



Nepal Family Health Program Technical Brief #6 Improving Access to Family Planning Services in Rural Areas



A family planning client receives her injection of Depo Provera from a trained maternal and child health worker.

BACKGROUND

Family planning (FP) services have been available in Nepal for over 50 years, most extensively from the public sector health system, with nongovernmental agencies involved from the very beginning. Social marketing of contraceptives started in 1978. Over the past three decades, FP use has increased dramatically from three percent in 1976 to 44 percent in 2006. Concomitantly, access to FP services has improved tremendously, especially in rural areas through public sector service delivery. Seven modern methods are available, with female and male sterilization (55% of current users) being the most popular followed by Depo Provera® injectable (23% of current users). By and large, the injectable is the most popular temporary contraceptive in Nepal and its use has doubled in the last 10 years from 4.5% (among all currently married women) in 1996 to 10.1% in 2006¹ and has the potential to continue to increase given significant unmet need for FP in Nepal.

The Ministry of Health and Population (MOHP) remains the main provider of FP services in Nepal. According to the Nepal Demographic Health Survey (NDHS) 2006, four out of five current FP users received services from the public sector system. The sub-health post is the most peripheral health facility in the health system, with three designated service providers: Auxiliary Health Workers (AHWs), Village Health Workers (VHWs) and Maternal and Child Health Workers (MCHWs). AHWs provide primary health care including clinical services, integrated management of childhood illnesses (IMCI), FP counseling and services (condoms, pills and Depo), infectious disease control and overall management of the SHP as an In-Charge. MCHWs conduct ante- and postnatal care and assist in delivery, IMCI, FP counseling, and contraceptive distribution (condoms and pills). The VHW conducts immunizations, IMCI, primary health care outreach clinics, FP counseling and contraceptive distribution (condom & pills). At present there are 3,504 VHWs and 2,539 MCHWs under the MOHP.

Family planning services are largely delivered by facility-based service providers, except for the distribution of condoms and pills and, occasionally, injectables. Community workers such as VHWs and MCHWs could potentially fill the gap if they were given the necessary knowledge and skills. While VHWs and MCHWs are identified as FP service providers in the National Medical Standards: Volume 1², they have generally lacked the necessary knowledge and skills to provide quality FP services.

Key Achievements

- Developed a competency-based in-service FP refresher package for community-based providers.
- Enhanced capacity and potential institutionalization of the VHW/MCHW training package into the national training system in close collaboration with MOHP/National Health Training Center.
- Trained 1630 community level providers (905 VHWs and 725 MCHWs) from 17 program districts together with partner agencies SC/US and CARE/Nepal.
- Improved quality of FP services in 30 MOHP rural health facilities which enabled them to serve as the clinical practicum for this training.
- Increased utilization of FP methods in communities with the help of VHWs and MCHWs.

STRATEGIC APPROACH

Among the three types of service providers at a SHP, only AHWs receive the 13-day Comprehensive Family Planning and Counseling (COFP/C) in-service training³ and are considered qualified to provide FP information and contraceptives such as injectables, oral pills and condoms. Though VHWs and MCHWs have some FP knowledge from their basic training, so far they have not received the comprehensive training. They do, however, spend a significant portion of their work time at various outreach sites and are therefore in frequent contact with potential FP clients. Therefore, training VHWs and MCHWs has the potential to increase access and availability to potential clients for comprehensive FP counseling and temporary FP methods. This can contribute to achieving the government policy of more equitable access to services for underserved and disadvantaged populations.

The number of Village Development Committees (VDCs) in the 17 NFHP core program districts (CPDs) range from 18 in Rasuwa to 106 in Siraha. The population varies from around 47,000 in Rasuwa to about 900,000 in Morang. However, the number of health facilities and community health workers/volunteers are not in proportion to the population or to the physical size of districts—resulting in uneven distribution and access to health services. This uneven distribution of health facilities (HFs) combined with only one trained FP provider at SHPs restricts access to FP services in rural areas—especially Depo. By training all VHWs and MCHWs in a district, access to quality FP counseling and services can be enhanced tremendously.

