cost per DALY averted was 7.5 times and 31 times less in comparison to GDP per capita for modalities A and B respectively. We also estimated the additional costs of adding LARC services to the VSC camps using the marginal costing approach and found that the marginal cost was extremely low in relation to each modality's total cost. This additional cost was calculated to be 3% for modality A and 5% for modality B.

³ Only sterilisation and LARC users were counted for the costing analysis. The low numbers of other contraceptives delivered in the camps does not affect the costing analysis in any significant way.

An economic model was developed to assess the cost per client and per CYP if LARCs were not provided in the VSC+ camps. The modelling results showed the cost per client and per CYP would have been 49% and 12% higher respectively for the overall pilot.

The cost-benefit analysis suggests a good return on investment, where \$1 invested in this project is likely to produce a return of \$3.5. The cost-benefit was found to be slightly higher in the case of modality A, where \$1 produced a return of \$3.9 as compared to \$3.1 for modality B. As mentioned before, the main driver of the difference is that more sterilisations were done under modality A, which translates into more CYPs.

Evaluation question 5 - What are the main factors affecting or determining the feasibility, scalability and sustainability of the VSC+ intervention as implemented? What are the lessons for scaling up this approach?

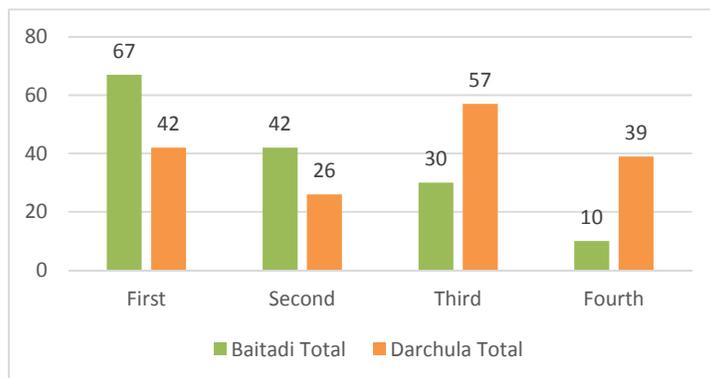
The following points summarise the main factors: we have tried to rank the factors by importance although the ranking is somewhat subjective.

- a) **The availability of trained service providers in the government district health services network.** This seems the primary factor to consider when deciding between government and private provision. Where the government has the required human resources competence in counselling, LARC and sterilisation the DHO is best placed to deliver the VSC+ camps. In districts where the government lacks competent service providers, private providers are a cost effective way to deliver the services.
- b) **The availability of referral facilities to deal with eventual post-surgery complications,** as this in turn determines the feasibility of doing sterilisations and thereby the behaviour of service providers, who may counsel for less invasive (non-surgical) options like LARC in spite of these resulting in lower CYPs. This seems to be the main reason why more LARC than sterilisations were delivered in Darchula rather than the service provision modalities – private and public - as such.
- c) **The availability of suitable health facilities to conduct the camps** (enough rooms, space for counselling, beds). Sterilisation requires conditions of hygiene over and above those required by LARC, a much less invasive procedure with less risk of complications. Nevertheless, availability of private rooms and beds should be guaranteed at any VSC+ camp.
- d) **The effectiveness of mobilisation and the focus on dissemination messages.** Information dissemination and mobilisation of potential clients is paramount in explaining client flows. This could only be indirectly assessed by the evaluation but anecdotal evidence suggests that most clients in Baitadi attended the VSC+ camps in order to be sterilised rather than with an open mind about which form of contraception would better suit their needs: this fact may have influenced less uptake of LARC in Baitadi, but this remains a working hypothesis.
- e) **The focus of counselling as a determinant of client choice.** Combined with mobilisation the focus of counselling is a key factor determining client choice of contraception. The high uptake of implants in Darchula seems closely linked to the

options offered to clients during counselling. Clients are likely to be open to choices if these are well justified by service providers, particularly if the said choices are less invasive and bear less potential complications, as is the case for implants. However, poor counselling can lead to the wrong choices hence the importance of providing good training on counselling to service providers.

- f) **The number of consecutive camps run in the same health facility.** We obtained different results on whether consecutive, monthly camps result in an increase or decrease of uptake, as shown in the figure below. In Baitadi uptake decreased with successive phases, but not in Darchula where the highest uptake took place during the third phase. In any case, for equity reasons, the district health office should decide on the best way to spread the VSC+ camps during a year in order to reach the maximum number of clients in the district. At the moment there is not a clear guideline to follow (on timing and number of camps) and the characteristics of demand in each district should drive supply decisions. It is also important to note that differences in mobilisation could have also influenced the uptake by phase.

Figure 1.2: Uptake of different family planning methods by phase in Baitadi and Darchula



- g) **Seasonal considerations.** There were many views expressed among health managers and service providers on the timing of the VSC+ camps. Many argued that the combination of hot weather, festival season, harvest season and transport limitations imposed by the fuel crisis affected uptake. It was not possible to assess the impact of these realities on uptake as comparison with VSC camps conducted in the past – often during a different season - remained inconclusive.
- h) **The coordination and oversight roles (and associated costs) of NHSSP.** While difficult to quantify, the support provided by NHSSP in setting up the pilots, coordinating implementation and overseeing camp reporting should not be underestimated at the time of scaling up. For example, the oversight from NHSSP contributed positively to the consistency of implementation across camp sites and also enabled consistent and timely data collection and reporting. Such oversight is a key reason why this evaluation for the first time has provided a proper analysis of uptake and costs of VSC camps, which was not possible in the past as camp specific data was either not available (it was merged with that from other health facilities) or unreliable. Lack of camp specific data was a key obstacle to the analysis of VSC

camps that evaluators undertook prior to this pilot, which has been summarised in Annex 3.

There were other factors that may have had an impact on uptake that could not be properly assessed in the evaluation. For example, the presence of the husband in the household is likely to be important as decisions on contraception are often made jointly by husband and wife, so households affected by migration may prefer the festival season when the husbands often come home. Beliefs and misconceptions by potential clients probably play a role too, but this could not be properly assessed.

Finally, while interpreting the results of this evaluation one should keep in mind the short implementation period of the pilot (four months), as well as the unusual circumstances (earthquake, fuel crisis, commodity shortages) that surrounded pilot implementation. The short implementation period is also important in relation to the costing work, because the unit costs might have been lower if the pilot had run for another year or so, as a good proportion of costs in a new intervention are fixed in nature and would have decreased (relatively) with increased numbers of new users.

Recommendations

These recommendations apply to both implementation modalities, i.e. whether VSC+ camps are implemented by DHO or private providers.

- a) VSC+ camps are a very cost effective way to deliver sterilisation services as well as other family planning options, particularly LARC. The cost of adding LARC to 'standard' VSC camps is negligible. All previously called VSC camps should adopt the comprehensive VSC+ format and offer any form of contraception desired by clients based on proper information dissemination and counselling.
- b) Counselling skills are essential and not necessarily available among service providers. Not all service providers had been trained in counselling or it was simply assumed that they had the right counselling skills. It is recommended that VSC+ camp staff should be trained regularly (periodically) to offer clients the best option, taking into account the circumstances of the client and the health infrastructure of the district. For example, sterilisation should not be provided where follow up of complications is not guaranteed, in which case LARC are a safer option.
- c) There should be proper benchmarking of health facilities to be used in VSC+ camps, to ensure that sufficient rooms and beds can be provided to guarantee hygienic procedures, privacy and confidentiality. Clients should not be expected to lie on the floor after the procedure.
- d) The number of successive camps to be held at a particular location cannot be established empirically. In theory, successive camps should be held while the uptake is high but this decision should also consider equity principles to ensure that most parts of the district are served by the VSC+ camps and not just the catchment areas of 3-4 selected locations. The same principle should apply to seasonality considerations, as some seasons often considered as less suitable (like the festival season) may actually suit areas affected by migration as they may enable husband

and wife to discuss contraceptive options for each of them. Spreading VSC+ camps along the year (avoiding the very rainy or very hot months) makes common sense.

- e) Ensuring national coordination, lesson learning and support to the DHO on VSC+ implementation. While cost effective, VSC+ represents a substantial investment for a poor country like Nepal, so if VSC+ camps are to be held they should also be properly implemented, lessons should be learnt and disseminated, and DHOs across the country should be helped to analyse uptake and performance factors. At the moment the national guidelines for VSC implementation are quite generic and leave much decision making to the DHO, but not all DHOs have the capacity or competence to analyse results on the go. In this pilot NHSSP provided coordination and support to the DHOs of Baitadi and Darchula. We recommend the MoH to institutionalise support to DHOs on VSC+ camps within Family Health Division, whether through NHSSP or through other means, to ensure that DHOs regularly engage in proper analysis of VSC+ camp uptake and performance. The emphasis should be on on-going monitoring of VSC+ camp uptake to properly interpret flows in demand and in client choice, and to strengthen equity in access to VSC+ camps in most parts of the district through proper site selection and linked dissemination efforts. At the moment this monitoring does not necessarily take place at the DHO, as revealed by the rapid appraisal of VSC camps that we conducted prior to this evaluation study. At the time, data on VSC camps was disperse, unreliable and lying dormant: it was not being used for decision making.

Recommendations for Modality A – DHO implementation

DHO implementation of VSC+ camps is highly cost-effective as it incurs lower set up and incremental costs than private provision. Where the district health system has the required trained human resources DHO implementation is recommended as the best option. However, the option of drawing human resources from a neighbouring district may not be a good option as it incurs opportunity costs in the district where the human resources originate. This aspect was not documented by the evaluators but seems common sense.

Recommendations for Modality B – implementation by private provider

Where the district does not have the required human resources to conduct VSC+ camps private provision is a cost effective alternative, even if the setup costs, incremental costs and operational costs are slightly higher than for the DHO modality. Much depends of course on whether private providers are available to take up such a role in all the districts where the DHO cannot run the camps, as such districts are often the more under-resourced and difficult ones – in terms of access, population dispersion, etc - which can make these less attractive to private providers. In any case, the private provision model that has been tested in the pilot is more a public-private partnership than a strictly private provision model, and this makes it very attractive to draw on all types of resources – private and public - available in Nepal.

2. Introduction

2.1 Background

The UK Department for International Development (DFID) and the United States Agency for International Development (USAID) in collaboration with the Government of Nepal have been providing for more than a decade technical and financial support to increase access to quality family planning services to the population of Nepal. As part of that support, DFID and USAID commissioned in 2014 a series of evaluations of innovative interventions to increase access to family planning by specific population groups or in geographical areas that are known to have limited access to family planning services.

This evaluation report refers specifically to the evaluation of one of the pilot interventions, expanding the range of family planning services through comprehensive “VSC events (VSC+)” in Baitadi and Darchula districts.

2.2 Justification

The information provided herein that supports and justifies this pilot is based on the NHSSP’s implementation guide and VSC rapid assessment study conducted by HERD (before the pilot began).

The Nepal Family Planning Programme aims to reduce unmet need for contraception and promote the rights of women to exercise choice when selecting a contraceptive method. Unmet need for contraceptives is very high in Nepal, estimated at 27% in 2011, increased from 25% in 2006 according to the Nepal Demographic and Health Surveys (NDHS 2011). The overall contraceptive prevalence rate is also low, estimated at 43% in 2011 for modern methods, reduced from 44% in 2006 (NDHS 2011).

Permanent methods of family planning (often known as male and female sterilisation) are generally unavailable in most rural and hard-to-reach areas of Nepal as delivery of these services requires skilled providers and appropriate infrastructure and equipment. Even where skilled personnel are available it may not be possible for the service to be provided on a continued basis due to staffing, logistics or efficiency reasons. The Government of Nepal (GoN) introduced mobile outreach FP services in the form of ‘VSC camps’ in the 1970s with a view of increasing access to permanent FP methods especially among the geographically hard-to-reach groups in the areas where the services are not available. Provision of FP services through mobile sterilisation camps (VSC camps) to reach rural people in Nepal has been one of the pillars of the Nepal Family Planning programme. VSC camps have shown to be an important way of meeting FP demand where hospital or clinic-based services are not routinely available. Although such camps do not offer a wide range of contraceptive options, they enhance access to permanent methods and are frequently offered free of charge.

Consequently, clients spend less on transportation and time away from work and family (MoHP, 2010a).

A few VSC camps also offer short-acting and long-acting reversible contraceptive (LARC) methods in addition to the permanent methods but the range of these additional services varies, depending on the availability of skilled health providers, FP logistics, geographic access, camp location, weather conditions, camp service provider i.e. GoN, NGOs, among others (Wickstrom 2013). The Government of Nepal often organises VSC camps by mobilising the district human resource pool, though sometimes they are recruited from other districts or from other family planning service providers - NGOs such as Sunaulo Parivar Nepal (SPN), Marie Stopes International (MSI), Family Planning Association of Nepal (FPAN) - whenever trained health personnel is not available in the district. NGOs provide 44% of male and female VSC, with SPN accounting for 75% of NGO-provided VSC services (MOHP, 2010b).

2.3 The pilot and its implementation modalities

As shown in the concept note for this pilot and following considerable research in other countries, delivery of health care services through outreach mobile camps has been recognized as an effective way to increase uptake of FP services, especially among those who have limited access to these services. In view of this positive experience elsewhere, as well as the potential for comparable results in Nepal, the VSC+ pilot offers an appealing opportunity for evaluation.

This pilot was implemented between August and December 2015 in Baitadi and Darchula districts, two hill districts of the Far-western Development Region of Nepal. The Family Health Division (FHD) of the MoH through its District Health Office (DHO) and linked health facilities were responsible for implementing the pilot. Implementation was technically supported by the Nepal Health Sector Support Programme (NHSSP) in terms of design, standard operating procedures, training and oversight. Financial support for the pilot and its evaluation were provided by DFID and USAID. Mott MacDonald (MM) and HERD were responsible for the monitoring and evaluation (M&E) of this initiative.

This is an operational research study that aimed to assess if provision of FP mobile services (VSC, LARC, counselling) at selected rural health facilities at a regular frequency expands availability, choice and uptake of family planning services in rural Nepal. The intervention integrated LARC and contraceptive counselling services to existing VSC camps, hence the term 'VSC+' to refer to this expanded range of services when compared to the traditional VSC camps. Four sites were selected in each district on the basis of location, coverage, expected demand and physical infrastructure in a facility for quality service provision. A team of government and/or private contracted service providers delivered these services at selected locations.

Two modalities of implementation were adopted in this pilot, one in Baitadi and one in Darchula, which are briefly explained below:

I. **Modality A: Service provision by the DHO in Baitadi**

In Baitadi, a trained surgical team from within the district (district hospital) provided comprehensive VSC+ services through the camps. Four sites were

selected for implementing camps – one District hospital, one Primary Healthcare Centre (PHCC) and two health posts (HPs). In the district hospital, a fixed day static approach was adopted where VSC+ services were provided by trained providers of the same facility on fixed days throughout the intervention period. On the other hand, this operating team from the district provided sterilisation and other contraceptives in the three remotely located facilities where these services are not routinely available.

II. Modality B: Service provision by MSI/SPN in Darchula

In Darchula a trained surgical team from outside the district travelled to the district health facilities to provide comprehensive VSC+ services. The four sites selected were one district hospital, one peripheral hospital, and two HPs. Marie Stopes International and Sunaulo Pariwar Nepal (hereafter MSI/SPN) were contracted by NHSSP to provide the services. The MSI/SPN team brought with them equipment and supplies that are required and unavailable in the service delivery sites.

The target population in both modalities were men and women of reproductive age (WRA) residing in the catchment areas of the selected health facilities.

The main justification for testing two implementation modalities – DHO and MSI/SPN - is that the government health system in Baitadi is better resourced to provide family planning services than Darchula, primarily because it has more human resources who can deliver family planning services, particularly sterilisation. For example, Baitadi has its own pool of doctors (N=2) to provide vasectomy and Minilap regularly from the district hospital, and the district hospital have a sufficient number of LARC providers who can be mobilised during the camps to deliver services in peripheral locations. In contrast, Darchula district does not have health staff who can offer sterilisation on a regular basis, which is the main reason why all VSC camps held in previous years were conducted by a team from MSI. At least one LARC method was found to be available in all of the health facilities selected for the pilot in both districts (with the exception of Talladehi health post in Baitadi district).

2.4 Evaluation methodology

The evaluation methodology that was planned at design has been included in Annex 1. As is often the case in most evaluations, the original design had to be adapted or even substantially modified along the way, often for reasons outside the control of both pilot implementers and evaluators (see 2.5). In the section on evaluation findings we will discuss the extent to which the data collection tools and sources planned at design could be actually used and the effects resulting from these changes on the reliability and validity of the evaluation results.

The following is just a brief summary of the main evaluation questions and design issues.

2.4.1 Evaluation focus and main evaluation questions

The pilot offers two major areas of interest in this evaluation. The first focuses on the pilot's overall effectiveness in meeting its objectives, that is, whether the expected results have

been achieved. This would have required the implementing agency (DHO) to set specific targets, but it was discussed and agreed at design that targets would not be set and that, instead, a series of outputs would be measured comprising service uptake, perceived and observed quality of services and levels of user satisfaction.

The second topic of interest is to assess why or why not has the pilot met its objectives, with a view to determine the main factors influencing results that would guide an eventual replicability or scalability of the intervention elsewhere in Nepal. Furthermore, we are also interested in assessing the dynamics of the intervention through a close monitoring of the intervention in a sample of sites, as described later.

This evaluation attempted to answer the following evaluation questions:

1. Does the provision of an expanded range of FP services through comprehensive VSC camps (VSC+) increase the availability, choice and uptake of FP services in addition to sterilisation services among men and women of reproductive age?
2. Were the users of VSC+ camps able to choose the FP service/commodity of their choice? Was the choice properly informed through counselling?
3. What is the perspective of beneficiaries/clients about quality of services provided through the camps?
4. Were the advocacy activities by FCHVs and Health Facility Operation and Management Committee (HFOMC) effective to raise awareness about comprehensive FP services on offer and to generate demand among men and women of reproductive age?
5. What are the main factors affecting or determining the feasibility, scalability and sustainability of the VSC+ intervention as implemented? What are the lessons for scaling up this approach?

Costing analysis: What are the main costs incurred in the proposed approach? What are (roughly) the incremental costs incurred when compared with the traditional VSC camps (where only VSC services were being provided)? Are there any significant differences in the cost of the approach between the two models being tested in Baitadi and Darchula respectively?

2.4.2 Evaluation design, questions and overall approach

Prior to designing the evaluation we conducted a rapid appraisal (literature review plus interviews with key informants) of VSC camps in Nepal⁴ in order to familiarise ourselves with the main issues affecting this approach and to explore data availability pertaining to the performance of VSC camps. A summary of key points emerging from the appraisal study can be found in Annex 3.

The process of selecting an evaluation design began with assessing the best ways to address the six evaluation questions above. This is briefly discussed next and should be looked at jointly with the questions, means of verification and data sources shown in Annex 1.

⁴ Rapid Assessment of Voluntary Surgical Contraception Camps in Nepal. Review undertaken by Health Research and Social Development Forum (HERD) and supported by Mott MacDonald. Working document, May 2015.

Experimental and quasi-experimental designs were ruled out at design for a number of reasons: they were not necessary to answer the evaluation questions, which can be assessed through a more simple evaluation design that combines elements of performance and process evaluation – this in turn reduces data collection complexity and evaluation costs in equal measure; the implementation time was too short (5 months) and the scale of the pilot too small to justify the kinds of baseline and endline surveys that might have been required; and the pilot modalities implied that the users of the new services would be self-selected, so they could not be possibly randomly assigned to intervention and control groups.

