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

POLICY BRIEF

INDEPENDENT EVALUATION

This policy brief is based on the external evaluation of a pilot intervention aimed at expanding the range of contraception options offered at the traditional Voluntary Surgical Contraception (VSC) camps that are periodically run in most districts of Nepal.

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

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

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Why expand contraceptive options in the VSC camps?

Voluntary surgical contraception (VSC) camps are the main or only means for the Ministry of Health (MoH) to deliver sterilisation services to the rural population of Nepal, particularly in remote locations of hill districts. For most of the rural population the sterilisation services delivered from district hospitals – if and where district hospitals deliver these services - remain inaccessible due to distance, cost of travel and disruption to normal life.

What did the pilot intervention attempt to demonstrate?

Traditional VSC camps tended to focus on delivering male and female sterilisation services only. This pilot and its evaluation aimed to assess if provision of a wider range of family planning services (including LARC, injectable contraceptives, oral contraceptives and counselling to the standard VSC services) delivered through VSC camps would attract the interest of potential female clients interested in alternative forms of contraception. The evaluation assessed if the approach actually expands availability and choice and leads to increases in uptake of family planning. Hence the term 'VSC+' to refer to this expanded range of services.

The pilot intervention was delivered between August and December 2015 in Baitadi and Darchula, two hill districts of Nepal. Two modalities of implementation were piloted, one delivered by the District Health Office (DHO) of the MoH in Baitadi and one delivered by a private provider, Marie Stopes International/Sunaulo Pariwar Nepal (hereafter MSI/SPN) in Darchula, as follows:

- **Modality A: Service provision by the DHO in Baitadi.** In Baitadi, a trained surgical team from within the district provided comprehensive VSC+ services in the camps under the stewardship and coordination of the DHO. Four government health facilities (camp sites) were selected where VSC+ camps were run once a month for four consecutive months.

- **Modality B: Service provision by MSI/SPN in Darchula.** In Darchula a trained surgical team from outside the district was contracted to provide comprehensive VSC+ services once a month in four government health facilities over a period of four consecutive months. MSI/SPN were contracted by the Nepal Health Sector Support Programme (NHSSP) to provide the services.

The primary target population in both modalities were women of reproductive age (WRA) residing in the catchment areas of the selected health facilities. Please note that men were also targeted but were offered just voluntary surgical contraception whereas women were offered a wider range of services.

Pilot implementation and evaluation took place simultaneously over a period of approximately 4 months.

Summary findings

- All types of contraception were offered in the camps for each of the two modalities.
- The uptake of additional family planning options different to the traditional sterilisation services clearly increased. Long Acting Reversible Contraception (LARC) was the option chosen by most women as alternative to sterilisation. More than 90% of LARC adopters chose implants rather than IUCD.
- Total uptake of family planning services was similar in Baitadi and Darchula (150 and 169 clients respectively). However, the *composition of uptake* was quite different in each modality:
  - In Baitadi 90% of clients opted for sterilisation and only 10% opted for LARC, whereas 58% of clients in Darchula opted for LARC.
  - While the reasons for these differences are not fully understood they seem to be linked to contextual factors and to supplier-induced demand, and not to intrinsic differences between public and private provision.
- Interviews conducted among a sample of 64 clients who took a service in the camps showed that only 10% were new users of family planning (so 90% switched methods). All clients were satisfied with the service and received the contraception of their choice.
- Adding LARC to sterilisation services was highly cost effective and resulted in very low marginal costs, meaning that the costs of adding LARC to sterilisation are negligible.

Policy implications and recommendations from evaluators

1) **VSC+ camps are worth scaling up**. The provision of alternative contraceptive options delivered alongside traditional sterilisation attracted a significant number of clients, was highly cost effective and incurred low marginal costs. It is recommended that VSC+ camps should substitute the traditional VSC camps.

2) **The main factors determining the feasibility, scalability and sustainability** of the VSC+ model through public or private provision include the following:

   a) **Availability of trained service providers**. In districts where government service providers are competent in sterilisation and LARC are not available, the private provision modality is a good option. Private provision is indeed a better option than using staff from neighbouring districts to run the camps as this would affect continuity of family planning provision in the neighbouring districts.

   b) **Availability of referral facilities** able to deal with eventual complications (mainly of sterilisation) is a key consideration, as this affects both the quality of the service as well as the behaviour of service providers. Where referral facilities are not available the case for delivering sterilisation services involves risk to patients, so LARC clinics are likely to be a better, safer alternative. LARC clinics can be delivered either by existing district staff or by contracted visiting providers (see visiting providers policy brief).

   c) **VSC+ camps require a minimum infrastructure** in order to guarantee hygienic conditions, privacy of counselling and service and comfort to clients (enough rooms and beds etc). This should be the government policy.

   d) **Uptake in VSC+ camps relies heavily on effective mobilisation** of potential clients and on clarity of dissemination messages. Poor mobilisation can result in higher unit and opportunity costs.

   e) **Counselling is a key determinant of client's choice,** and therefore it should be provided professionally by service providers who are regularly trained and refreshed on counselling skills.

   f) **The number of consecutive VSC+ camps cannot be established empirically** and should be linked to ongoing demand. Therefore, the traditional approach of conducting 3-4 consecutive monthly camps in the same location should be revised. VSC+ camps incur significant set up costs, so it is important for the DHO to monitor demand, and if demand falls after the first camp alternative camp locations should be selected. This approach would be more efficient and would also improve equity of service availability by reducing 'pockets' of under-served potential clients.

   g) **The coordination and oversight of camps is crucial for effective decision making** and for lesson learning across districts. DHOs play a crucial role and need to be technically supported in data analysis. NHSSP played that role during the pilots and an equivalent support should be provided during scale up.

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