NFHP's approach was to develop a training curriculum, select training sites, and conduct training and follow-up after training in collaboration with the MOHP, National Health Training Centre (NHTC), partners, and nongovernmental organizations (NGO), with the expectation that this would lead to building capacity for more such activities in the future.

KEY ACTIVITIES

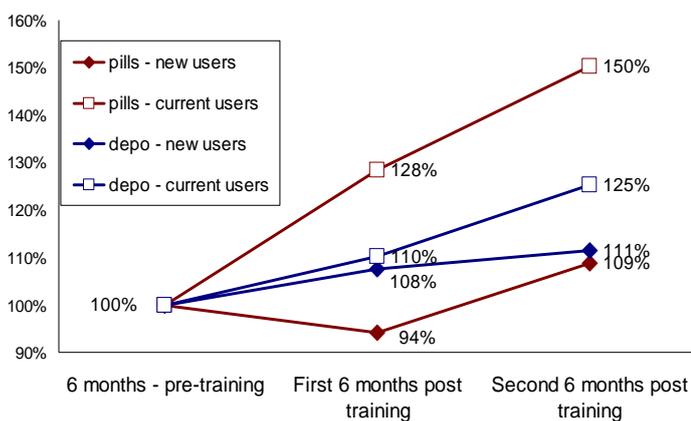
- The basic training curriculum for VHWs and MCHWs and the training curriculum from Save the Children/US (SC/US) were reviewed.
 - The acceptability of provision of FP services to female clientele by male VHWs was briefly assessed as requested by the Department of Health Services. All the male VHWs (23) providing FP services to female clients under SC/US-Siraha district pilot reported their clients had no problem receiving FP services from male VHWs.
 - A competency-based training (8 (+1) days) was designed and developed with clinical exposure at pre-arranged practicum sites. NFHP helped develop: Reference Manual, Trainers' Guide and Participant Hand-book and tools to assess the skills and knowledge of the MCHWs and VHWs after training
 - Staff from the National Health Training Center (NHTC) were involved in designing the curriculum and both NHTC and District Health Office (DHO) staff participated during training, thus contributing to the institutionalization within the national health training system.
 - Appropriate clinical training sites were assessed, selected, and prepared by providing minor equipment and supplies, orientation, or training.
 - In all, 1630 health workers (905 VHWs and 725 MCHWs)—nearly 88% of all VHWs/MCHWs in these 17 core program districts—received FP refresher trainings over a period of 4 years. Reasons for not participating included: retired/vacant positions; ill health, transferred out and study leave (MCHWs studying to become assistant nurse midwives).
 - Almost all the trained VHWs/MCHWs (99%) were contacted at least once after training, either through onsite follow-up visits (806) or off-site follow-up workshops (802). During these follow-ups, their knowledge and skills were assessed and they were coached as needed.
 - In order to maintain the quality of training the following activities were conducted:
 1. Orientation of implementing agencies and trainers to ensure they followed the standardized training package and understood the importance of maintaining quality;
 2. Ensured training was conducted only by qualified trainers from approved training centers;
 3. NFHP and MOHP staff conducted supervision visits during training; and
 4. Arrangements were made for clinical practicum's, considering the caseload, quality of services and infrastructure and, if needed, support was provided by NFHP to upgrade training sites.
 - An assessment of the impact of training on quality and utilization of FP services was conducted.
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RESULTS

Information was gathered and analyzed from multiple sources, including: training records, field staff, trainers, trainees, clinical assessments during and after training, and service statistics. 60 SHPs, 10 from each of the selected six program districts, were assessed. Selection included districts where training had been conducted at different periods to avoid the effect of seasonal variations in FP utilization. A second follow-up visit was made to all 60 sampled facilities 12 months after training was completed. Complete records for the complete 18 months period, 6 months prior to training and 12 months after training (2 distinct 6 months periods), were available from 48 health facilities for Depo, 41 HFs for oral contraceptive pills, and 50 for condoms, respectively.

- After this intervention, regular and routine FP information, counseling and services were available at 100% of SHPs (846) in the 17 CPDs. These are the most peripheral health facilities of the public health system and, therefore, have contributed to increasing access to family planning services in rural areas.
- The total number of new and continuing Depo and pill users in the 12 months period after training has increased significantly (Figure 1). The total number of new pill acceptors had initially decreased slightly but this number picked up in the next 6 month period.