The chosen alternative was to undertake a process evaluation using a mix of qualitative and quantitative methods that would enable triangulation of results in order to propose plausible explanations for the results achieved. There were also some elements of performance evaluation, that is, assessing indirectly achievement of outcome. These methods are briefly summarised in the table below.

Table 2.1: Main study questions and proposed evaluation methods

Main Study Questions	Evaluation designs considered and adopted
1. Does the provision of an expanded range of FP services through comprehensive camps (VSC+) increase the availability, choice and uptake of FP services in rural Nepal?	Using the HMIS register, data from the intervention period on uptake of FP methods and commodities (male vasectomy, female Minilap, LARC and Depo) will be compared with an equivalent period in the previous year, as a means of comparison. The limitations of this approach will be summarised in the chapter on findings when presenting the uptake tables. Data will also be collected from service users on service days for choice and availability of contraceptives, and from service providers in selected service sites in both districts.
2. Were the users of VSC+ camps able to choose the FP service/commodity of their choice? Was the choice properly informed through counselling?	This information will be collected primarily through exit interviews with service users from the service sites in both districts. Information from exit interviews will be complemented by observation notes taken by research assistants during VSC+ camp days.
3. What is the perspective of beneficiaries/clients about quality of services provided through the camps?	This information will be collected primarily through exit interviews with service users from the service sites in both districts. Information on perceived service quality will also incorporate views of service providers through in depth interviews.
4. Were the advocacy activities by FCHVs and HFOMC effective in raising awareness of comprehensive FP services on offer and to generate demand among men and women of reproductive age?	It will not be possible to quantify or assess accurately the effectiveness of mobilization and awareness raising by FCHVs and HFOMC as this would require collection of population based data in a large number of population given that the number of potential men and women seeking FP services in camps would be relatively small and that they are self-selected users. As an alternative (proxy), service users will be asked about the source of information on the new services

	during the exit interviews.
5. What are the main factors affecting or determining the feasibility, scalability and sustainability of the VSC+ intervention as implemented? What are the lessons for scaling up this approach?	Information will be collected from in-depth interviews at end line with service providers, district health managers and staff from NHSSP and MSI/SPN Nepal overseeing the implementation of the pilot.
6. Costing analysis: what are the main costs incurred in the proposed approach? What are (roughly) the incremental costs incurred when compared with the traditional VSC camps (where only VSC services were being provided)? Are there any significant differences in the cost of the approach between the two models being tested in Baitadi and Darchula respectively?	A costing analysis will be undertaken in parallel to the evaluation. The scope of the costing review will focus primarily on replication and eventual scalability of the intervention and will attempt to compare the cost effectiveness and cost benefit of each implementation modality.

2.4.3 Monitoring and evaluation sites

We monitored all eight service delivery sites (four sites in each district) where VSC+ camps were implemented in order to generate rich information to answer the evaluation questions. Monitoring took place during the whole implementation of pilot (August to December 2015) by two research assistants (one in each district).

We proposed in our evaluation design to monitor 8-10 comprehensive VSC+ events in each district (out of the 15 VSC+ camps envisaged in the pilot's concept note – see figure 2.1 for location of camp sites). In the end though research assistants attended 9 and 10 VSC+ events in Baitadi and Darchula respectively. The main focus of monitoring by the research assistants was to ensure, to the extent possible, that the level of detail and effort required to capture and process the data was performed in the right way and at the required periodicity, and that changes in the process and context of implementation were swiftly captured. NHSSP also monitored the VSC+ events with a view to identifying emerging issues linked to implementation and addressing these, again to the extent possible, along the implementation period.

For evaluation purposes, a monitoring checklist was prepared and research assistants (RAs) were trained on its use. This checklist helped the evaluation team monitor if the required standard operating procedures were being adopted in the pilot as planned and if continuous supply of commodities had been ensured. Monitoring activities by RAs also included: observation notes on camp days; interviews with users (LARC and sterilisation only⁵) exiting the VSC+ camps; interviews with service providers during camp days; and interviews with NHSSP and DHO staff. A small sample of FCHVs and HFOMC members were also

⁵ The reason for only interviewing LARC and sterilisation users was to collect information from processes that required a higher degree of sophistication by service providers than just putting an injection or administering oral contraceptive pills or condoms) in order to generate richer information on service delivery, quality and satisfaction.

interviewed for evaluators to understand the mobilisation and communications processes used at community level during the pilot. In addition to these tasks RAs collected FP uptake information from the service registers.

Figure 2.1: VSC+ camp sites



While figure 2.1 may give the appearance that VDCs are relatively close to the district headquarters the roadmaps of the districts (which we could not super-impose to our maps for technical reasons) do show considerable limitations in terms of road access to several VDCs, particularly in the case of Darchula district.

2.4.4 Staff arrangements

This evaluation was undertaken by an evaluation team comprising HERD with technical support and oversight from Mott MacDonald's International Health Division. HERD appointed one Senior Research Officer (SRO) based in HERD Kathmandu and two full-time field Research Assistants (RAs). The SRO was responsible for implementing the evaluation and ensuring its compliance with the original plan of work. She was also responsible for the processing and analysis of qualitative data, and for its triangulation with quantitative data. HERD also appointed one Data Analyst and Data Management Officer for the management of quantitative data. A communication officer was responsible for desk-based communication with RAs in order to obtain field updates and for communicating such updates to the SRO. Furthermore, the Operations Manager at HERD was responsible for overall operational and logistics management during the entire project.

The Mott MacDonald team included a senior evaluation specialist, a health economist, two health systems specialists (responsible for quality assurance and project management, respectively) and a project officer. The team provided technical support – both desk based and through teleconferencing and visits – to the team in Nepal on evaluation design, data collection and analysis, report writing and dissemination of results.

2.4.5 Data analysis and quality assurance

Routine monitoring of the intervention in both districts ended by end of December 2015, at which time the data cleaning and data quality checks began. The processing of the backlog of qualitative and quantitative information from observations notes, observation checklist, key-informant interviews and exit client interviews also began at that time and triggered the pre-analysis of data. By pre-analysis we refer to the process of triangulating data for each of the 8 evaluation sites in two districts in order to bring together the results from the service uptake data, the baseline interviews and the observation notes and checklists. The pre-analysis was also used to better prepare the endline interviews and to brainstorm on indicative findings among the evaluation team.

The pre-analysis was followed in February to April 2016 by the endline interviews and costing work. The costing work was undertaken in parallel to the endline interviews by an appointed researcher who worked under the guidance of the evaluation team's health economist.

Final data analysis and evaluation report writing began in March and were completed by April, as soon as the endline interviews and costing work had been completed.

2.5 Nepali and Western calendar months

For the research we used Nepali calendar months, however for this report we converted them to their closest Western equivalent to facilitate understanding of the data by readers unfamiliar with the Nepali calendar, and for data management reasons. Each Nepali month begins towards the middle of a Western month, and transforming them into their exact Western equivalent would have added considerably to the data management burden. The table below shows how we converted Nepali to Western months.

Figure 2.2: Equivalence of Nepali to Western calendar months

January	Magh (mid –January to mid-February)
February	Falgun
March	Chaitra
April	Baishakh
May	Jestha
June	Ashar
July	Shrawan
August	Bhadra
September	Ashwin
October	Kartik
November	Mangsir
December	Poush

2.6 Research ethics approval

An application for ethics approval of this evaluation was submitted to the Nepal Health Research Council (NHRC) in August 2015. Approval was granted in March 2016 without any request for modification of the research protocol submitted. The delay in response caused delays in the commencement of the costing work and thereby in our ability to deliver the evaluation findings at the time initially agreed with the client (April 2016). Hence the two months delay in submission of this report.

2.7 Limitations affecting the pilot and its evaluation

The specific limitations linked to the application of the proposed evaluation methodology or to the availability or quality of data will be discussed in the chapters presenting the findings of this evaluation. This chapter briefly summarises important contextual factors that affected implementation and evaluation of this pilot in ways that the risks and risk mitigation measures prepared at design could not possibly predict.

Since the evaluation of this pilot began in October, it was not directly affected by the massive earthquake that hit Nepal on 25 April 2015. However, the pilot and its evaluation were

affected by other issues in several ways. For example, our field researchers were unable to travel to their respective district in August 2015 (as planned) due to the strike against the promulgation of the constitution in the Far-West region. As a result we could not monitor the first round of camps in Baitadi which were conducted at that time.

Moreover, the people of Nepal were affected by civil unrest in the terai from August and by a blockade at the border with India that caused a severe fuel and commodities crisis from September 2015 till February 2016. Apart from the additional suffering caused to poor people as the winter was setting, the fuel crisis affected pilot implementation and evaluation in several ways that are difficult to account for with precision. For example: service users may have faced difficulty in travelling to health facilities; health commodity shortages were reported; researchers could not travel to health facilities to collect data or observe service delivery as planned; evaluation staff based in Kathmandu could not support field researchers, obtain data from them, interview service providers or verify data quality; etc.

The implications of all these factors will be referred to in the findings chapter but it is undeniable that these events may have biased the evaluation results in ways that cannot be fully measured or controlled, particularly when compared to what a 'business as usual' situation would have shown.

3. Evaluation Findings - Modality A – Service provision by DHO in Baitadi

3.1 Uptake of FP services

To measure the uptake of LARC and sterilisation delivered through VSC+ camps, we used NHSSP data. NHSSP prepared a register in each camp site to record FP services delivered from camps conducted in that facility. This register was the main recording source as camp sites later updated the facility service delivery register (HMIS) from this NHSSP register. Using NHSSP data we counted the total number of LARC and IUCD delivered in all 12 camps between August-December 2015. In the following sections we present summary tables and figures.

3.1.1 Number and frequency of camps

Between August and December 2015, a total of 12 camps were conducted in four health facilities (termed as camp sites hereafter) in Baitadi. We have termed one round of camps in four camp sites as one phase. One camp in district hospital in first phase was cancelled due to unknown reasons. In addition, the research assistant from HERD could not go to the district and monitor the first phase of the camps because of political unrest in the Far-west region during August 2015. All the remaining camps were covered by the research assistant from September and thereafter. The table below shows the camp sites and the schedule in Baitadi.

Table 3.1: VSC+ camps conducted and observed – Baitadi

Name of the Health Facilities	Phase I	Phase II	Phase III	Phase IV	Total
District Hospital	Cancelled	19-21 Sep *	4- 6 Nov *	4-6 Dec*	3
Kulau Health Post	7-8 Aug	27-28 Sep *	10- 11 Dec *		3
Talladehi Heath Post/ Patan HP in 1 st phase	10 Aug	1-2 Oct *	14-15 Dec *		3
Haat Health Post	12-13 Aug	4-5 Oct *	17- 18 Dec *		3
Total camps conducted	3	4	4	1	12
Total camps monitored	0	4	4	1	9
Total camp days	5	9	9	3	26

* indicates that the camp was visited and observed by the research assistant.

Source: NHSSP

3.1.2 Implementation of camps in proposed site and schedule

During the initial phase of the pilot and as mentioned in the implementation guide of NHSSP, the four proposed camp sites in Baitadi were District Hospital, Haat, Kulau and Patan. But after implementation of the first phase, Patan PHC was replaced by Talladehi HP as no client attended the camp in Patan. The reported reason for selection of Talladehi was that it had better infrastructure and a wider population coverage. (Source: KII with DHO and NHSSP staff)

In the design phase NHSSP planned to conduct a total of 15 camps in the district: 6 camps in the district hospital, and three camps in each of the three selected peripheral sites. However, only 12 camps were conducted (three camps in each site), as shown in Table 3.1. In general, the camp hours were 10 am to 4 pm which was found to be extended according to client load. (Source: Observation notes)

3.1.3 Uptake of family planning in VSC+ camps

The uptake of contraceptives during VSC+ camps will provide the evidence to respond to the first evaluation question: Does the provision of an expanded range of FP services through comprehensive camps (VSC+) increase the availability, choice and uptake of FP services in rural Nepal?

The Table below summarises the uptake of family planning services in the 12 VSC+ camps delivered in Baitadi during the pilot.

Table 3.2: Uptake of FP in 12 camps during VSC+ pilot

Baitadi	Minilap	Vasectomy	Depo	Pills	Implants	IUCD	Only Counselling
District Hospital	8	1	0	0	1	0	0
Haat	46	15	0	0	3	1	0
Kulau	20	2	0	0	0	0	1
Talladehi	31	11	1	0	10	0	0
Total	105	29	1	0	14	1	1
Average per VSC+ camp	8.75	2.42	0.083	0	1.17	0.083	0.083

Source: NHSSP

151 clients were served by the VSC+ camps, which generated an uptake of 150 contraceptives/sterilisation services.

The VSC+ in Baitadi achieved a total of 1800.05 Couple Years of Protection (CYP). The CYP achieved for sterilisation was 1742 (134 sterilisation x 13 CYP per sterilisation), for implant 53.2 (14 implants x 3.8 CYP per implant), for IUCD 4.6 (1 IUCD x 4.6 CYP per IUCD) and for depo 0.25 (1 dose x 1 CYP per 4 doses).

The figures suggest that the camps played a role in increasing availability and choice of family planning methods. They delivered a significant number of sterilisation services (134) and a modest number of LARC (15). Nevertheless, when the average uptake per VSC+

figures are considered even the uptake of sterilisation looks modest at 8.7 Minilap and 2.4 vasectomies on average per camp. As for the remaining contraceptives on offer (temporary or reversible) the uptake can only be described as extremely low.

It is also noteworthy that the uptake (for both LARC and sterilisations) was much higher in the mobile VSC+ camps than in the district hospital.

Uptake results also suggest that the large majority of clients (89%) went to the VSC+ camps for the specific purpose of being sterilised. Only 10% of clients attended the VSC+ camp to access other family planning commodities: among these clients implants were by far the most popular option.

We will try to explore later in this chapter (using the results from interviews of users, service providers and health managers the possible reasons behind all the above findings).

3.1.4 Characteristics of service users (live children)

We looked at the characteristics of service users in terms of number of live children for the users of the VSC+ camps. We only included users of LARC and sterilisation services since the numbers of users of other commodities were so low. These characteristics are summarised in Table 3.3 below.

As expected, the characteristics in terms of numbers of live children when attending the camp were different for LARC and sterilisation users. The following observations can be made:

- Among LARC adopters the proportion of women who had two live children or less was the same (47%) than those who had three to four live children. Among users of sterilisation the proportions were quite different: only 22% had two live children or less whereas 60% had between three and four live children.
- The large majority of sterilisation users (60%) had between three and five live children, suggesting that for most users this is the notional number of children considered enough to justify the adoption of a permanent method.

Table 3.3: Number of live children among LARC and sterilisation users

No. of live children	LARC	Sterilisation	Totals
1	2	2	4
2	5	27	32
3	3	42	45
4	4	39	43
5+	1	24	25
Total	15	134	149

Source: NHSSP

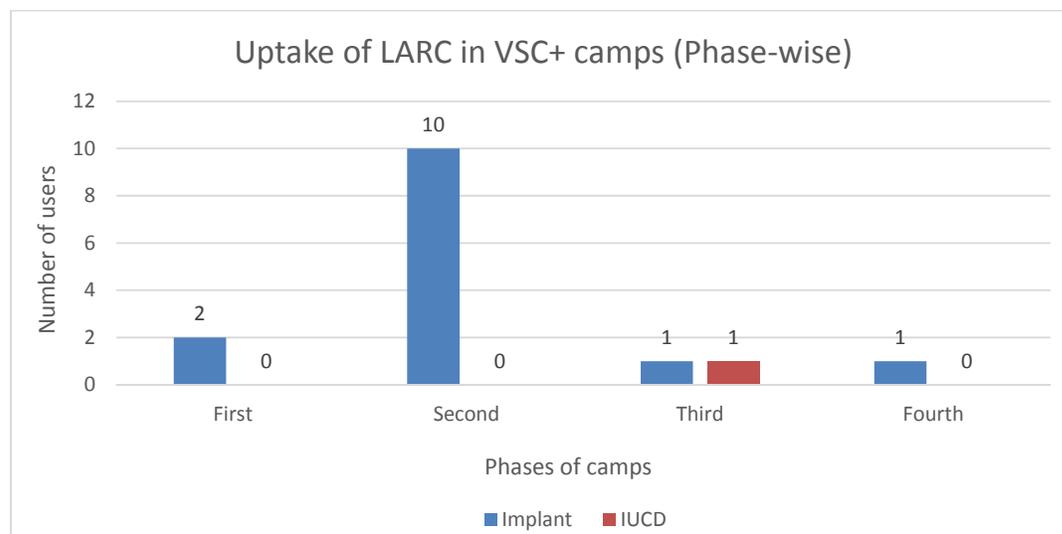
3.1.5 Further analysis on uptake in each of four delivery phases

This section provides additional analysis on the uptake of family planning in successive VSC+ camp phases.

Uptake of LARC

As Table 3.3 above has shown, between September and December 2015, a total of 14 implants and 1 IUCD were inserted through 12 VSC+ camps. All LARC users were women aged 20 years or more. Figure 3.1 shows that the uptake of implants was larger in the second phase and then dropped to negligible levels during the third and fourth phases. The only conclusion that can be drawn is that demand for LARC and other temporary or reversible contraceptives during the VSC+ camps was low and that therefore VSC+ camps were not an effective way of increasing access to temporary contraceptives when compared to other approaches like static delivery in birthing centres or provision through visiting providers (although all these approaches are not really comparable, so it cannot be concluded that one approach should be adopted instead than another – see conclusions in chapter 6).⁶

Figure 3.1: New users of LARC in 4 VSC+ camps, Baitadi, 2015



Source: NHSSP data

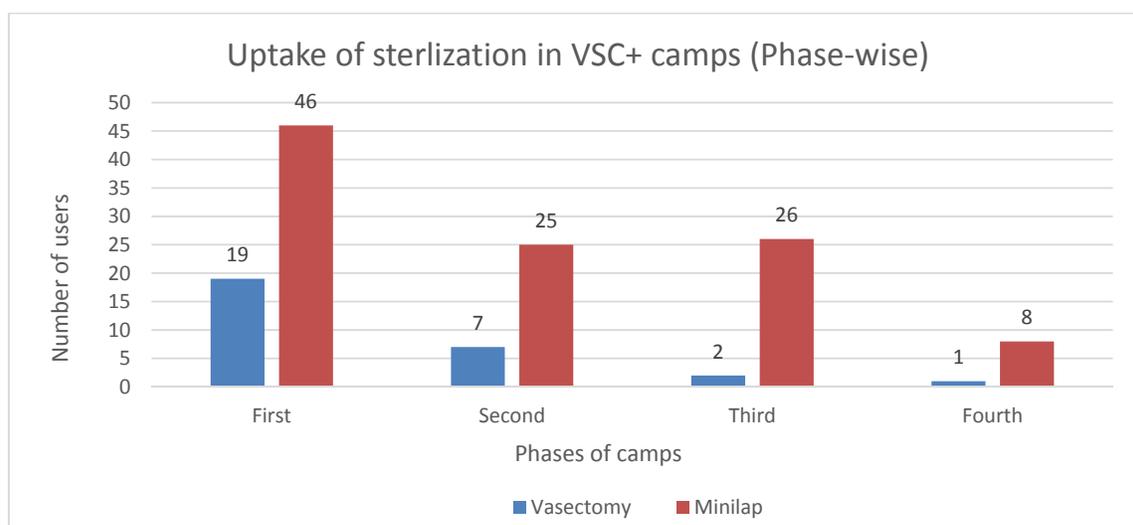
Uptake of Sterilisation

Between August and December 2015, a total of 29 vasectomies and 105 Minilap were performed through 12 VSC+ camps. All users were aged 20 years or more. The uptake of Minilap was 3.62 times higher than that of vasectomy. The average number of Minilap and vasectomies delivered per camp was 8.75 and 2.41 respectively.

As can be seen in Figure 3.2 the uptake of sterilisation shows a decreasing trend, this suggesting that demand for sterilisation decreased over time (as one might expect when consecutive phases of the same service are delivered in the same site). However, a decreasing demand does not necessarily mean that unmet need for sterilisation was fully or largely met by the camp in the catchment areas of the health facilities. The latter aspect will be further explored using information from exit interviews.

⁶ Just for comparison purposes, during the visiting provider pilot intervention in Ramechhap each visiting provider (essentially a ANM) delivered on average 11.8 LARC per clinic day i.e. ten times more LARC than were delivered on average per VSC+ camp. Some visiting providers delivered in a single day more LARC than were delivered in all the 12 VSC+ camps conducted in Baitadi.

Figure 3.2: Sterilisation users in four camp sites, 2015



Source: NHSSP data

3.1.6 Brief discussion

Did the availability, choice and uptake of planning *increase* as a result of the VSC+ approach? While availability did increase it is not possible to fully answer this question with the available data. In the case of LARC and as reported earlier, the uptake of LARC (15 LARC over 12 VSC+ camps) was very low and many women did not opt for it for reasons unknown. Since there are no records of whether or how many LARC were delivered in VSC camps in previous years, all LARC delivered in VSC+ camps will be considered additional.

The uptake of sterilisation certainly increased as a result of the VSC+ camps, but this was to be expected since VSC camps have traditionally been the main or only means for people to access sterilisation services, with the exception of those who may seek sterilisation in the district hospital at any time during the year.

How did the uptake of sterilisation in VSC+ camps compare with that achieved in VSC camps in the same district in previous years or in other parts of the district on the same year? Answering this question could be an indirect way of (a) assessing if provision of other contraceptives during VSC+ camps ‘displaced’ sterilisation in favour of other forms of contraception (like LARC), and (b) how the uptake of sterilisation in VSC+ camps compares with that achieved through the traditional VSC camps. The first question regarding ‘displacement’ of sterilisation by other contraceptives does not seem relevant in the case of Baitadi due to the low uptake of other forms of sterilisation, as discussed earlier. On the performance of VSC+ camps vis a vis the previous VSC model, we compared uptake of sterilisation during VSC+ camps with uptake in previous years using the number of camp days as denominator. This is shown in Table 3.4 below (data for previous years was taken from the DHO and is presented in Annex 2). The comparison shows that VSC+ camps delivered roughly the same number of sterilisations per camp day as in FY 2013/14 and about half of the average uptake reported for FY 2014/15. In sum, the comparison is inconclusive.

Table 3.4: Uptake of sterilisation reported in Baitadi in previous years

Fiscal Year	Number of camp days	Vasectomy	Minilap	Total	Average per camp day
2013/14	42	37	208	235	5.6
2014/15	22	71	165	236	10.7
2015/16*	44	39	193	245	5.5
VSC+ 2015	26	29	105	134	5.15

Source: DHO Baitadi. Detail of camps in previous years is shown in Annex 2.

* Data from entire Baitadi district, including VSC+ camps

In conclusion, this evaluation can state with some degree of confidence (but not prove) the following:

- The VSC+ camps contributed significantly to the uptake of sterilisation in the catchment areas and in the district as a whole because sterilisation is mainly provided through VSC camps. VSC+ camps did increase availability of sterilisation services and choice for those men and women interested in this family planning method.
- VSC+ camps did not increase significantly the uptake of other forms of contraception (LARC, pills or Depo). Whether this was linked to low demand, ineffective mobilisation or to other reasons is not known, but demand for these services was very low. It can therefore be concluded that VSC+ camps had a marginal or insignificant effect in terms of increasing availability or choice for contraceptives other than sterilisation.
- While these conclusions suggest that VSC+ camps did not significantly increase uptake or choice of other forms of contraception in Baitadi they do not mean that offering these contraceptives in VSC+ camps is not cost-effective. In fact, as the costing analysis will show it is both cost effective and cheap to offer LARC in VSC+ camps, regardless of their uptake, although the higher the uptake the more cost effective it would be.
- VSC+ camps work well where there is high unmet need for sterilisation. However, even in these areas the number of VSC+ camp phases should be either reduced (as the last two phases offered worse results than the first two phases) or the phases be more evenly spread during the year instead of taking place in four consecutive months.

3.2 Quality of FP services provided

The quality of services in the camps was assessed in three ways: a) through direct observation by the research assistant of services delivered in the four camp sites, b) by asking a sample of women (24 clients) exiting the camps about their perceptions on the quality of the service received, and c) by seeking perceptions of quality of services among a range of key informants using key-informant interviews (KII). This section presents the findings originating mainly from observations by the research assistant and from KIIs.

Our research assistant made observation visits to each of the four camp sites and covered 9 out of 12 camps (as shown in section 3.1.1). They used an observation checklist and prepared observation notes of each visit.

To complement observations and views from clients, we also interviewed a range of key informants to explore their perceptions on the quality of FP services delivered through

camps and the barriers they experienced. Two staff from the District Health Office (DHO) - the District Health Officer and the FP Supervisor - were interviewed. We also interviewed service providers: three health facility in-charge and three FP service providers from the three camp sites (except the district hospital); and a doctor and a nurse from the camp team belonging to the district hospital. To better understand mobilisation we also interviewed four FCHVs and three members of the HFOMC. Finally, the NHSSP district coordinator was also interviewed. Most of these informants were interviewed twice - during monitoring and then at endline. The information from these interviews is presented next.

3.2.1 Availability of FP commodities

It was observed and reported that all FP services – condom, pills, depo, LARC (implant and IUCD) and sterilisation (vasectomy and Minilap) were offered from all four camp sites. FP commodities and emergency medicines were reported to be generally available in all camp sites and no stock-outs were reported. However, the DHO staff reported that the fare that had to be paid to transport commodities to the camp sites was expensive and represented a management challenge for the DHO team. (Source: KII with in-charges, DHO staffs and observation notes)

3.2.2 Availability of equipment and physical infrastructure

All the necessary equipment was reported to be available in all of the camp sites as it was reported that NHSSP supported the district by providing required equipment. (Source: KII with in-charges).

In-charges of the three peripheral camp sites reported that their sites did not have enough beds for clients to take rest after sterilisation. And it was found that clients were lying on the floor after receiving sterilisation, some of them crying in pain. It was also observed that this situation created fear and discomfort among people who were waiting for the service. (Source: KII with in-charges and observation notes)

Availability of space and separate rooms for counselling and service delivery in the peripheral camp sites was not reported to be a major problem by facility in-charges. Service providers from the camp team reported lack of enough rooms in the district hospital for effective functioning of the camps. They stated that they had to shift things from one room to another in order to free enough space and rooms for the camp. It was also reported and observed that maintaining confidentiality of clients was a challenge in the district hospital due to unavailability of a separate room for counselling. (Source: KII with service providers and observation notes).

3.2.3 Availability of trained human resources

A team from the district hospital that included one doctor (Minilap and vasectomy provider), two to three nurses (LARC providers), a helper/peon and a driver were mobilised to run the camps in all four sites. It was reported that the technical team of a doctor and nurses were trained and skilled. Trained LARC providers were found to be available in three out of the four camp sites (with exception of Talladehi HP) and these sites were offering LARC before the intervention began. These trained providers in the camp sites had the primary role of

providing counselling to clients and were also engaged in assisting the camp team during camp hours. (Source: KII with DHO staffs and in-charges and observation notes)

The camp teams including the health workers were found to be regularly available in all of the camp sites and were reported to be enough for the effective functioning of the camp. However, there was one instance when the trained doctor of the camp team was not available in the District Hospital during the 2nd phase of the camp due to which sterilisation service could not be delivered and clients had to return back home. (Source: Observation notes)

3.2.4 Dissemination of information about VSC+ camps

All the key informants reported that FM radio was used to disseminate information about the camp as it was considered that this approach would reach a larger number of people. In addition, FCHVs and HFOMC members were also reported to have been mobilized to disseminate information in their respective communities.

Key informants also reported distribution of posters and pamphlets in different places. Information about VSC+ camps was also shared by service providers to patients visiting health facilities, to teachers and school students, and to communities from EPI clinics in three peripheral locations. The health facility in-charge of one of the camp sites (Haat) reported that since they did not receive any client in the first VSC+ camp, he identified potential couples and sent them an invitation for the FP service, which he thought was a good strategy to attract clients. (Source: KII with DHO staffs, NHSSP staff, in-charges and service providers).

The timing of information dissemination about the camp was considered an important factor to attract clients. The DHO staff and in-charges of four camp sites reported that the information about the camp was disseminated after the Pre-VSC meeting which was generally conducted about a week before the camp date. Moreover, they stated that orientation was provided to the FCHVs and HFOMC members during the pre VSC meeting and were actively mobilized in information dissemination. (Source: KII with DHO staffs and in-charges)

We also talked with a person from the radio station to find out when exactly was the information of the camp disseminated in the district. It was found that the message through radio FM was aired for 7 days before the camp date and was aired 8-10 times per day (during morning, afternoon, evening and night). The message was shared in Nepali, before, during and after some popular programmes were aired. From our observation it was felt that sharing the message in Nepali might not have been an effective approach because the majority of the women we interviewed were not comfortable with speaking Nepali as they speak a local language '*Doteli*'. Knowing this scenario in advance, we had hired a local research assistant fluent in the local language to ensure quality M&E data collection.

We interviewed FCHVs and HFOMC members to get further information about their engagement in information sharing to the communities. They reported that information was mainly spread through mothers' group meetings and discussion during informal meetings with community people. One of the FCHVs from Haat stated that she also made door-to-door visits to the houses of potential users to inform them about the camp. The research

assistant also observed that FCHVs brought clients with them to the camps from their respective community and also took them back after they received service. Members of HFOMC reported that they informed people in their village through informal talks and meetings. (Source: KII with FCHVs and HFOMC, and observation notes)

Different means of dissemination were reported to have been used to reach the potential couples in the communities. However, the research assistant reported that the service providers from the district hospital were not aware that that day was the camp day and were therefore not prepared accordingly. The doctor in the district hospital during camp day was available on a call basis only. Given all the efforts made to mobilise potential users it is not clear why few clients (or even zero clients) turned up on camp days. Understanding this important issue about the effectiveness of mobilisation would have required collecting a large amount of data from communities which was not attempted due to the time and resources that such an approach would involve.

3.2.5 Monitoring and supervision visits

The FP focal person and DHO were responsible for undertaking monitoring and supervision visits to camp sites. However, it was reported that monitoring was not done on a regular basis due to the busy schedule of the DHO staff and that they had visited only one or two camps during the intervention period. QI (Quality Improvement) tool was mentioned to be used by the DHO staff during their visit to the camp sites for the improvement of the service provided from the camp (Source: IDI with DHO staffs, NHSSP staff and observation notes)

3.2.6 Factors affecting client flow in VSC+ camps

The relatively modest uptake in the VSC+ camps and the low client attendance to some of them – which in some cases reached zero clients - triggered a number of questions to key informants about the reasons for that. This section includes perceptions and opinions of key informants. It is impossible to independently verify these views but we consider them worth consideration to put the findings in context.

Time of camp

The majority of the key informants stated that the camp was not conducted at an appropriate time as it was conducted in hot weather and during the festive season. The informants were of the opinion that had the camps been conducted during the winter season, they would have received more clients. Moreover, they also emphasized that it was the harvesting season and hence clients could not come for service leaving their work behind. (Source: KII with DHO staff, health in-charges, service providers and FCHVs).

However, some informants considered that the season was appropriate as migrant men return to their home for festivals. (Source: KII with service providers and DHO staff)

Attractive incentive in India

As Baitadi is a border district to India, it is quite common for people visit India to get basic supplies. People are also attracted by the incentive scheme for sterilisation provided in India which is reported to be quite high when compared to Nepal (see Box below). Hence, clients may have preferred to receive services in India, which may have reduced the uptake for

similar services offered in the VSC+ camps. (Source: KII with DHO staff and service Providers).

Box – reported incentives offered in India

The proposed enhanced scheme in 11 high focus states is as follows:

A. Public (Government) Facilities: (all amounts in Rupees)

SN	Procedure	Tubectomy			Vasectomy	
		<i>Existing</i>	<i>Proposed</i>	<i>PPS</i>	<i>Existing</i>	<i>Proposed</i>
	<i>Details of the package</i>					
1	Acceptor	600	1400	2200	1100	2000
2	Motivator/ASHA	150	200	300	200	300
3	Drugs and dressings	100	100	100	50	50
4	Surgeons' compensation	75	150	250	100	250
5	Anaesthetist/ Assisting MO (if any)	25	50	50	-	-
6	Nurse/ANM	15	30	50	15	30
7	OT technician/helper	15	30	50	15	30
8	Clerks/ documentation	-	20		-	20
9	Refreshment	10	10	-	10	10
10	Miscellaneous	10	10	-	10	10
	TOTAL	1000	2000	3000	1500	2700

*PPS: (Post Partum Sterilisation)

B. Accredited Private/NGO Facilities: (all amounts in Rupees)

S.N	Procedure	Tubectomy		Vasectomy	
		<i>Existing</i>	<i>Proposed</i>	<i>Existing</i>	<i>Proposed</i>
	<i>Details of the package</i>				
1	Facility	1350	2000	1300	2000
2	Acceptor	-	1000	-	1000
	TOTAL	1500	3000	1500	3000

Source: Picture taken from official letter from the Joint Secretary, Health and Family Welfare, Government of India. Document No. 11026/11/2914-FP, Dated 20.10.2014. Document kindly facilitated by NHSSP

Transportation

Transportation was found to be another barrier for the clients to receive service from the camp. The camps targeted people from places/VDCs with no transportation access and from where clients have to walk for 5-6 hours to reach the sites. (Source: IDI with health in-charges, service providers and HFOMC member). As evaluators we add that the fuel crisis also reduced the availability of transport across Nepal.

Lack of trust towards FCHVs

One of the interviewed FCHVs stated that it was very difficult for her to convince community people about the available FP services in the camp because they did not want to listen and did not take her suggestions. Another FCHV added that she was accused of receiving the allowance for visiting their homes and so did not pay much attention to her advice.

Lack of knowledge and misconceptions among community people

FCHVs and HFOMC members reported that the people in their communities were ignorant and illiterate. It was reported that people do not understand no matter how much you try to inform about family planning methods. Moreover, there is a tendency not to use a device if other people faced any side effects of the same method.

3.3 User satisfaction with services received

3.3.1 Generalisability of results from exit interviews

A total of 24 exit interviews were undertaken using a structured questionnaire with women who received LARC or sterilisation from the four camp sites in Baitadi district. We aimed to interview 40 clients but we were unable to meet this target because three of the observed camps did not receive any clients and the research assistant could not reach the district on time to observe three camps in the first phase of the pilot. Table 3.5 below shows the number and distribution of exit interviews conducted.

The main purpose of collecting data through exit interviews was to assess client satisfaction with the service received from the camp. This was assessed on the basis of indicators such as choice of method received, distance to the health facility, waiting time, perceptions of the counselling process, and satisfaction with providers' behaviour and overall services received.

Information presented in this section of the report should be seen as *indicative rather than statistically representative* because the number of exit interviews was small and not evenly distributed across the 12 camps. In total 14.37% of the total number of LARC and sterilisation users were interviewed in the four camp sites; 22 were sterilisation users (16.4% of the total sterilisation users) and 2 were LARC users (13.33% of the total LARC users).

In addition to conducting exit interviews, we also followed up 10 users from the 24 clients that we interviewed by interviewing them one month after receiving the service. The aim was to explore their experience of the VSC+ camp in detail and to find out if they experienced any complications or side effects of the method received from the camp. The findings from the follow-up interviews are also presented in this section.

Table 3.5: Distribution of exit client interviews by facilities and phase

Name of health facilities	Phase I	Phase II	Phase III	Phase IV	Total
Baitadi					
Kulau HP	*	0	4		4
Talladehi HP	*	4	4		8
Haat HP	*	4	4		8
District hospital		0	0	4	4
Total	0	8	12	4	24

Note: * denotes that the camp was not visited/monitored by a research assistant; grey boxes denote that the camp was not conducted and "0" indicates that no client attended the camp in that phase.

3.3.2 Received FP method of choice

All the interviewed women (N=24) stated that they had received the family planning method of their choice. We only interviewed LARC and sterilisation users as they represented the large majority (99%) of all VSC+ camp users.

3.3.3 Previous family planning method used and switch in method

Among the 24 clients interviewed, 21 reported that they were previously using a FP method (so they were 'existing users'), while the remaining 3 were using a contraceptive for the first time ever (so they were 'new users'). As shown in Table 3.6, the majority of interviewed clients switched FP method (i.e. from short term to either LARC or sterilisation). For instance, we can see that 18 clients who were using short acting methods before, switched to either LARC or sterilisation.

Table 3.6: FP method utilization by clients before and on the camp day

	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total
Previous FP method used (before coming to the Camp)					
Condom	3	0	4	3	10
Pills	0	0	0	0	0
Depo Provera	1	1	2	4	8
Implant	0	0	2	1	3
Total	4	1	8	8	21
FP device received on camp day					
I.U.C.D	0	0	0	0	0
Implant	1	0	0	1	2
Male sterilisation	1	1	3	4	9
Female sterilisation	2	3	5	3	13
Total	4	4	8	8	24

Source: Exit client interviews

We asked the clients about the reasons for the method switch and the majority (16 out of 21) stated that they do not desire more children, while clients also reported other reasons such as side effects of the previous method used and lack of effectiveness, amongst others (see Table 3.7 below).

Table 3.7: Reasons for switch in method

	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total
No desire for more children	3	1	6	6	16
Side effect of methods used	1	0	3	1	5
Lack of effectiveness of method used	1	0	1	0	2
Can give birth to child in need	0	0	0	1	1

Due to effectiveness of method	1	0	0	0	1
Total	4	1	8	8	21

Source: Exit client interviews

3.3.4 Source of information about availability of FP methods in VSC+ camps

FCHVs and health service providers were the most commonly reported source of information about the camp. Despite the fact that FM radio was used as the main source for information dissemination, only four clients reported FM radio as a source of information. Eleven out of 24 clients reported that they did not know about the availability of comprehensive FP services in the camps i.e. they believed that only sterilisation services were provided. Friends and neighbours were also seen as other sources of information about the camp.

Table 3.8: Source of information about the camp

Sources	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total
HFOMC Member	0	0	0	0	0
FCHV	2	0	3	2	7
Health Service Provider	3	0	2	1	6
F.M. Radio/Newspaper	1	1	1	1	4
Friends	0	0	1	0	1
Neighbour	0	0	1	0	1
Posters	0	0	0	0	0
Did not know about other contraceptives being available in the camp apart from sterilisation before arrival to camp	0	3	3	5	11
Total	4	4	8	8	24

Source: Exit client interviews

3.3.5 Distance to the camp site

The time taken by users to reach the VSC+ camp was not uniform across the four sites, this illustrating the differences in access that clients in rural Nepal can experience depending on where they live and of the location of the facilities. Only one third of users reached the camp sites in less than 30 minutes whereas 75% took two hours or less, which is not an unreasonable distance for rural, hilly Nepal. The majority of clients (23/24) reached the camp sites by walking. While exploring with the clients about their reasons for visiting the camps, the most frequently reported reasons were: expert delivering the service (10), services near to home (7), comprehensive services available (7) and partners asked them to use the service (7).