Figure 1. Change in FP Service Delivery Data for HFs with Trained HWs (vs. baseline =100%)



- Similarly, condom distribution increased by 56% in the 7-12 month period post-training.
- The Health Management Information System (HMIS) records FP current users, indicating how many clients are served at each health facility. The numbers of current users of both Depo and pills have increased, suggesting better counseling and quality of services. Current pill and Depo users have increased by 31% and 9%

respectively. The trainees' perception is that this increase is due to better quality of FP services provided at health facilities.

Other observed changes:

- During follow-up visits, knowledge and skill assessments indicate that the FP refresher training has been successful in upgrading VHWs' and MCHWs' *knowledge and skills* pertaining to FP service provision.
- A sample of trained VHWs and MCHWs (N=58) was followed up and interviewed—they felt that the quality of services they provide improved as a consequence of the refresher training. Aspects of improved quality that they noted included: quality of counseling, side-effects management, infection prevention, FP skills, method choice, and maintenance of privacy.

LESSONS LEARNED

- **A more participatory process of design and consensus building requires relatively more time, but is necessary to ensure ownership.** Involving the National Health Training Centre (NHTC) as a true partner from design through implementation resulted in building ownership and capacity of the MOHP training system and staff. District Health Office staff support new trainings with new cadres of providers more readily because the initiative is supported by a central office, such as NHTC.
- **Once consensus has been reached on a training approach, design and interventions, it should be introduced quickly.** Subcontracting the training to district-based NGOs or other capable agencies and implementing training in close collaboration with the District Health Office was a successful model for implementation.
- **Selecting and supporting key MOHP health facilities as clinical training sites serves several important purposes:** All trainees received adequate practice to develop necessary skills to confidently provide FP information and counseling and to give injectables, pills and condoms. This support not only developed the capacity of these health facilities to serve as practicum sites but also enhanced the quality of services provided at these facilities. Thus the National Health Training Center can consider applying a similar approach in their other training activities.
- **Providing suitable training and follow-up support can increase access to and utilization of FP services at the community level.**

- **Detailed baseline information is an important component to monitor program success.** NFHP would have been able to better assess and document the impact of this intervention had a baseline study been conducted.
- **Training VHWs and MCHWs can have an immediate impact.** The trained VHWs and MCHWs put their new knowledge and skills into use quickly. The data showed that there was a significant increase in FP clients served in the six-month period immediately after training and this increase was sustained over time.

CHALLENGES

- The institutionalization of training into the national health training system was both time consuming and labor intensive, though eventually we were able to achieve our objectives. District coordination of clinical trainings as well as their commitment and buy-in was difficult at times.
- There were many challenges in maintaining the quality of training. For example, the lack of sufficient client caseload for practicum, the availability of clinical trainers, infrastructure, and convincing DHOs of the importance of clinical training sites at district level.
- The standardization in training, post-training follow-up, and on-site follow-up of the trained VHWs/MCHWs to assess the quality of services provided to the community was difficult due to the different working styles of partner agencies.
- The security situation in Nepal caused difficulty in planning and conducting training as well as the post-training follow-up.

RECOMMENDATIONS

- Given the success of the trainings for community providers, it appears that MOHP/FHD/NHTC could quite easily expand this approach to other districts in Nepal. This is especially important in remote areas where transportation systems are less developed and communities would prefer services closer to their homes and communities.
- Currently NHTC uses a 13-day comprehensive family planning/ counseling training package to provide service providers with similar skills. It would be useful for NHTC to review the new 8-day and the current 13-day training curricula and look for opportunities to improve time efficiency of FP training.
- This program has demonstrated the feasibility and usefulness of decentralizing FP training, by preparing a pool of district-level clinical trainers. They also developed selected peripheral service sites (primary health care centers or health posts) for training/coaching purposes, which gave relevant socio-cultural exposure and actual clinical experiences to the trainees.

REFERENCES

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3. Comprehensive Family Planning and Counseling (COFP/C) Training Package (Reference Manual, Trainers' Notebook and Participant Handbook); NHTC, MOHP, February 2003.

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