Table 3.9: Distance to health facility, means of transport and reasons for attending the camp

	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total

	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total
Time to reach CAMP from home					
Within 30 minutes	3	0	3	2	8
30 minutes to 2 hours	1	3	4	2	10
More than 2 hours	0	1	1	4	6
Total	4	4	8	8	24
Means of transport used					
Public Vehicle	0	0	0	0	0
Motorcycle	1	0	0	0	1
By walk	3	4	8	8	23
Total	4	4	8	8	24
Reasons for coming to camp					
Nearest to home	2	0	3	2	7
All the services are available	2	2	1	2	7
Specialists are available	1	3	5	1	10
Recommended by spouse	1	0	2	4	7
Recommended by Friends/Neighbour	0	0	0	2	2
Recommended by Health worker	0	2	0	0	2
Total	4	4	8	8	24

Source: Exit client interviews

3.3.6 Waiting time

The majority of the clients interviewed (20 out of 24) reported that they received services in less than 1 hour, and 20 out of the 24 clients interviewed reported that they did not consider that they had had to wait for too long. The clients load was the most frequently reported reason for having to wait for a longer time.

Table 3.10: Waiting time to receive service

	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total
Waiting time					
Did not have to wait	0	0	0	1	1
Less than 30 minutes	2	2	6	6	16
30 minutes to 1 hour	0	2	1	0	3
1-2 hours	1	0	1	0	2
more than 2 hours	1	0	0	1	2
Total	4	4	8	8	24
Think had to wait long for service					
Yes	1	0	1	1	3
No	2	4	7	7	20

Don't know	1	0	0	0	1
Total	4	4	8	8	24
Reasons for waiting long					
Doctor not available on time	0	0	0	0	0
Client loads	1	0	1	1	3
Insufficient equipment	0	0	0	0	0
Don't know	0	0	0	0	0
Total	1	0	1	1	3

Source: Exit client interviews

3.3.7 Counselling

Twenty-one out of 24 interviewed clients reported that they had received counselling. All three clients who did not receive counselling were from the district hospital. Among the 21 clients, 18 clients had received counselling both before and after taking the service.

Table 3.11: When did clients receive counselling?

	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total
Before taking services	1	0	1	0	2
After taking services	0	0	1	0	1
Both time	0	4	6	8	18
Total	1	4	8	8	21

Source: Exit client interviews

To assess if privacy and confidentiality were maintained, clients were asked about the place where they received counselling. All 21 clients who received counselling reported that they received counselling in a separate room.

Table 3.12: Where did clients receive counselling?

	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total
Separate room	1	4	8	8	21
At a corner of a service delivery room	0	0	0	0	0
OPD room	0	0	0	0	0
Total	1	4	8	8	21

Source: Exit client interviews

From the observation of camps at the district hospital, it was noted that there was a lack of staff providing counselling, and even though a separate room was available the service providers provided counselling at their discretion. (Source: Observation notes)

3.3.8 Satisfaction with the service provider and service received

All of the interviewed clients reported the behaviour of the service provider to be either very good or good, and none of them reported the behaviour of the provider to be bad (Table 3.13).

Table 3.13: Client rating of the behaviour of the service provider

	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total
Rate the behaviour of the service provider					
Very good	3	1	6	2	12
Good	1	3	2	6	12
Satisfactory	0	0	0	0	0
Not good	0	0	0	0	0
Very bad	0	0	0	0	0
Total	4	4	8	8	24

Source: Exit client interviews

We also asked clients to rate the overall service that they received from the camp. All rated the overall service good or very good (Table 3.14).

Table 3.14: Satisfaction with the service received

	Baitadi hospital	Kulau HP	Talladehi HP	Haat HP	Total
Rate the overall services you received					
Very good	0	1	6	2	9
Good	4	3	2	6	15
Satisfactory	0	0	0	0	0
Not good	0	0	0	0	0
Very bad	0	0	0	0	0
Total	4	4	8	8	24

Source: Exit client interviews

These findings reflect positively on the professionalism of the service providers and camp staff and their effort to provide a quality service often in challenging circumstances. Although all interviewed clients reported to be satisfied with the service, four out of 10 clients (mainly women) followed up after the camp responded that they would feel more comfortable if the service provider had been a female. (Source: KII with follow-up clients)

3.3.9 Complication/side effects

We explored the occurrence of complications and side effects with the 10 clients that we followed up one month after receiving the service. Two out of 10 clients interviewed did not face any complication or side effects. However, remaining clients reported they faced a side effect of the method they received from the camp, seven reporting that they either experienced pain, or bleeding. One complication was also reported when a vasectomy user had swollen testes for which he was referred to the district hospital.

4. Evaluation Findings – Modality B – Service provision by MSI/SPN in Darchula

4.1 Uptake of FP services

To measure the uptake of LARC and sterilisation delivered through VSC+ camps, we used NHSSP data, as mentioned earlier in 3.1. We counted the total number of sterilisations, LARC, pills and depo delivered in all 16 camps between September-December 2015. In the following sections we present summary tables and figures.

4.1.1 Number and frequency of camps

Between September and December 2015, a total of 16 camps were conducted in Darchula. Camps were conducted in four phases, i.e. four camps in each health facility. As proposed in our evaluation plan, the research assistant from HERD monitored 10 camps (out of 16). Similar to Baitadi, the camps in Darchula were not conducted as planned initially in the implementation guideline of NHSSP. Four camps were conducted in each of the four sites compared to the original plan of conducting 15 camps (six camps in the district hospital, and three camps in each of the three selected peripheral sites). Table 4.1 below shows the camp sites and the schedule in Darchula.

Table 4.1: VSC+ camps conducted and observed in Darchula

Name of the Health Facilities	Phase I	Phase II	Phase III	Phase IV	Totals
Latinath Health Post	20-21 Sept *	30-31 Oct	25-26 Nov *	9-10 Dec	4
Gokuleshwor Hospital	23- 24 Sept *	27-28 Oct	28-29 Nov *	12-13 Dec	4
Hikila Health Post	27- 28 Sept *	3-4 Nov *	2-3 Dec	15-16 Dec	4
District Hospital	30Sept-2 Oct *	6-8 Nov *	5-7 Dec *	18-19 Dec *	4
Total camps conducted	4	4	4	4	16
Total camps monitored	4	2	3	1	10
Camp days	9	9	9	8	35

* indicates that the camp was visited and observed by the research assistant

4.1.2 Uptake of family planning services in VSC+ camps

The uptake of contraceptives during VSC+ camps will provide the evidence to respond to the first evaluation question: Does the provision of an expanded range of FP services through

comprehensive camps (VSC+) increase the availability, choice and uptake of FP services in rural Nepal?

Table 4.2 below summarises uptake of family planning services in the 16 VSC+ camps delivered in Darchula.

Table 4.2: Uptake of FP in 16 camps during VSC+ pilot, Darchula

Darchula	Minilap	Vasectomy	Implant	IUCD	Pills	Depo	Counselling	Condom
District Hospital	14	16	8	5	0	0	0	0
Hikila	8	12	17	0	0	0	0	1
Gokuleshwor	4	9	15	0	4	8	0	0
Latinath	1	6	52	0	0	0	0	2
Total	27	43	92	5	4	8	0	3
Average per VSC+ camp	1.69	2.69	5.75	0.31	0.25	0.5	0	0.19

Source: NHSSP

Between September and December 2015, a total of 182 clients received contraceptives or sterilisation from 16 VSC+ camps. The uptake figures show that the camps delivered 97 LARC, 70 sterilisations and a much smaller number of depo and pills. Therefore, the majority of clients (53.3%) opted for LARC (95% of these clients were implant users) while 38.46% clients chose sterilisation. Only 8.24% of clients opted for other FP commodities. Even for LARC and sterilisations the uptake is considered quite low, as the average uptake per camp was 4.38 sterilisations and 6 LARC per VSC+ camp.

The VSC+ camps in Darchula achieved a total of 1284.6 Couple Years of Protection (CYP). The CYP achieved for sterilisation was 910 (70 sterilisation x 13 CYP per sterilisation), 349.6 CYP for implants (92 implants x 3.8 CYP per implant), 23 CYP for IUCD (5 IUCD x 4.6 CYP per IUCD) and 2 CYP for depo (8 doses x 1 CYP per 4 doses). We have not calculated CYP for pills because we do not know the exact number of cycles of pills distributed to these 4 clients.

4.1.3 Characteristics of service users (live children)

As explained in the previous chapter, by characteristics of service users we mean the number of live children for the users of VSC+ camps. These characteristics are summarised in Table 4.3 below, and the following observations can be made:

- More than one third of LARC (37%) and sterilisation (35.7%) users had two live children or less.
- The majority of LARC (59.78%) and sterilisation (64.29%) users had three and more live children.

- 14% of LARC users and 10% sterilisation users had more than five live children, the highest number of live children reported to be 9.

Table 4.3: Number of live children among LARC and sterilisation users

No. of live children	LARC	Sterilisation	Pills	Depo	Condoms	Totals
1	4	0	0	1	0	5
2	33	25	0	5	2	65
3	22	17	3	1	0	43
4	20	21	1	0	1	43
5+	13	7	0	1	0	21
Total	92*	70	4	8	3	177

Note: *details of 5 implant cases missing, therefore total LARC user is 92 instead of 97

4.1.4 Further analysis on uptake in each of four delivery phases

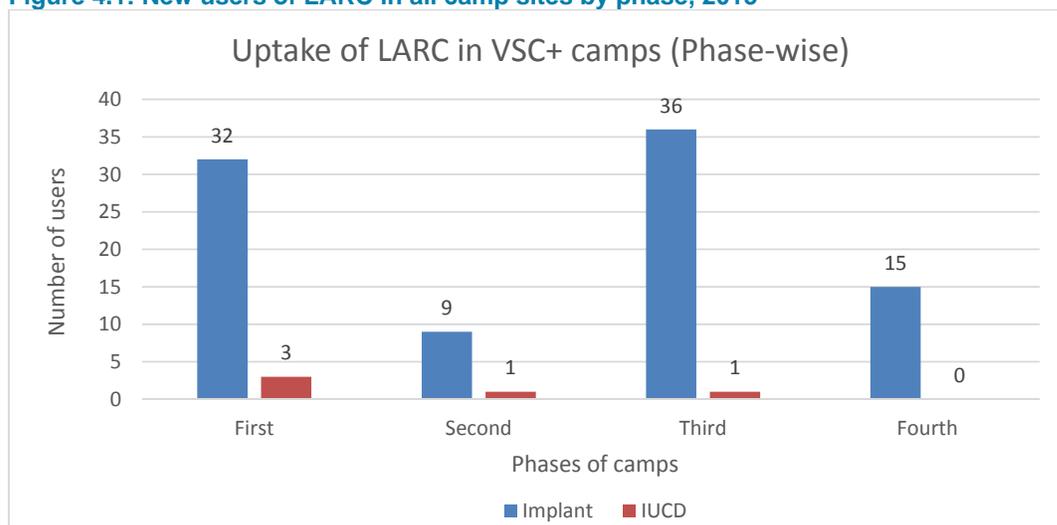
This section provides further analysis on the uptake of family planning methods in each of the four delivery phases.

Uptake of LARC, Pills and Depo

Only one LARC user was 18 years old, while all remaining LARC users were women aged 20 years or more. In the same period, four pills, eight Depo and 3 condoms were distributed from the VSC+ camps.

Figure 4.1 below shows the variation in the uptake of LARC during the four phases. There is not a clear increasing or decreasing pattern in LARC provision (except for IUCDs, but the numbers are too small to speak of a pattern). Uptake of implants was 15 times higher than for IUCD. The average number of IUCDs and implants inserted per camp was 0.31 and 4.81 respectively.

Figure 4.1: New users of LARC in all camp sites by phase, 2015



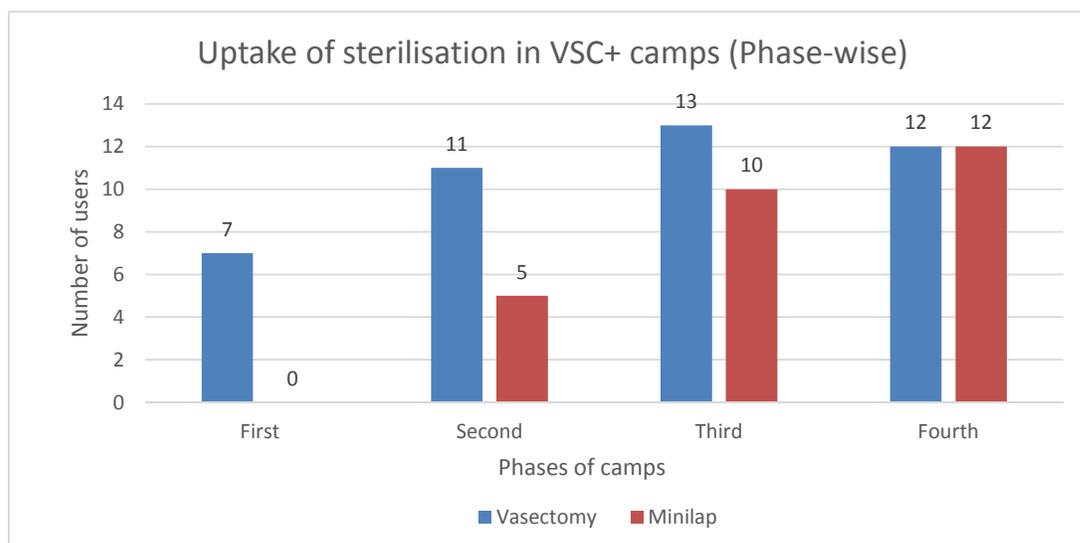
Source: NHSSP data

Uptake of Sterilisation

All sterilisation users were aged 20 years or more. The uptake of Minilap was 1.59 times lower than that of vasectomy. The average number of Minilap and vasectomy delivered per camp was 1.68 and 2.68 respectively.

Figure 4.2 below shows that the uptake of sterilisation followed a slightly increasing trend.

Figure 4.2: Sterilisation users in all camp sites by phase, 2015



Source: NHSSP data

It was also observed that LARC uptake (N=97) is 1.38 times higher than sterilisation (N=70) delivered from the VSC+ camps.

4.1.5 Brief discussion

Total uptake of family planning services in Darchula was similar to that achieved in Baitadi (169 versus 149 respectively), particularly if we consider the number of users per camp (10.5 and 12.6 respectively). However, the proportion of users who chose LARC and sterilisation respectively under each modality was quite the opposite, as shown in Table 4.4 below. This finding will be thoroughly discussed in the costing analysis (Chapter 5) and in the Conclusions (Chapter 6) because it has important implications in terms of cost effectiveness, cost benefit and scalability costs.

Table 4.4: Comparison of family planning uptake between Darchula and Baitadi

	Minilap	Vasectomy	Total sterilisation	Implant	IUCD	LARC total	Depo and pills	All users	Camps	Clients per camp

Baitadi	105	29	134	14	1	15	1	149	12	12.4
Darchula	17	43	60	92	5	97	12	169	16	10.5

Note: shaded cells show the biggest differences in uptake between the two modalities.

Did the uptake and choice of family planning *increase* as a result of the VSC+ approach in Darchula district?

The uptake of sterilisation services increased, as was to be expected since VSC camps have traditionally been the main or only means for people to access sterilisation services in Darchula where sterilisations are not regularly delivered at any hospital. Nevertheless, the uptake of sterilisations was very modest, at an average of 3.75 sterilisations per camp. Surprisingly, there were more vasectomies than Minilaps performed, when the opposite is usually the case.

The relatively small number of Minilaps performed in Darchula is probably the most salient, unexpected feature in terms of uptake. In relation to this, MSI/SPN service providers and our research assistant reported that service providers were reluctant to provide Minilap in two camp sites (Hikila and Latinath) because of the difficulty of referring clients who suffered any complications from those sites to the district hospital in Darchula, which apart from being distant had been damaged by floods.⁷ Service providers were concerned that should any complications occur these might not be properly treated and the service providers could be blamed. As a result, women attending these facilities may have been counselled to opt for LARC (specifically implants) rather than Minilaps. While this explanation would largely explain the modest and unusually low uptake of Minilap in Darchula evaluators have been unable to prove it because some service providers only mentioned these issues 'off the record' and because there is no record of what women were advised during counselling sessions, as counselling is by definition private and confidential.

The uptake of LARC was 1.5 times higher than that for sterilisations (6.06 LARC per camp on average) and implants were demanded far more (18 times so) than IUCDs. Since no LARC were being delivered in any of the four camp sites all LARC delivered through the VSC+ were additional, and therefore the camps increased access to and choice of FP services.

How did the uptake of sterilisation in VSC+ camps compare with that achieved in VSC camps in the same district in previous years or in other parts of the district on the same year? Answering this question could be an indirect way of (a) assessing if provision of other contraceptives during VSC+ camps 'displaced' sterilisation in favour of other forms of contraception (like LARC), and (b) how the uptake of sterilisation in VSC+ camps compares with that achieved through the traditional VSC camps.

⁷ The unprecedented rainfalls in June 2013 caused floods and claimed heavy loss of land and property in Darchula. The sudden spillway gate opening from the reservoir added to the heavy floods in Mahakali that devastated Khalanga, the headquarters of Darchula district where the district hospital is located. Several infrastructures were damaged in the floods, including the district health office and district hospital, both of which lost part of its space and functionality.

- The first question regarding ‘displacement’ of sterilisation by other contraceptives appears relevant in the case of Darchula as the camps delivered more LARCs than sterilisations.
- On the performance of VSC+ camps vis-a-vis the previous VSC model, we compared uptake of sterilisation during VSC+ camps with uptake in previous years using the number of camp days as a denominator. This is shown in Table 4.5 below (data for previous years was taken from the DHO and is presented in Annex 2).
- The comparison shows that VSC+ camps delivered less sterilisations per camp than the VSC camps conducted in previous years. While this finding would suggest that the availability of LARC in VSC+ camps did displace sterilisations, in the case of Darchula this finding is far from robust⁸ and the results remain inconclusive.

Table 4.5: Uptake of sterilisation reported in Baitadi in previous years

Fiscal Year	Number of camp days*	Vasectomy	Minilap	Total	Average per camp day
2013/14	14*	82	64	146	10.4
2014/15	12*	98	76	174	14.5
2015/16*	14*	51	22	73	5.21
VSC+ 2015	16**	43	27	70	4.37

Source: DHO Baitadi. Detail of camps in previous years is shown in Annex 2.

* The estimation of number of camp days is approximate and probably an underestimation based on calculations shown in Annex 2

** This figure represents camps rather than camp days. See footnote explaining why.

In conclusion, this evaluation can state with some degree of confidence (but not prove) the following:

- The VSC+ camps contributed to the uptake of sterilisations, although the number of sterilisation users (particularly Minilap) was very low for reasons we do not know. The uptake of LARC, being modest was higher than that for sterilisations. It is possible that offering LARC in VSC+ camps made some women opt for LARC instead of sterilisation, but this cannot be proved with the available data. Service providers did say that they were reluctant to insert Minilaps in two camp sites as there was not a nearby district hospital capable of dealing with potential complications of Minilap. Again, this statement may explain lower uptake of Minilap in some cases but does not constitute evidence as such.
- It can be concluded that VSC+ camps had a significant effect in increasing availability and choice of contraceptives other than sterilisation for women attending the camp.
- While the proportion of sterilisations and LARC in VSC+ camps in Darchula has rendered sterilisation services less cost effective when compared to LARC the costing analysis will show that it is both cost effective and relatively cheap to offer LARC and

⁸ The calculations are not robust because the denominator for VSC+ camps is the number of camps while for VSC camps from previous years the denominator is camp days, but the camp days calculation is just notional (taken from Annex 2) since the information on camp days for VSC camps from previous years was not available at the DHO.

sterilisations in VSC+ camps, regardless of their uptake, although the higher the uptake the more cost effective they would be.

- Interestingly, and in contrast with Baitadi, the uptake of LARC and sterilisation in VSC+ camps did not decrease as successive phases of the camp were being run in the same site. It is not possible to explain this difference but the implication is that, unlike in Baitadi, reducing the number of camps run in the same location would reach a much lesser number of potential users. Likewise, and for the same reasons, a more even spread of camps during the year may not improve the uptake of family planning in the camps.

4.2 Quality of FP services provided

Quality of services in camps in Darchula was assessed in similar ways as in Baitadi, that is: through a) direct observation of services delivered in four camp sites by the research assistant, b) by asking a sample of LARC and sterilisation users (40 clients) exiting the camps about their perceptions on quality of the service received, and c) by seeking perceptions of quality of services among a range of key informants using key-informant interviews (KII). This section presents the findings originating from observations by research assistant and from KIIs.

Research assistants from HERD made observation visits to each of the four camp sites and covered 10 out of 16 camps (distribution of monitored camps presented in section 4.1.1). During their visits they made use of observation checklist and prepared notes to capture the implementation process.

To complement observations and views of clients, a range of key informants were also interviewed; they included two staff from the DHO (the District Health Officer and the Family Planning Supervisor), three in-charges and two service providers (FP service providers, but not LARC providers) of three camp sites/health facilities, five MSI/SPN service providers and four FCHVs. In addition, the district coordinator of NHSSP was also interviewed. Most of these informants were interviewed twice, during monitoring and at endline. The information provided by these informants is included in the following sections.

4.2.1 Availability of FP commodities

All FP services – condom, pills, depo, LARC (implant and IUCD) and sterilisation (vasectomy and Minilap) were offered from all four camp sites during the intervention period. FP commodities and emergency medicines were reported to be generally available in all camp sites and no stock-outs were reported. All FP commodities and equipment required for the camps were carried by MSI/SPN team to the camp sites. (Source: KII MSI/SPN service providers, DHO staffs and observation notes)

4.2.2 Availability of equipment and physical infrastructure

All the necessary equipment was reported to be available in all of the camp sites as the MSI/SPN team carried all the equipment including bed, autoclave and stretcher to the camp sites. (Source: KII with MSI/SPN service providers, NHSSP staff and DHO staff)

Physical infrastructure to provide FP services in camp sites was found not to be enough in three of the camp sites (except Latinath) (Source: KII with local service providers, MSI/SPN Service Provider, NHSSP staff, and DHO staff). Some key informants reported that there was lack of space in these camp sites due to the flood that occurred in the past year that had destroyed some parts of the facilities' buildings (source: DHO staff and local service providers).

The researcher also observed that there was a lack of beds to rest after receiving service and clients were lying on the floor. (Source: Observation notes)

4.2.3 Availability of trained human resources

A team of MSI/SPN that included one doctor, 3 nurses, 1 clinic helper and 1 driver were mobilised to run the camps in all four sites. In the health facilities, locally trained LARC providers were not available in two out of the four camp sites. The LARC providers in two camp sites were trained a few months before the pilot began and therefore all the four sites were not offering LARC before the intervention. (Source: KII with DHO staffs and in-charges and observation notes)

The local staff from the camp sites were involved in counselling, registration and record keeping. It was found that during counselling, the MSI/SPN team faced a language barrier and hence sought support from local service providers. It was observed that MSI/SPN mobilised different service providers for different phases and because of this local staff and MSI/SPN staff did not seem comfortable. (Source: Observation notes and KII with in-charges, MSI/SPN service provider)

4.2.4 Dissemination of information about VSC+ camps

As was found in Baitadi, FM radio was used to disseminate information about the camp considering this approach would reach a larger number of people. In addition, FCHVs were mobilized to disseminate information in their respective communities. Information sharing was also done through the help of teachers, school students and health facility staff. Local service providers also reported that potential users were contacted through telephone and through home visits by FCHVs and local health facility staff. Posters and pamphlets were also reported to be distributed. (Source: KII with DHO staffs, NHSSP staff, in-charges and local service providers).

The timing of information dissemination about the camp is similar to what was found in Baitadi. The DHO staff and facilities' in-charges reported that the information about the camp was disseminated after the Pre-VSC meeting which was generally conducted 10-15 days before the camp. Moreover, they stated that orientation was provided to the FCHVs and HFOMC members during the pre-VSC meeting and were actively mobilized in information dissemination. (Source: KII with DHO staffs and in-charges)

We also talked with a person from the radio station of Darchula to find out when exactly the information on the camp was disseminated in the district. The pattern of information dissemination was the same in both districts. It was found that the message through radio FM was aired for 7 days before the camp date and was aired 8-10 times per day (during

morning, afternoon, evening and night). The message was shared in Nepali, before, during and after some popular programmes were aired.

As reported for Baitadi, the language could also be a barrier in the case of Darchula as the majority of the population speak *Doteli*. Moreover, it was reported by local health workers that the FM radio of Darchula does not cover the entire district as it has poor network coverage. Hence, this fact cannot be neglected as some people may not have received the information.

We interviewed FCHVs and HFOMC members to get further information about their engagement in information sharing to the communities. HFOMC members were found not to have been involved in dissemination and during the informal discussion by our research assistant with a few HFOMC members it was found that they were not fully aware of the intervention. Only FCHVs were mobilised for information dissemination. FCHVs reported that people were mainly informed through mothers' group meetings, gathering in community programs and discussion during informal meetings.

4.2.5 Monitoring and supervision visits

The FP focal person and DHO were responsible for undertaking monitoring and supervision visits to camp sites. NHSSP staff were also found to be involved in monitoring. Overall, monitoring and supervision visits were reported to be regular in the district. (Source: IDI with DHO staffs, NHSSP staff and observation notes)

4.2.6 Factors affecting effective implementation of the camps

This section includes perceptions and opinions of key informants on factors affecting implementation of the camps.

Time of camp

The majority of the key informants were of the opinion that the weather and season were not appropriate for increasing the client flow in the camp sites. They stated that the winter season would have been more appropriate to conduct the camp as wounds would heal faster and there would be less chance of infection. (Source: KII with DHO staff, health facilities' in-charges, MSI/SPN service providers and FCHVs).

Carrying instrument

MSI/SPN service providers stated that it was very difficult for them to carry the required instruments to the faraway locations. They stated that there was a lack of transportation facilities in some of the camp sites. In such situations they hired 4-5 porters to carry all materials. (Source: KII with MSI/SPN service providers).

Lack of infrastructure

There was an issue concerning the availability of enough rooms for providing FP services in three out of the four camp sites. This also affected the process of counselling as it was very difficult for service providers to maintain privacy and confidentiality of clients. (Source: KII with local service providers).

Moreover, a lack of beds in the peripheral sites resulted in clients having to rest on the floor. (Source: KII with facility in-charge and Observation Notes)

Lack of support from local health staff

Local staff from the peripheral camp sites were reported to be helpful during the camp period but the staff of the district hospital were not considered helpful, which affected the quality of services delivered. MSI/SPN service providers reported that they did not receive any support from the hospital staff during camp days. (Source: KII with MSI/SPN service providers and observation notes)

Beliefs and misconceptions among community people

Key informants reported misconceptions among the people of Darchula, who believed that the person undergoing sterilisation should not participate in death rituals or visit any temple. (IDI-Doctor, Service Provider; IDI-HI, Hikila HP). FCHVs reported that even after providing information and counselling about sterilisation; people did not understand and would not opt for sterilisation. It was also stated that some women did not want sterilisation because of their heavy workload; neither would some of them allow their husband to undergo vasectomy for fear of husbands getting weak and becoming unable to earn their living. (Source: FCHVs and MSI/SPN service provider)

Language barrier

ANMs from MSI/SPN reported that they faced difficulty in dealing with some clients because women were speaking their local language, which the service providers did not understand. The situation was handled by seeking help from local staff fluent in the local language. (Source: Observation Notes). It was therefore felt among service providers that the camp team should include staff familiar with the local language to ensure effective service delivery.

4.3 User satisfaction with services received

4.3.1 Generalisability of results from exit interviews

A total of 40 exit interviews were undertaken by research assistants with users of LARC or sterilisation from the four camp sites in Darchula district. Research assistants used a semi-structured questionnaire to interview clients who had received LARC or sterilisation on a day when the research assistant was present in the camp. Table 4.6 shows the number and distribution of exit interviews conducted.

The main purpose of collecting data through exit interviews was to assess client satisfaction using the same questions and indicators as in Baitadi. We were less interested in the statistical significance of views expressed, as this would have required a more evenly distributed sample of exit interviews, proportionate to the number of users in each facility. This was not feasible for operational and budgetary reasons. Therefore, all the information presented in this section should be seen as *indicative rather than statistically representative* of the satisfaction of service users across the four sites. Limited generalisability is not in this case linked to a small sample size of exit interviews: roughly, 24% of all LARC and sterilisation adopters in the camp sites were interviewed, i.e. a very good sample size by any standards (17.53% of LARC and 32.86% of sterilisation). The problem is related to the skewed distribution of exit interviews vis-a-vis the number of LARC and sterilisation adopters in each of the 4 camp sites.

In addition to conducting exit interviews, we conducted follow up interviews with 10 LARC or sterilisation users from the 40 clients that we interviewed at the camps. We interviewed them one month after receiving the service. The main purpose was to explore their experience of the VSC+ camp in detail and to find out if they experienced any complications or side effects of the method received from the camp. The findings from the follow-up interviews are also presented in this section.

Table 4.6: Distribution of exit client interviews conducted by facilities and phase

Name of health facilities	Phase I	Phase II	Phase III	Phase IV	Total
Darchula					
Latinath HP	4	*	4	*	8
Gokuleswor hospital	4	*	4	*	8
Hikila HP	4	2	*	*	6
District hospital	4	6	4	4	18
Total	16	8	12	4	40

Note: * denotes that camp was not visited/monitored by research assistant

4.3.2 Received preferred method of FP

All interviewed clients (N=40) stated that they received the preferred method. We only interviewed LARC and sterilisation users as they represented the large majority of all VSC+ camp users.

4.3.3 Method received and switch in method

Among the 40 clients interviewed, 36 (90%) reported that they were previously using a FP method (so they were 'existing users'), while the remaining 4 were using a contraceptive for the first time ever (so they were 'new users'). It was noticed (Table 4.7 below) that the majority of interviewed clients (35 out of 40) had switched FP method (i.e. from short term to either LARC or sterilisation).

Table 4.7: FP method utilization by clients before and on the camp day

	Latinath HP	Gokuleswor Hospital	Hikila HP	Darchula hospital	Total
Previously used FP devices before coming to the Camp/HP					
Condom	2	1	3	3	9
Pills	1	3	0	8	12
Depo Provera	5	3	1	5	14
Implant	0	1	0	0	1
Total	8	8	4	16	36
FP method received on the camp day					
I.U.C.D	0	0	1	4	5
Implant	5	2	3	2	12
Male sterilisation	3	3	1	6	13
Female sterilisation	0	3	1	6	10

	Latinath HP	Gokuleswor Hospital	Hikila HP	Darchula hospital	Total
Total	8	8	6	18	40

Source: Exit interviews

We also asked the clients about the reasons for the method switch and the slight majority (22 out of 40) stated that they had no desire for more children, while clients also reported other reasons such as side effects of the previous method used, health issues of partner and effectiveness of new method used, amongst others (see Table 4.8 below).

Table 4.8: Reasons for switch in FP method

	Latinath HP	Gokuleswor Hospital	Hikila HP	Darchula hospital	Total
No desire for more children	3	4	3	12	22
Side effect of methods used	4	4	0	6	14
Health issues with partners	2	0	0	0	2
Can give birth to child in need	1	0	0	0	1
Heard that Depo will not be available	1	0	0	0	1
Camp being conducted nearby	0	1	0	0	1
Lack of effectiveness of method used	0	2	1	1	4
Due to effectiveness of method	0	1	1	3	5
Total	8	7	4	16	35

Source: Exit interviews

4.3.4 Source of information about the availability of FP methods in VSC+ camps

Nearly all of the interviewed clients (39 out of 40) reported that they had heard about the camp from FM radio/newspaper. 17/40 and 8/40 reported that they heard about the camp from their friends and neighbours respectively while only four clients reported that an FCHV was their source of information about the camp.

Table 4.9: Source of information about the camp

Sources	Latinath HP	Gokuleswor Hospital	Hikila HP	Darchula hospital	Total
HFOMC Member	0	1	0	0	1
Female Community Health Worker	2	1	1	0	4
Health Service Provider	0	1	1	0	2

Sources	Latinath HP	Gokuleswor Hospital	Hikila HP	Darchula hospital	Total
F.M. Radio/Newspaper	7	8	6	18	39
Friends	5	1	3	8	17
Neighbour	1	0	1	6	8
Posters	0	0	0	2	2
Total	8	8	6	18	40

Source: Exit client interviews

4.3.5 Distance to the camp site

The distance to the camp site was not found to be uniform, this reflecting the differences in access that clients in rural Nepal can experience depending on where they live and of the location of the facilities. Only 10 users (25%) interviewed reached the camp in less than 30 minutes, whereas 14/40 users reached the camp in 2 hours or less. 40% of the users (16/40) reached the nearest camp site in more than three hours. It was also reported that the majority of clients (90%) reached the camp sites by walking. The most frequently reported reasons to visit that particular camp site were due to availability of the specialized human resources (27), availability of comprehensive services (9), followed by nearest location (2) amongst others.

Table 4.10: Distance to the camp site

	Latinath HP	Gokuleswor Hospital	Hikila HP	Darchula hospital	Total
Time to reach CAMP from home					
Within 30 minutes	2	2	2	4	10
30 minutes to 2 hours	4	2	4	4	14
More than 2 hours	2	4	0	10	16
Total	8	8	6	18	40
Means of transport used					
Public Vehicle	0	2	0	0	2
Motorcycle	0	0	0	0	0
By walk	8	6	6	18	38
Total	8	8	6	18	40
Reasons for coming to camp					
Nearest to home	1	0	1	0	2
All the services are available	2	3	1	3	9
Free services	0	0	0	1	1
Specialists are available	5	5	4	13	27
Recommended by spouse	1	0	0	1	2
Recommended by Friends/Neighbour	0	0	0	0	0
Recommended by Health worker	0	0	0	0	0
Total	8	8	6	18	40

Source: Exit interviews

4.3.6 Waiting time to receive service

Only 2 out of 40 clients interviewed reported no waiting time, whereas 19 users reported to wait for less than 1 hour and 9 users to wait for more than one hour. 17 out of 40 interviewed clients thought that they had to wait for a long time to receive the service.

Table 4.11: Waiting time to receive service

	Latinath HP	Gokuleswor Hospital	Hikila HP	Darchula hospital	Total
Waiting time					
Did not have to wait	0	2	0	0	2
Less than 30 minutes	3	0	2	9	14
30 minutes to 1 hour	2	4	3	6	15
1-2 hours	2	1	1	2	6
more than 2 hours	1	1	0	1	3
Total	8	8	6	18	40
Think had to wait long for service					
Yes	3	5	1	8	17
No	5	3	3	8	19
Don't know	0	0	2	2	4
Total	8	8	6	18	40
Reasons for waiting long					
Doctor not available on time	0	0	0	1	1
Client loads	3	1	0	1	5
Insufficient equipment	0	0	0	2	2
Don't know	0	4	1	4	9
Total	3	5	1	8	17

Source: Exit interviews

4.3.7 Counselling

All interviewed clients reported to receive counselling from the camp. 36/40 clients had received counselling both before and after the service and 4 clients had received counselling only before utilizing the service.

Table 4.12: Did clients receive counselling, and when?

	Latinath HP	Gokuleswor Hospital	Hikila HP	Darchula hospital	Total
Received any counseling service					
Yes	8	8	6	18	40
No	0	0	0	0	0
Total	8	8	6	18	40
Time of counselling					
Before taking services	0	0	0	4	4

After taking services	0	0	0	0	0
Both times	8	8	6	14	36
Total	8	8	6	18	40

Source: Exit interviews

Most of the interviewed (26 out of 40) clients reported that they received counselling in a separate room. However, 9 and 5 clients reported that they received counselling in the service delivery room and OPD room respectively.

Table 4.13: Where did the clients receive counselling?

	Latinath HP	Gokuleswor Hospital	Hikila HP	Darchula hospital	Total
Place where counselling was received					
Separate room	8	2	6	10	26
At a corner of a service delivery room	0	5	0	4	9
OPD room	0	1	0	4	5
Total	8	8	6	18	40

Source: Exit interviews

4.3.8 Satisfaction with the service received

All of the interviewed clients reported the behaviour of the service provider to be either very good (18/40 clients) or good (22/40 clients) and none of them were dissatisfied with the provider's behaviour.

Table 4.14: Satisfaction with the behaviour of provider

	Latinath	Gokuleswor	Hikila	Darchula	Total
Rate the behaviour of the service provider					
Very good	4	5	0	9	18
Good	4	3	6	9	22
Satisfactory	0	0	0	0	0
Not good	0	0	0	0	0
Very bad	0	0	0	0	0

Source: Exit interviews

When asked about the satisfaction with the overall service received from the camp, all the clients reported the service to be either good or very good.

Table 4.15: Satisfaction with the overall service received

	Latinath	Gokuleswor	Hikila	Darchula	Total
Rate the overall services you received					
Very good	4	5	0	8	17
Good	4	3	6	10	23
Satisfactory	0	0	0	0	0
Not good	0	0	0	0	0
Very bad	0	0	0	0	0

Source: Exit interviews

During follow up interviews, two of the 10 clients interviewed reported that they would feel more comfortable if the service providers were of the same sex. Minor side effects were reported by 8 out of 10 users that included back pain and vaginal bleeding. (KII with follow up clients)

5. Costing Analysis

A costing study was conducted as part of the evaluation of the VSC+ pilot in Baitadi and Darchula. A full costing analysis report has been produced and submitted separately from this evaluation report. This chapter summarises the main findings from the costing analysis.

As shown in the table below, while the total uptake of family planning services (LARC and sterilisation combined) for modalities A and B was quite similar, the majority of clients under modality A opted for sterilisation (90%), whereas under modality B a larger proportion opted for LARC (58%). This difference in uptake by type of service has had direct implications on the results of the costing analysis, to the extent that the main differences reported in terms of cost effectiveness, cost benefit and scalability costs between modalities A and B can be explained by the differences in the proportions of LARC and sterilisations delivered under each modality.

Table 5.1: Summary of service uptake in Baitadi and Darchula, 2015

District	LARC	Sterilisation	Total
Baidati	15	134	149
Darchula	97	70	167
Total	112	204	316

Source: NHSSP data

5.1 Main findings

The overall investment in the pilot resulted in provision of FP services to 316 users⁹, providing 3,082 couple years of protection (CYP). Under modality A, total of 1,800 CYPs (58 CYPs for LARC and 1,742 CYPs for sterilisation) were delivered as compared to 1,283 CYPs (373 CYPs for LARC and 910 CYPs for sterilisation) delivered under modality B.

The total cost of implementing the pilot project is estimated to be NPR 7.01 million (US\$ 68,350) over the evaluation period. The share of modality A in the total costs was 49.8% and 50.2% for modality B.

Costs were bifurcated by fixed and variable and it was found that a larger proportion of costs for the whole pilot were variable costs (58%). This means that 58% of the costs are likely to increase

Figure 5.1: Cost under modality A and B



⁹ Only sterilisation and LARC users were counted for the costing analysis. In addition to sterilisation and LARC, the VSC+ camp delivered other family planning commodities such as Depo Provera and Oral Contraceptive Pills.

with each camp organised. The proportion between fixed and variable costs was different for each modality, variable costs being 64% and 52% for modality A and B respectively.

We also estimated the additional costs of adding LARC services to the VSC camps using the marginal costing approach. We found that the additional (marginal) costs of adding LARCs to the VSC camps is extremely low in relation to each modality's total cost. This additional cost was calculated to be 3% for modality A and 5% for modality B.

Table 5.2: Costs for the entire pilot by modality and by type of method offered

Modality	Cost by Method (\$)		Total Costs (\$)
	Sterilisation	LARC	
Modality – A	32,947	1,098	34,045
Modality – B	32,624	1,681	34,306
Total			68,351

An economic model was developed to assess the cost per client and per CYP if LARCs were not provided in the VSC+ camps. The modelling results showed the cost per client and per CYP would have been 49% and 12% higher respectively for the overall pilot.

We found that the cost for providing one sterilisation through the VSC+ camp was almost double under modality B (\$466) in comparison to modality A (\$246). The main driver behind lower costs of sterilisation under modality A was the fact that more number of clients opted for sterilisation under modality A, allowing the fixed costs to be spread over a larger number of users.

The costing study also analysed the variation in cost for providing one LARC. The cost of providing one LARC through the VSC+ camps was more than four times higher under modality A (\$73) as compared to modality B (\$17). The main reason for this difference is that a significantly larger number of clients under modality B opted for LARC as compared to modality A.

The cost per camp was considered important information to be analysed. The average cost of conducting one camp under modality B (\$2,144) was 24% lower than for modality A (\$2,837).

In order to facilitate the planners and policy makers to estimate the resource requirements should the pilot be scaled-up we also calculated the operational cost of running one VSC+ camp. The results are presented below.

Table 5.3: Operational costs of running one VSC+ camp for scalability purposes

Type of cost ¹⁰	Cost – (\$)	Explanation
Category 1	610	This cost will be incurred each time the camp is conducted.
Category 2 – <i>Sterilisation (per procedure performed)</i>	8	In addition to category 1 cost, this cost will be incurred for each sterilisation performed.
Category 2 – <i>Implants (per</i>	11	In addition to category 1 cost, this cost will be

¹⁰ Category 1 – refers to those costs that are essential to conduct one camp, but will not change (increase/decrease) with the number of clients that take up the service. Category 2 – refers to those costs that will only be incurred if the FP services are provided in the VSC+ camps.

Type of cost ¹⁰	Cost – (\$)	Explanation
<i>device inserted)</i>		incurred for each implant inserted.
Category 2 – IUCD (<i>per device inserted)</i>	3	In addition to category 1 cost, this cost will be incurred for each IUCD inserted.

Both modalities are highly cost-effective when compared with the WHO benchmark of costing less than the per capita GDP. However, comparison of the modalities suggests that modality A is more cost-effective than modality B, albeit, the difference is marginal. Adding LARCs to the VSC camps was found to be highly cost effective, as the cost per DALY averted was 7.5 times and 31 times less in comparison to GDP per capita for modalities A and B respectively.

The cost-benefit analysis suggests a good return on investment, where \$1 invested in this project is likely to produce a return of \$3.5. The cost-benefit was found to be slightly higher in the case of modality A, where \$1 produced a return of \$3.9 as compared to \$3.1 for modality B. The main reason of modality A producing better results is due to the fact that more sterilisations were done under modality A, which translates into more CYPs. To understand this difference it is important to note that one sterilisation provides 13 CYPs, whereas 1 LARC results in less CYPs (for implant = 3.8 and for IUCD = 4.6).

5.2 What do the costing findings mean?

This costing study provides crucial information on the costs of providing family planning services – specifically sterilisation and LARC – through the use of VSC+ camps under two different modalities.

These findings have policy and programme implications to be borne in mind for scalability purposes and at the time of bringing together all the evaluation results. The following preliminary conclusions will be further contextualised in Chapter 6, the conclusions chapter:

- Offering sterilisation services through the VSC+ camps proved to be highly cost-effective under both modalities tested. However, reasons for low uptake of sterilisation under modality B need to be better understood before any scaling-up decision is made.
- The cost effectiveness of the VSC+ camps would improve if these were better organised (ensuring mobilisation reaches the target beneficiaries), if less consecutive camps were held in the same site (spread the sites and limit the camps to, say two camps per site¹¹) and if the duration of each camp was a bit longer. This argument is well supported by the costing analysis, which informs that the major driver of the operational costs is the number of VSC+ camps conducted. These costs include, for example, transporting health workers and equipment to the camp site, airing FM radio messages and so forth. In our analysis we found that such costs are around 55% of the total camp costs.

¹¹ The argument of holding less consecutive camps per site is less relevant in Darchula where, unlike in Baitadi, successive camps were not attracting a lesser number of clients, although the overall principle holds true from a costing perspective due to the operational costs incurred in each camp.

- While VSC+ camps in Baitadi (modality A) did not prove to be an effective way to increase LARC utilisation (in comparison to other possible approaches to achieve the same result), still LARC can, and probably should, be offered in VSC+ camps as LARC provision represents a very small and one off additional investment. Besides, LARC proved to be highly cost-effective even under modality A, where they generated a return of \$5.9 for each \$ invested.

Finally, while interpreting costing results one should keep in mind the short implementation period of the pilot (four months), as well as the unusual circumstances (earthquake, fuel crisis, commodity shortages) that surrounded pilot implementation. The short implementation period is important in relation to the costing work, because the unit costs might have been lower if the pilot had run for another year or so, as a good proportion of costs in a new intervention are fixed in nature and would have decreased with increased number of new users.

6. Conclusions and recommendations

6.1 Main conclusions: answering evaluation questions

As already reported in Nepal, voluntary surgical contraception (VSC) camps are the main or only means for delivering sterilisation services to the rural population of Nepal, particularly those living in remote locations of hill districts. For many of them the sterilisation services delivered from district hospitals – if and where district hospitals deliver these services - remain largely inaccessible due to distance, cost of travel and disruption to normal life. What the pilot interventions in Baitadi and Darchula aimed to test was whether the provision of an expanded range of family planning services in the VSC camps would attract clients interested in other forms of contraception different to sterilisation, with a particular focus on Long Acting Reversible Contraception (LARC) commodities like implants and IUCD.

A second area of interest was to compare supply and demand in the VSC+ camps through two implementation modalities: direct service provision by the DHO (modality A piloted in Baitadi) and provision by a contracted agency (modality B piloted in Darchula with MSI/SPN delivering the services from existing government facilities).

The main conclusions are presented next using the 6 questions that this evaluation study has attempted to answer.

6.1.1 Evaluation Question 1 - Did availability and uptake increase?

Does the provision of an expanded range of FP services through comprehensive camps (VSC+) increase the availability, choice and uptake of FP services in rural Nepal?

Availability

All forms of contraception plus counselling services were offered in all the VSC+ camps of both Baitadi and Darchula, so the availability and choice of family planning services clearly increased both when compared to the traditional VSC camps and also when compared to the range of services offered from those facilities on a regular basis.

Another dimension of availability (and indirectly of coverage) is the time that it took camp users to reach the camp. In Baitadi, 33% of clients took 30 minutes or less to reach the camp, 41% took between 30 minutes and two hours and only 25% took more than two hours. In Darchula, 25% took 30 minutes or less, 35% took between 30 minutes and 2 hours and 40% took more than 2 hours. In the context of rural, hilly Nepal these travel times imply that most clients lived within 2 hours of the camp and that the clients in Darchula had to travel longer distances on average. The overwhelming majority of clients in both districts travelled to the health facilities by foot, whether by choice or because of the transport restrictions experienced in Nepal at the time caused by the fuel crisis.

Uptake

Did the uptake of family planning increase? By increase in uptake we refer to the additional family planning services that were taken up in the camps and that would have *probably* not been taken up in the absence of the VSC+ camps. We did not attempt to measure the additionality of VSC+ camps in a rigorous manner because neither the methodology nor the available HMIS data allowed for that type of comparison. When we compared the uptake of sterilisations in VSC+ camps with HMIS data provided by the DHO on uptake of sterilisation during VSC camps held in previous years we concluded that the numbers of camp users remained roughly similar, although the analysis was inconclusive as available data used different denominators (camps or camp days – see Tables 3.4 and 4.5 and related comments in the findings chapters).

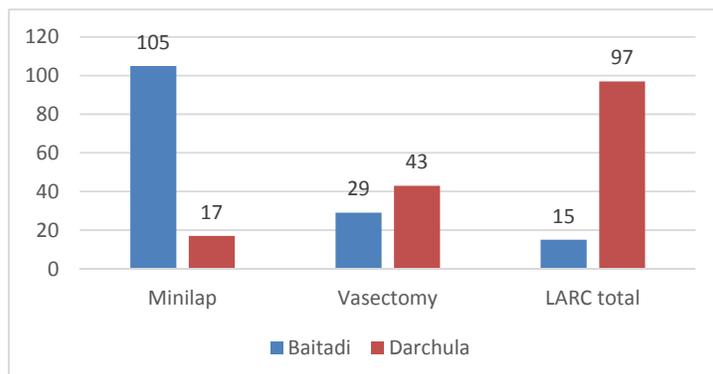
The uptake of family planning clearly increased as a result of the VSC+ camps, particularly for LARC and sterilisation services. Importantly though, the camps attracted a small proportion of new users who were not using any family planning method at the time of visiting the camps. Specifically, 87% of interviewed clients in Baitadi (21/24) and 90% in Darchula (36/40) reported to have switched family planning methods on the day of the camp, usually from a short term to a longer term method or from a reversible to a permanent method.

The reproductive background of clients who opted for either LARC or sterilisation (measured by the number of live children at the time of visiting the camp – see Tables 3.3 and 4.3) shows that 85% of clients in Darchula and 97% in Baitadi had 2 live children or more at the time of adopting either LARC or sterilisation.

Total uptake of family planning services was roughly similar in Baitadi and Darchula where 150 and 169 clients respectively took up family planning services offered at the camp. The average number of clients per camp was 12.4 (Baitadi) and 10.5 (Darchula).

As shown in Figure 6.1 below, while the total uptake of family planning services (LARC and sterilisation combined) for both modalities was quite similar, the majority of clients under modality A (Baitadi) opted for sterilisation (90%), whereas under modality B a larger proportion opted for LARC (58%). This difference in uptake by type of service is explained mainly by the modest uptake of LARC in Baitadi and by the surprisingly low uptake of Minilap in Darchula.

Figure 6.1: Comparison of uptake of family planning in Baitadi and Darchula



The reasons for the differences in the choices made by users remain unknown and unexplained by this evaluation. The low uptake of Minilap in Darchula could be linked to provider-induced counselling of women to take LARC rather than Minilap due to the difficulty of referring any women suffering to post-surgical complications of Minilap to the district hospital in Khalanga that had been damaged by the 2013 floods. According to service providers this factor affected greatly Minilap provision in the Hikila and Latinath camp sites (see discussion in 4.1.5 for more details). In any case, provider behaviour seems to have been the main reason for lower uptake of Minilap, which biased the supply in favour of LARC (particularly implants) with lower risks of complications. To be clear, evaluators do not think that the differences found respond to intrinsic differences between modalities A and B (public versus private provision) but by the specific characteristics of Darchula district that influenced provider behaviour in a particular manner.

The differences in the composition of demand i.e. the relative weight of LARC versus sterilisations under each modality have had a profound effect in the cost effectiveness and cost benefit analysis that will be discussed later when responding to evaluation question 6 (the costing analysis).

6.1.2 Evaluation Question 2 – Counselling and choice

*Were the users of VSC+ camps able to choose the FP service/commodity of their choice?
Was the choice properly informed through counselling?*

The increased availability of family planning services enabled men and women attending the camps to exercise their choice. The exit interviews conducted with a sample of service users (24 users in Baitadi and 40 in Darchula) who had received either sterilisation or LARC showed that all of them had received the family planning service of their choice. Likewise, all the camp users interviewed had received counselling and most of them had been counselled both before and after receiving the service. The privacy and confidentiality of counselling could not be always guaranteed due to lack of adequate space in some facilities, a few of which had been damaged by floods (in Darchula).

In terms of the contents of counselling (were the best options properly presented to would be users?) the specific orientation received during counselling was not explored, as counselling is by definition private and confidential so research assistants did not record counselling sessions. It is reported that the counselling provided in Darchula may have influenced choice, as discussed in 4.1.5 and two paragraphs above.

6.1.3 Evaluation Question 3 – Quality of services received

What is the perspective of beneficiaries/clients about quality of services provided through the camps?

The exit interviews with men and women who had received services showed high levels of satisfaction with the services received. Specifically, all respondents rated the quality of the service and the behaviour of service providers to be either good or very good.

As to waiting times for the service, 83% of interviewed clients in Baitadi (20/24) and 47% in Darchula (19/40) reported that either they did not have to wait for receiving the service or that the waiting time was reasonable.

Ten clients in each of Baitadi and Darchula were interviewed one month after receiving the service. None of them reported any major complications but 8 out of 10 clients in each district reported minor side effects and discomfort on the days following surgery or insertion.

Observations notes from research assistants show that all family planning commodities were generally available during the camps, with no stock outs being reported. Likewise the camps included all the required equipment and human resources, although a shortage of beds/stretchers was reported in Darchula where some patients had to lie on the floor after the procedure. There was generally good cooperation between service providers and government staff based in the facilities, with the exception of the district hospital in Darchula, as reported by service providers interviewed.

6.1.4 Evaluation Question 4 – information dissemination and demand generation

Were the advocacy activities by FCHVs and HFOMC effective in raising awareness of comprehensive FP services on offer and to generate demand among men and women of reproductive age?

The evaluation methods did not allow for a proper assessment of the effectiveness of demand generation and information dissemination approaches used for the camps, as this would have required a population based survey that was discarded for cost, time and other reasons. We could only assess the effectiveness of dissemination indirectly by asking clients interviewed how they became aware of the VSC+ camps.

There were some differences between both districts even though the reported approach to information dissemination in both districts was in principle the same, namely FM Radio, FCHVs, health facility staff/service providers, HFOMC and posters. Please note that the samples are not representative so percentages shown below should be interpreted carefully. Percentages of respondents may exceed 100% because respondents were allowed to mention more than one source.

In Baitadi, 29% of clients interviewed reported to have learnt about the camp through the FCHV, 25% from the health facility staff and 16% from the FM radio. Surprisingly, 45% of interviewees said they were not aware the camps would deliver other contraceptives in addition to sterilisation at the time of arriving to the camp, which suggests that the information dissemination was not as effective as it might have been and that most clients in Baitadi attended the camp to be sterilised. The small number of clients who learnt through the FM radio (4/24) is also surprisingly low and may be linked to the language in which the messages were disseminated (Nepali) while the local language is Doteli, implying that many people in Baitadi may not listen to that radio station.

In Darchula the proportions of people who learnt about the camps by source was quite different to Baitadi. 97% of interviewed clients had heard about the camp through the local radio and 42% reported to have also heard about the camps from friends. Only 10% said to

have heard about the camp from the FCHV and 5% from the health facility staff or service provider (MSI/SPN).

No clients in Baitadi and only one in Darchula reported to have heard about the camp from the HFOMC.

6.1.5 Evaluation Question 6 - the costs of the interventions

We present deliberately the conclusions for question 6 before question 5 as it makes more sense.

What are the main costs incurred in the proposed approach? What are the incremental costs incurred when compared with the traditional VSC camps)? Are there any significant differences in the cost of the approach between the two models being tested in Baitadi and Darchula respectively?

The total cost of implementing the pilots was estimated at NPR 7.01 million (US\$ 68,350) over the evaluation period. This figure covers all costs, including NHSSP supervision costs. The share of modality A in the total costs was 49.8% and 50.2% for modality B. Therefore both modalities costed roughly the same. It was the difference in the proportions of uptake by type of service – LARC versus sterilisations - that determined the differences in the cost effectiveness, cost benefit and scalability of each of the two modalities. This is because sterilisations have a much higher CYP than LARC. The overall investment in the pilot resulted in provision of FP services to 316 users¹², providing 3,082 couple years of protection (CYP): 1,800 CYPs for modality A and 1,283 CYPs for modality B.

It is safe to assume that the differences in the proportion of type of services under each modality were largely determined by contextual realities affecting each modality (distance, effectiveness of mobilisation, messages delivered through counselling, availability of referral services in case of complications in Darchula, etc) rather than by the modality of implementation as such. In other words, the same modalities applied to other districts would have most likely achieved a different composition of LARC and sterilisation uptake that would have offered different results in terms of cost effectiveness, cost benefit, cost per LARC/sterilisation and scalability costs.

Both modalities were found to be highly cost-effective, although modality A was slightly more cost-effective than modality B because more sterilisations were delivered than LARC.

When comparing the cost effectiveness of the previous model (VSC camps offering only sterilisation services) with the comprehensive VSC+ camps it was found that adding LARCs to the VSC camps is highly cost effective, as the cost per DALY averted was 7.5 times and 31 times less in comparison to GDP per capita for modalities A and B respectively. We also estimated the additional costs of adding LARC services to the VSC camps using the marginal costing approach and found that the marginal cost was extremely low in relation to each modality's total cost. This additional cost was calculated to be 3% for modality A and 5% for modality B.

¹² Only sterilisation and LARC users were counted for the costing analysis. In addition to sterilisation and LARC, the VSC+ camp delivered other family planning commodities such as Depo Provera and Oral Contraceptive Pills.

An economic model was developed to assess the cost per client and per CYP if LARCs were not provided in the VSC+ camps. The modelling results showed the cost per client and per CYP would have been 49% and 12% higher respectively for the overall pilot.

The cost-benefit analysis suggests a good return on investment, where \$1 invested in this project is likely to produce a return of \$3.5. The cost-benefit was found to be slightly higher in the case of modality A, where \$1 produced a return of \$3.9 as compared to \$3.1 for modality B. The main driver of the difference is that more sterilisations were done under modality A, which translates into more CYPs.

6.1.6 Evaluation question 5 - Factors affecting feasibility, scalability and sustainability

What are the main factors affecting or determining the feasibility, scalability and sustainability of the VSC+ intervention as implemented? What are the lessons for scaling up this approach?

The following points summarise the main factors affecting the feasibility, scalability and sustainability of VSC+ camps and of the two modalities – DHO and private provision - that were tested. We have tried to rank the factors by importance although the ranking is somewhat subjective.

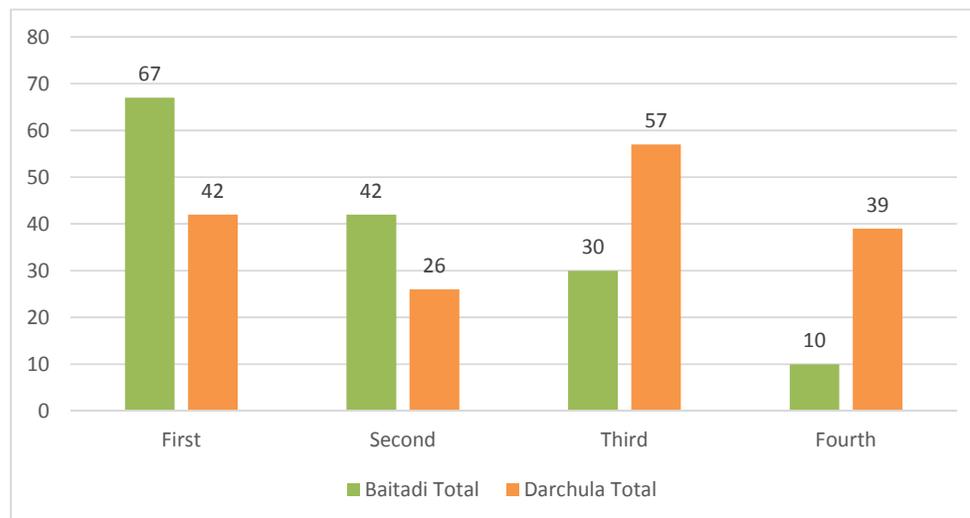
- i) **The availability of trained service providers in the government district health services network.** This seems the primary factor to consider when deciding between government and private provision. Where the government has the required human resources who are competent in counselling, LARC and sterilisation the DHO is best placed to deliver the VSC+ camps. In districts where the government lacks competent service providers, private providers are a cost effective manner to deliver the services.
- j) **The availability of referral facilities to deal with eventual post-surgery complications,** as this in turn determines the feasibility of doing sterilisations and thereby the behaviour of service providers, who may counsel for less invasive (non-surgical) options like LARC in spite of these resulting in lower CYPs. This seems to be the main reason why more LARC than sterilisations were delivered in Darchula rather than the service provision modalities – private and public - as such.
- k) **The availability of suitable health facilities to conduct the camps** (enough rooms, space for counselling, beds). Sterilisation requires conditions of hygiene over and above those required by LARC, a much less invasive procedure with less risk of complications. Nevertheless, availability of rooms (for private, confidential counselling and for hygienic insertion of LARC and surgical procedures) and beds (patients should not be expected to lie on the floor) should be guaranteed at any VSC+ camp.
- l) **The effectiveness of mobilisation and the focus on dissemination messages.** Information dissemination and mobilisation of potential clients is paramount in explaining client flows. This could only be indirectly assessed by the evaluation but anecdotal evidence suggests that most clients in Baitadi attended the VSC+ camps

in order to be sterilised rather than with an open mind about which form of contraception would better suit their needs.

- m) **The focus of counselling as a determinant of client choice.** Combined with mobilisation the focus of counselling is a key factor determining client choice of contraception. The high uptake of implants in Darchula seems closely linked to the options offered to clients during counselling. Clients are likely to be open to choices if these are well justified by service providers, particularly if the said choices are less invasive and bear less potential complications, as is the case for implants. However, poor counselling can lead to the wrong choices hence the importance of providing good training on counselling to service providers.

- n) **The number of consecutive camps run in the same health facility.** We obtained different results on whether consecutive, monthly camps result in an increase or decrease of uptake, as shown in Figure 6.2 below. In Baitadi uptake decreased with successive phases, but not in Darchula where the highest uptake took place during the third phase. In any case, for equity reasons, the district health office should decide on the best way to spread the VSC+ camps during a year in order to reach the maximum number of clients in the district. However, at the moment there is not a clear guideline to follow and the characteristics of demand in each district should drive supply decisions. It is also important to note that differences in mobilisation could have also influenced the uptake by phase.

Figure 6.2: Uptake of LARC and sterilisations combined by phase in Baitadi and Darchula



- o) **Seasonal considerations.** There were many views expressed among health managers and service providers on the timing of the VSC+ camps. Many argued that the combination of hot weather, festival season, harvest season and transport limitations imposed by the fuel crisis affected uptake. It was not possible to assess the impact of these realities on uptake as comparison with VSC camps conducted in the past – often during a different season - remained inconclusive.

- p) **The coordination and oversight roles (and associated costs) of NHSSP.** While difficult to quantify, the support provided by NHSSP in setting up the pilots, coordinating implementation and overseeing camp reporting should not be underestimated at the time of scaling up. For example, the oversight from NHSSP contributed positively to the consistency of implementation across camp sites and also enabled consistent and timely data collection and reporting. Such oversight is a key reason why this evaluation for the first time has provided a proper analysis of uptake and costs of VSC camps, which was not possible in the past as camp specific data was either not available (it was merged with that from other health facilities) or unreliable. Lack of camp specific data was a key obstacle to the analysis of VSC camps that evaluators undertook prior to this pilot, which has been summarised in Annex 3.

There were other factors that may have had an impact on uptake that could not be properly assessed in the evaluation. For example, the presence of the husband in the household is likely to be important as decisions on contraception are often made jointly by husband and wife, so households affected by migration may prefer the festival season when the husbands often come home. Beliefs and misconceptions by potential clients probably play a role too, but this could not be properly assessed.

Finally, while interpreting the results of this evaluation one should keep in mind the short implementation period of the pilot (four months), as well as the unusual circumstances (earthquake, fuel crisis, commodity shortages) that surrounded pilot implementation. The short implementation period is also important in relation to the costing work, because the unit costs might have been lower if the pilot had run for another year or so, as a good proportion of costs in a new intervention are fixed in nature and would have decreased (relatively) with increased numbers of new users.

6.2 Recommendations for both implementation modalities

These recommendations apply to both implementation modalities (A and B), i.e. whether VSC+ camps are implemented by DHO or private providers.

- f) VSC+ camps are a very cost effective way to deliver sterilisation services as well as other family planning options, particularly LARC. The cost of adding LARC to 'standard' VSC camps is negligible. All previously called VSC camps should adopt the comprehensive VSC+ format and offer any form of contraception desired by clients based on proper information dissemination and counselling.
- g) Counselling skills are essential and not necessarily available among service providers. Not all service providers had been trained in counselling or it was simply assumed that they had the right counselling skills. It is recommended that VSC+ camp staff should be trained regularly (periodically) to offer clients the best option, taking into account the circumstances of the client and the health infrastructure of the district. For example, sterilisation should not be provided where follow up of complications is not guaranteed, in which case LARC are a safer option.

- h) There should be proper benchmarking of health facilities to be used in VSC+ camps, to ensure that sufficient rooms and beds can be provided to guarantee hygienic procedures, privacy and confidentiality. Clients should not be expected to lie on the floor after the procedure.
- i) The number of successive camps to be held at a particular location cannot be established empirically. In theory, successive camps should be held while the uptake is high but this decision should also consider equity principles to ensure that most parts of the district are served by the VSC+ camps and not just the catchment areas of 3-4 selected locations. The same principle should apply to seasonality considerations, as some seasons considered *prima facie* as less suitable (like the festival season) may be more suitable areas affected by migration to enable husband and wife to discuss contraceptive options for each of them. Spreading VSC+ camps along the year (avoiding the very rainy or very hot months) makes common sense.
- j) Ensuring national coordination, lesson learning and support to the DHO on VSC+ implementation. While cost effective, VSC+ represents a substantial investment for a poor country like Nepal, so if VSC+ camps are to be held they should also be properly implemented, lessons should be learnt and disseminated, and DHOs across the country should be helped to analyse uptake and performance factors. At the moment the national guidelines for VSC implementation are quite generic and leave much decision making to the DHO, but not all DHOs have the capacity or competence to analyse results on the go. In this pilot NHSSP provided coordination and support to the DHOs of Baitadi and Darchula. We recommend the MoH to institutionalise support to DHOs on VSC+ camps within Family Health Division, whether through NHSSP or through other means, to ensure that DHOs regularly engage in proper analysis of VSC+ camp uptake and performance. The emphasis should be on on-going monitoring of VSC+ camp uptake to properly interpret flows in demand and in client choice, and to strengthen equity in access to VSC+ camps in most parts of the district through proper site selection and linked dissemination efforts. At the moment this monitoring does not necessarily take place at the DHO, as revealed by the rapid appraisal of VSC camps that we conducted prior to this evaluation study. At the time data on VSC camps was disperse, unreliable and lying dormant: it was not being used for decision making.

6.3 Recommendations for Modality A – DHO implementation

DHO implementation of VSC+ camps is highly cost-effective as it incurs lower set up and incremental costs than private provision. Where the district health system has the required trained human resources DHO implementation is recommended as the best option. However, the option of drawing human resources from a neighbouring district may not be a good option as it incurs in opportunity costs (services that cannot be run while camps are implemented) in the district where the human resources originate. This aspect was not documented by the evaluators but seems common sense.

6.4 Recommendations for Modality B – implementation by private provider

Where the district does not have the required human resources to conduct VSC+ camps private provision is a cost effective alternative, even if the set up costs, incremental costs and operational costs are slightly higher than for the DHO modality. Much depends of course on whether private providers are available to take up such a role in all the districts where the DHO cannot run the camps, as such districts are often the more under-resourced and difficult ones – in terms of access, population dispersion, etc - which can make these less attractive to private providers. In any case, the private provision model that has been tested in the pilot is more a public-private partnership than a private provision model as such, and this makes it very attractive to draw on all types of resources – private and public - available in Nepal.

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Annex 1 Evaluation Methodology

Note from the evaluation team. This annex summarises the methodology as it was planned at evaluation design stage. It is not meant as a complete methodological annex or to include all aspects considered during the evaluation design. In fact, the evaluation design included several documents that were shared with our clients (DFID and USAID) at different stages of the evaluation process and which our clients shared with other stakeholders in Nepal at their own discretion. These documents include the original M&E plan (July 2015) and the mid-term progress report (December 2015). There were other interim, technical documents produced by the evaluation team along the way, including the data management plan that links evaluation questions to data collection tools and sources. These documents can be shared with interested parties upon request to the authors.

Main focus of the evaluation

There are two major topics of interest in this evaluation.

The first topic of interest focuses on the pilot's overall effectiveness in meeting its objectives, that is, whether the expected results have been achieved. This would have required the implementing agency (DHO) to set specific targets, but it was discussed and agreed at design that targets would not be set and that, instead, a series of outputs and outcomes would be measured comprising service uptake, perceived and observed quality of services, levels of user satisfaction, etc.

The second topic of interest is to assess why or why not, the pilot has or has not met its objectives. Furthermore, we are also interested in assessing the dynamics of the intervention through documentation of processes and learning. Illustrative questions include:

- How effectively and efficiently were the comprehensive VSC camps organised?
- How are the services delivered through comprehensive camps being perceived in terms of relevance, ease of access and quality by the target population (both the service providers in targeted health facilities as well as the clients who used those services)?
- Has the uptake of FP methods increased in the district?
- What unanticipated problems arise, and what unexpected benefits and spill overs might there be with this approach?
- What suggestions do key stakeholders have to improve the pilot's effectiveness, efficiency, and sustainability?

This pilot has the potential to answer a number of questions that would be useful for future programme design of FP interventions. With this pilot, we seek to employ evaluation design

that is most suitable under the circumstances and that provides answers to the following evaluation questions:

1. Does the provision of an expanded range of FP services through comprehensive VSC camps (VSC+) increase the availability, choice and uptake of FP services in addition to sterilisation services among men and women of reproductive age?
2. Were the users of VSC+ camps able to choose the FP service/commodity of their choice? Was the choice properly informed through counselling?
3. What is the perspective of beneficiaries/clients about quality of services provided through the camps?
4. Were the advocacy activities by FCHVs and Health Facility Operation and Management Committee (HFOMC) effective to raise awareness about comprehensive FP services on offer and to generate demand among men and women of reproductive age?
5. What are the main factors affecting or determining the feasibility, scalability and sustainability of the VSC+ intervention as implemented? What are the lessons for scaling up this approach?
6. Costing analysis. What are the main costs incurred in the proposed approach? What are (roughly) the incremental costs incurred when compared with the traditional VSC camps (where only VSC services were being provided)? Are there any significant differences in the cost of the approach between the two models being tested in Baitadi and Darchula respectively?

Evaluation design

The process of selecting an evaluation design begins with assessing the best ways to address the five questions above. This is briefly discussed next and should be looked at jointly with the questions, means of verification and data sources shown in the table located at the end of this annex. Experimental and quasi-experimental designs have been ruled out due to the limited implementation time, the low cost/benefit of these methods, the small size of the intervention and the fact that the users of the new services will be self-selected, so cannot be randomly assigned. Instead the following methods will be used.

Main Study Questions	Evaluation designs considered and adopted
<p>1. Does the provision of an expanded range of FP services through comprehensive camps (VSC+) increase the availability, choice and uptake of FP services in rural Nepal?</p>	<p>A before and after approach will be used comparing FP uptake data (from the HMIS register). Data from the intervention period on utilization of FP will be compared with an equivalent period in the previous year, as a means of comparison. Data will also be collected from service users on service days for choice and availability of contraceptives, and from service providers in selected service sites in both districts.</p>
<p>2. Were the users of VSC+ camps able to choose the FP service/commodity of their choice? Was the choice properly informed through</p>	<p>This information will be collected primarily through exit interviews with service users from the service sites in both districts. This can also be verified</p>

Main Study Questions	Evaluation designs considered and adopted
counselling?	through observation.
3. What is the perspective of beneficiaries/clients about quality of services provided through the camps?	This information will be collected primarily through exit interviews with service users from the service sites in both districts.
4. Were the advocacy activities by FCHVs and HFOMC effective in raising awareness of comprehensive FP services on offer and to generate demand among men and women of reproductive age?	We will assess this question through exit interviews. Service users will be asked about the source of information on the new service in the exit interviews.
5. What are the main factors affecting or determining the feasibility, scalability and sustainability of the VSC+ intervention as implemented? What are the lessons for scaling up this approach?	Information will be collected from in-depth interviews at end line with service providers, district health managers and staffs from NHSSP and MSI/SPN Nepal overseeing the implementation of the pilot.
6. Costing analysis: What are the main costs incurred in the proposed approach? What are (roughly) the incremental costs incurred when compared with the traditional VSC camps (where only VSC services were being provided)? Are there any significant differences in the cost of the approach between the two models being tested in Baitadi and Darchula respectively?	Given the time and resources available a full costing study will not be pursued. As an alternative, we propose to undertake a simple mapping of the main types of resources – the level of effort - required (human resources, commodities, logistics, etc) for conducting the camps. The specific methodologies will be assessed separately with support from our health economist.

Monitoring and evaluation sites

We propose to visit all eight service delivery sites (four sites in each district) to be monitored and evaluated to generate rich information to better answer the evaluation questions. Monitoring will take place during the whole implementation of pilot by 2 research assistants in the selected 8 sites. Each RA will visit the district hospital, one PHCC and two health posts in each district which are the service delivery sites proposed by NHSSP.

We propose that each RA will cover 8-10 comprehensive VSC+ events (out of 15 as proposed by NHSSP) in each district. This includes visits of 4 events in district hospitals, 2 events in PHCC, and 4 events in HPs. This will enable and ensure the level of detail and effort required for making sure that we or NHSSP capture and process the data in the right way and at the required periodicity and that changes in the process and context of implementation are swiftly captured and addressed.

Focus on monitoring. A **monitoring checklist** will be filled by RAs during their visits to VSC+ camps conducted in the 8 health facilities of two districts. The follow-up visits taking place after one month of the VSC+ camps will help to check for any reported complications from services received in VSC+ camps and to find out how the said complications were managed. We will also enquire whether the agreed incentives to providers and users (as indicated by the DHO) have been paid. These visits after the VSC+ camps will also be used to interview service providers in a more relaxed environment that would not be possible during the busy camp days.

We propose to conduct **exit client interviews** with around 40 clients visiting the 4 health facilities selected as evaluation sites in each district, so we expect to interview a total of 80 clients exiting the facilities. We will use semi-structured interviews with the help of a questionnaire to understand the availability of choice as well as their acceptance (social and cultural) and satisfaction with the services received. Clients will be interviewed after they complete the observation time at the camp (2 hours after surgery). In each district, we will purposely select clients according to the types of FP services received in three main categories: (a) patients who received counselling only and did not take up any contraception; (b) users of sterilisation services; (c) users of LARC. Depending on the clients flow in each health facility, the numbers of clients to be interviewed will vary. The exit client interviews will be conducted by RAs during their visit to the sites on VSC+ camp days.

Furthermore, we plan to make **follow up visits** for around 10 clients in each district, of which about half would have received sterilisation (both vasectomy and Minilap) while another half would have received LARC at the VSC+ camps. The clients will be visited at home to record their experiences before and after the service, including gathering information on the method they were using before, how they got motivated for the one they use now, whether they experienced any side effect/complications, if any, and how these were managed, etc. These clients to be followed up would be interviewed at least one month after receiving the service. Consent for a follow up visit will be taken from the participants at the day of interviews. It is expected that the information thus collected will help the evaluation gain depth and understanding about specific issues that cannot be properly captured at the time of the exit interview.

Likewise, we will interview key informants involved in the pilot (DHO, FP supervisor, health facility in-charges, service providers, FCHV, HFOMC member and other informants as relevant, and in case of Darchula district we also plan to interview NGO/private district coordinator involved in pilot implementation) as part of process documentation. Qualitative interviews with the use of semi-structured questionnaires with key informants will be conducted to cover the evaluation questions relating to the planning, demand generation, organization, management and delivery of the VSC+ events. For context and as part of process documentation the RAs will maintain a daily diary where they will record their experiences and the information that they have found informally.

Collection of 'Baseline' data

This pilot or its evaluation will not include a baseline study as such, in the way this is usually understood in evaluation sciences. The possibility of undertaking a baseline study was considered at design and ruled out, mainly because there was no time to undertake such a

study before the intervention began, and also because the costs of such a study largely exceeded the benefits derived from it, particularly as this is not an impact evaluation. Therefore, in this evaluation and in this report, baseline means the quantitative HMIS data collected from the DHO office for the year 2014 as well as the qualitative data emerging from interviews with a range of service providers that were conducted at the beginning of the intervention or just before the intervention began.

Staff arrangements

One part-time Senior Research Officer (SRO) based in HERD Kathmandu and two full-time field Research Assistants (RAs) will be recruited for 8-10 months to implement the evaluation. RAs will be responsible for monitoring the process of service delivery (against the standard protocol) in camp sites and collecting data from service delivery registers. The SRO will be involved in design and implementation of monitoring and evaluation plan and will be responsible for providing support to the RAs.

One Data Analyst and Data Management Officer will also be involved (part-time) in quantitative data management and analysis. The executive Director of HERD who is the national lead for this project, SRO and Data Analyst will design the M&E plan, tools for data collection, provide technical oversight and ensure the proper functioning of activities and timely delivery of all key deliverables. Likewise, a communication officer will have the responsibility of desk-based communication with SRO and RAs for regular field updates and communicate the update with the core teams. Furthermore, the Operations Manager at HERD will have the responsibility for overall operational and logistics management during the entire project.

The Mott MacDonald team will provide assistance on designing and quality assurance of M&E plan and tools for data collection, and assist in data analysis, report writing and dissemination of results.

Data analysis

Data analysis will begin as soon as the monitoring of the intervention is complete and will involve the following stages:

Pre-analysis of data from each facility. By pre-analysis we refer to the process of triangulating data for each of the 8 evaluation sites. This stage should bring together the results from the service uptake data, the baseline interviews and the observation notes and checklists. The pre-analysis is expected to deliver the following results:

- Help us explain cause-effect relationships in the service uptake data, discarding effects that cannot be directly attributed to the intervention
- Identify unexplained features from the qualitative and quantitative data in order to prepare questions for key informants to be covered during the endline interviews.
- Identify any gaps in the data to support the evaluation questions in an attempt to fill in these gaps during the endline interviews and visits to the facilities outside the evaluation period (which ends by December).

- Develop initial hypotheses from individual facilities, which will be then tested for the sum of the facilities during the data analysis phase.
- Assess what costing information is required to assess value for money and cost effectiveness considerations for the intervention as a whole.
- Develop the working patterns of the HERD/MM team and strengthen teamwork and internal discussion of results as these emerge. This will be achieved through weekly data analysis workshops where HERD staff will meet physically and MM staff will join through teleconferencing.

Completion of endline data collection. The pre-analysis will be followed by the endline key informant interviews (KII) with a sample of health facility staff, DHO personnel, NHSSP staff, HFoMC and FCHVs. The data collection of costing information will be undertaken at the same time, in parallel. The endline KII will reassess questions covered at baseline and will ask additional questions that help evaluators clarify issues identified during pre-analysis.

Data Analysis. Data analysis will take place as soon as KIIs and costing work are completed. The approach to analysis will be similar to the one used during pre-analysis, with the focus being on addressing the evaluation questions for the pilot as a whole and on testing hypotheses and assumptions developed during pre-analysis. The format of the analysis phase will be weekly analysis cum report writing workshops.

Data quality assurance

A quality assurance plan including data quality management will be developed as part of an overall field operations plan. In order to maximize the likelihood that tasks will be performed uniformly and with high quality, the plan will have detailed descriptions on field operations, data collection, processing and management; process of identification of obvious protocol deviations of the pilot; roles of project staff, among others. The data collection instruments will be designed in English and will then be translated into Nepali. These instruments will be pretested in a few sites to ensure the questions are clear and unambiguous and reviewed accordingly making them appropriate to the context. There will be over-the-shoulder observation and support to RAs with periodic field visits by the SRO and core project staffs.

Quantitative data will be uploaded to the main server and a daily back up system will be ensured at HERD's central office. Initial cleaning and validation of the data would ensure that data formats, missing values and so on are corrected or otherwise accounted for. All qualitative data will be transcribed in the field by respective RAs and SRO will perform random checks of transcribed data. Translation of transcribed data (as needed) will be performed by an experienced translator in the HERD office in close supervision of the SRO. RAs will plan monthly to the identified monitored sites and collect data on routine service utilisation from service delivery registers (HMIS) with verification checks. Likewise, the SRO will oversee the intervention activities based in the HERD office and will visit the district to monitor the field activities at least 3 times during the intervention to support the RAs and ensure the data quality.

The quality of recording in the health registers of the sites does present a problem that may be difficult to untangle. For example, while overall counts could be correct detailed

breakdowns on the type of service offered or commodities provided are less reliable and often missing. This and other considerations are based on observations by the evaluation team at the health unit level and the experiences of HERD in evaluating the Kalikot pilot. It is not immediately clear how this problem can be mitigated but comparisons of time trends of detailed data with overall numbers of patients seen may offer some indication of the likely effect which can then be discounted from the trends. HERD would undertake additional spot-checking as appropriate. In all cases, the Mott MacDonald team would verify that SPSS syntax is correct, re-run the routines and check the summarised outputs.

This table summarises the main evaluation questions and data sources (as envisaged at design). A separate data management table was prepared describing data collection methods to be used for each evaluation question and source (available on request)

Note: MSI/SPN when used in this table only refers to MSI/SPN staff in Darchula who are involved in the pilot as implementing partners.

Table A1.1: VSC+ model – evaluation questions, assumptions, data collection and sources

Evaluation topics	Specific questions/variables	Data sources & Data collection tools/approach
1. Planning and Organisation of the VSC+	<ul style="list-style-type: none"> ▪ What activities were conducted at district level to plan the camps? ▪ Was the camp conducted on the proposed site, date and time? ▪ Did the DHO or delegated person visit the camp site in advance to check the suitability of the venue and make the necessary arrangements? What implementation arrangements were made? ▪ What type of venue was used? ▪ Had this venue been used in the past or was it a new venue? 	<ul style="list-style-type: none"> ▪ Interview with health facility in charges and service providers of comprehensive camp sites ▪ Interview with DHO and NHSSP staffs ▪ Interview with MSI/SPN staffs (in Darchula)
2. Demand generation strategies	<ul style="list-style-type: none"> ▪ What was the main means for disseminating information on this VSC+ (FCHV, Radio, etc) ▪ How long before the camp did demand generation activities begin? ▪ Were any visual materials used to disseminate information of the VSC+? What type? ▪ Did information materials inform specifically about the range of services that would be available at the VSC+? ▪ Were FCHVs clear about the types of services that would be available at the VSC+ (in comparison with previous VSCs)? 	<ul style="list-style-type: none"> ▪ Exit client interviews ▪ Interview with DHO/MSI/SPN and NHSSP staffs ▪ Interview with FCHVs and HFOMC members
3. Availability and competency of service providers (SPs)	<ul style="list-style-type: none"> ▪ Had the SPs been trained on the specific services (LARC, etc) they were offering? ▪ How long ago was training received for the first time? ▪ Did SPs receive refresher training? How long ago? ▪ Were the providers specifically trained in counselling for FP? How long ago? ▪ Did the providers receive any training specifically for this pilot? What was it about? 	<ul style="list-style-type: none"> ▪ Interview with SPs of VSC+ camps

Evaluation topics	Specific questions/variables	Data sources & Data collection tools/approach
4. Service uptake	<ul style="list-style-type: none"> ▪ What was the uptake of FP services by method types, and how does it compare with last year's? ▪ Overall how much has the use of FP methods changed (increased or decreased) in the district/pilot sites compared to previous year? ▪ Uptake of services disaggregated by type of user (man/woman; caste; age; number of live children; etc (to complete from HMIS forms at the health facilities) ▪ Among the users of FP services (VSC and LARC), what proportions were new users and existing users? ▪ How many switched FP methods? ▪ Which method did they shifted to? Reasons for this switch? 	<ul style="list-style-type: none"> ▪ HMIS Register (at district level). We propose to compare results for a sample of months covered by the pilot and compare it with an equivalent period during the previous year (2014) ▪ Exit client interviews
5. Service quality (observation)	<ul style="list-style-type: none"> ▪ Was the full range of services available (as per plan and as per promotional materials)? What services were not offered (that should have been offered) and why? ▪ Was their availability of doctors and other supporting staffs as per plan in the VSC+ sites? ▪ Was there a waiting area for users? ▪ Were incoming users explained about the functioning of the camp (who to talk to for specific services, etc)? ▪ Was there proper space (privacy, quiet room, etc) for counselling patients ▪ Was the venue appropriate (cleanliness, comfort for providers and users, etc) for delivering the proposed services? Explain. ▪ Was the necessary equipment and the necessary commodities available? ▪ Was there a protocol being followed in terms of information to be provided to the users of each type of FP service? 	<ul style="list-style-type: none"> ▪ Observation checklist
6. Service quality (user perspective)	<ul style="list-style-type: none"> ▪ Did the user take up a service or just counselling? ▪ If a service, what service did s/he take? Was this the service that s/he intended to take before coming to the VSC+ camp? If not, why not (the service was not available; I changed my mind after counselling)? Briefly explain. ▪ How did the user know about availability of comprehensive services in the sites? 	<ul style="list-style-type: none"> ▪ Exit client interviews

Evaluation topics	Specific questions/variables	Data sources & Data collection tools/approach
	<ul style="list-style-type: none"> ▪ How long did the user have to travel to get to the camp? What was (were) the means of transport? (example: bus 45 minutes + walk 30 minutes) ▪ What was the total cost of transport for the user (include cost of accompanying person/s) ▪ How long did the user have to wait before being able to speak to a member of staff about the desired service? ▪ How long did the user have to wait before actually being provided with the service? ▪ What was the service received and what was the level of satisfaction (scale) with the service received? (close answers from v good to v bad) ▪ Was the user treated with respect and kindness at all times? If not, briefly describe the issue, preferably in a single sentence. ▪ Did the HF staff explain to the user various options of FP commodities available at the facility? Did s/he use any drawings or pictures to explain the various options? Could the user understand easily the options that were being offered to him/her? ▪ (To those who adopted a VSC or LARC) Was the provider skilled in delivering the service? Did the provider know what s/he was doing? Was the service delivered in a reasonable time? ▪ Did the HF staffs counselled the user about the possible side effects/complication of the method the client is using and the measures that should be taken in such situation? ▪ Was the user asked for follow-up visits? ▪ What was the sex of the SPs? Was the user affected in any way by the sex of the SPs? ▪ Was the user asked for any payments for the service received? (explain if so) ▪ Was the user paid any amount for using the camp (Travel allowance, etc...)? Was s/he happy with the amount, if received? ▪ Will the user return to the village right away? If not, where will s/he stay (friend, relative, paying guest house, etc)? 	

Evaluation topics	Specific questions/variables	Data sources & Data collection tools/approach
7. Service quality (SPs perspective)	<ul style="list-style-type: none"> ▪ To what extent are the full range of FP methods available on the day of FP clinic (for each FP method provide as possible answers: always, most of the times, seldom, never) ▪ What were the barriers to maintain the continuous supply of FP commodities and equipment? ▪ Did the SPs receive full support from DHO, and NHSSP staffs to deliver the services? If no, what support was missing? 	<ul style="list-style-type: none"> ▪ Interview with SPs and facility in-charges of VSC+ camps
8. Complications/side effects and management (user perspective)	<ul style="list-style-type: none"> ▪ Had the user experienced any side effects or complications after receiving a LARC or VSC from VSC camps? ▪ What complication/side effects did you face?(Record the side effects mentioned) ▪ Where did the user go to solve the problem? What was done to solve the problem? 	<ul style="list-style-type: none"> ▪ Follow-up interview
9. Complications/side effects and management (SPs perspective)	<ul style="list-style-type: none"> ▪ Have any women receiving FP services from the VSC+ camps reported side effects or complications to the SPs? ▪ If yes, how many cases can the SPs recall of such complications in the last camps? ▪ What were the main complications reported? ▪ Why do the SPs think such complications occurred? (Bad luck; bad practice by provider; lack of hygiene? Etc.) ▪ What is done when such complications or side effects are reported? Do the SPs deal with the problem themselves or refer the case elsewhere? 	<ul style="list-style-type: none"> ▪ Interview with SPs of VSC+ camps ▪ Interview with health facility in-charges camp sites
10. Incentives to SPs	<ul style="list-style-type: none"> ▪ Did the SPs and other staffs expect any incentive payments (including per diems, travel allowance, etc) for attending the camp? ▪ Were the expected incentives actually paid or were staff told when and how would the payments be made? ▪ What are the perspectives of the SPs on the incentives received? 	<ul style="list-style-type: none"> ▪ Interview with SPs of VSC+ camps ▪ Interview with DHO and MSI/SPN staffs
11. Feasibility, sustainability and	<ul style="list-style-type: none"> ▪ Where there any unintended affects during the pilot? What unintended effects occurred? 	<p>End line interview with</p> <ul style="list-style-type: none"> ▪ SPs, in-charges of VSC+ camps

Evaluation topics	Specific questions/variables	Data sources & Data collection tools/approach
scalability of the pilot	<ul style="list-style-type: none"> ▪ Did the unintended effect/s affect the sustainability and/or scalability of the pilot? ▪ What benefits or positive outcome were achieved that could lead to sustainability and scalability of the pilot? 	<ul style="list-style-type: none"> ▪ DHO and MSI/SPN staffs ▪ NHSSP staffs
12. Roles of DHO	<ul style="list-style-type: none"> ▪ What were the roles of DHO in planning process of the pilot? ▪ What were the roles of DHO in implementation phase? ▪ What were the roles of FP supervisor in planning and implementation of the pilot? ▪ Did they perform their roles as expected? ▪ Were they supportive in functioning of the pilot? 	<ul style="list-style-type: none"> ▪ Interviews with DHO staffs ▪ Interview with NHSSP staffs ▪ Observation
13. Roles of MSI/SPN (in Darchula only)	<ul style="list-style-type: none"> ▪ What were the roles of MSI/SPN in planning process of the pilot? ▪ What were the roles of MSI/SPN in implementation phase? ▪ Did the MSI/SPN staffs perform their roles as expected? ▪ Were they supportive in functioning of the pilot? 	<ul style="list-style-type: none"> ▪ Interviews with MSI/SPN district staffs ▪ Interview with NHSSP staffs ▪ Observation

Annex 2 Uptake data of VSC camps conducted in previous years in Baitadi and Darchula

Table A2.1: Uptake data of VSC camps conducted in previous years in Baitadi and Darchula

Fiscal Year	Camp sites	Duration	Total no. of camp days	Vasectomy	Minilap	Total	Supporting organizations
BAITADI							
070/071	Rudreshwor, Joshibunga, Salena, Kesharpur, Kulau, Kuwakot, Gajari, District Hospital	Kartik to Chaitra	42	27	208	235	Nepal Family Planning Association , Nepal Government
071/072	Bhumiraj HP, Phurachandi Haat HP, Mahadevsthan HP, Nwadeu HP, Kuwakot HP, Dudalakhn Bazar, Gajari HP, Patan , Melauli, Kulau, Salena, Shreekot HP, Siddheshwor HP, Haat, Bhumeswror	Asoj to Baishakh	22	71	165	236	Nepal Family Planning Association , Nepal Government

Fiscal Year	Camp sites	Duration	Total no. of camp days	Vasectomy	Minilap	Total	Supporting organizations
072/073	District Hospital (2 times), Kulau HP (2 times), Patan PHC (1 time), Haat HP (3 times), Talladehi HP (2 times), Sitad HP (1 time), Sarmali HP (1 time), Kesharpur PHC (1 time), Salena HP (1 time), Gajari HP (1 time), Chaukham HP (1 time), Shivlinga HP (1 time), Thalakada HP (1 time), Dhugadh HP (1 time), Sigash HP (1 time)	Bhadra to Magh	44	39	193	245	Nepal Government and NHSSP
DARCHULA							
070/071	Gokuleshwor, Latinath, Shikhar, Dethala, Dhuligada, Khar, Sipti, Malikaarjun, Pasti Uku, Dattu, Dhap, District Hospital	Magh	1 day/site and 3 days @ District	82	64	146	MSI/SPN
071/072	Gokuleshwor, Latinath, Shikhar, Dethala, Dhuligada, Rithachaupata, Pasti Uku, Dattu, Dhap, District Hospital	Poush	1 day/site and 3 days @ District	98	76	174	MSI/SPN
072/073	Gokuleshwor, Latinath, Shikhar, Dethala, Dhuligada, Khar, Sipti, Gwani, Pasti Uku, Dattu, Dhap, District Hospital	Falgun	1 day/site and 3 days @ District	51	22	73	MSI/SPN

Annex 3 Summary points from the Rapid Appraisal of VSC camps in Nepal

These points have been summarised from the report: Rapid Assessment of Voluntary Surgical Contraception Camps in Nepal. Review undertaken by Health Research and Social Development Forum (HERD) and supported by Mott MacDonald. Working document, May 2015.

- Planning and budgeting was centrally managed by FHD but the needs assessment to determine the needs and targets for the districts were neither done by FHD nor the region. District respondents also mentioned that the VSC camp only focuses on providing permanent methods and do not encourage to include LARCs. *(Need assessment and target setting)*
- Respondents mentioned that the main source of dissemination of the camp was FM radio and FCHVs. It was also said that as FCHVs were knew well the target population in their catchment area, they were able to reach them quickly. Some of the FCHVs also disseminated the information by using pamphlets and by discussing the camps in mother's group meetings. *(Information dissemination)*
- In the case of Baitadi, the health workers were informing the clients about the FP services available but were not providing counselling which meant that most of the clients were hesitating to opt for permanent methods. *(Field Observation of VSC camp in Baitadi)*
- Health service providers also complained about the difficulties in reaching the camp location and about the low level of incentive given to them. It was also seen that the camp service could not benefit the people living in the hardest to reach areas as they had to walk 6-7 hours to reach the camp sites. *(Field observation of VSC camps in Baitadi)*
- Health workers mentioned that the camps are generally conducted in the dry winter season as it reduces the risk of post-surgery infections and due to deeply rooted perception in the community. It was also said that the camps during the rainy season are intentionally avoided due to non-functional roads and vehicles and the challenge for the mobilization of logistics and the camp team. *(Timing of conducting the camp)*
- In Baitadi, VSC camps were seen as an opportunity to provide a comprehensive family planning package that is sterilisation and LARC service. As temporary methods are available on a regular basis, these services were not offered in the camps. It was seen that with the availability of skilled human resources, the VSC camp can provide comprehensive FP service in all the districts. *(Choice of contraceptive device available)*
- The range of services offered varied in districts as there was no clear guidance to the district as to whether they were to incorporate both permanent and LARC services in

the VSC camps. The comprehensive service completely depended on available resources and demand for service. However, more focus was given to permanent FP services in most of the VSC camps. *(Choice of contraceptive device available)*

- Maintaining privacy and confidentiality was seen to be poor in most of the districts which resulted in client drop out. The main reasons for not being able to maintain privacy and confidentiality were unavailability of proper infrastructure, lack of sufficient health workers, competence of health workers, short duration of camps and high client flow. In contrast, it was mentioned by the health workers of Baitadi that they practiced one-to-one counselling in a separate counselling room and that all the records were kept confidentially. *(Maintaining privacy and confidentiality of the client)*
- The information provided during the counselling was method focused rather than providing information about the range of FP methods available in the VSC camp. One of the users shared that she was not provided with the range of FP methods but instead was explained the possible complications for the method utilized at the camp. Upon inquiring with health workers, it was also seen that most of the service providers had not received training on counselling and that there was a need of much higher degree of institutional support. *(Counselling)*
- Incentives were perceived to be very low for the health workers and to the people involved in the camp. One of the clients in Baitadi confirmed not receiving any incentive even after the operation. Most of the respondents mentioned that the incentive should be proportionate to the real costs incurred by patients, accompanying persons and VSC camp staff to get to the camp and stay in the camp locations. *(Incentives)*
- An MSI/SPN informant mentioned that the service providers prefer to go to the terai for conducting VSC camps as they received the incentive provided by the government based on the number of cases, and the number of cases is always high in the terai belt as compared to hills and mountains. *(Incentives)*
- In terms of a referral point, the health workers reported that the clients were sent to the nearest health post in case of a minor complication and in case of a major one the client is referred to district or higher level institution. However, no major complications were reported in any districts. The clear pictures of follow-up mechanism were not observed in the districts. *(Referral and Follow up)*
- The practices in monitoring and supervision of the camps were seen to vary and were seen not to be implemented consistently or to follow any specific protocols or guidelines. The use of a proper checklist during the monitoring and supervision process was not mentioned by any of the respondents but the supervision of post VSC cases by mobilizing health workers to find the condition of the clients was being conducted in Baitadi. *(Monitoring and Supervision)*
- It was hard for the reviewers to assess what exactly is being provided in the way of counselling in VSC camps, and while specific recording sheets are available for that purpose, they are completed in a rush by health workers and are considered just a formality. *(Recording and reporting)*