EVALUATION REPORT

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

Final Report 24th June, 2016

HERD International

Mott MacDonald

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Acronyms

ANM	Auxiliary Nurse Midwife
BC	Birthing Centre
DFID	Department for International Development
DHO	District Health Office
FCHV	Female Community Health Volunteer
FHD	Family Health Division
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 Contraception
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
NBC	Non-Birthing Centre
NHRC	Nepal Health Research Council
NHSSP	Nepal Health Sector Support Programme
QI	Quality Improvement
RA	Research Assistant
SBA	Skilled Birth Attendant
SOP	Standard Operating Procedure
SRO	Senior Research Officer
USAID	United States Agency for International Development
VDC	Village Development Committee
VP	Visiting Provider
WRA	Women of Reproductive Age

1. Summary of key findings and recommendations

This is the report of the independent evaluation of a pilot intervention to expand access to Long Acting Reversible Contraception (LARC) in Nepal. The pilot, conducted in Ramechhap district in 2015, tested two modalities of LARC delivery:

- **Modality A: direct provision of LARC by visiting providers in non-birthing centres**. In 31 health facilities without birthing centres ('non birthing centres' or NBCs) visiting providers delivered LARC directly to interested clients on dates agreed with the District Health Office and local health facility staff. Direct provision was justified by the fact that LARC are not provided from NBCs nor are their staff trained in LARC insertion or removal.

- **Modality B: coaching the existing trained staff in birthing centres**. This modality aimed to explore if training on implant insertion and coaching facility staff on IUCD insertion and removal by a visiting provider would increase uptake of LARC. In Nepal, health facilities with a birthing centre ('birthing centres' or BC) are expected to provide LARC as some among the staff in the facility have been trained in LARC insertion and removal. However, it is a common observation across the country that birthing centres either do not tend to provide LARC, or very little.

The evaluation assessed the main factors affecting or determining the results achieved with a view to eventual replication and scale up in other parts of Nepal. This report presents the main findings, conclusions and policy and programme recommendations.

Findings

Uptake of LARC and CYP. Both modalities led to a statistically significant increase in the uptake of LARC. LARC uptake was substantially (five times) higher in modality A, and implants were by far (eleven times) the most demanded method for both modalities. The overall investment in the pilot resulted in provision of LARC services to an additional 1,123 users, providing 4,327 couple years of protection (CYP).

Cost analysis. The analysis of the costs of the intervention indicates that the visiting provider intervention is a cost-effective way to substantially increase the uptake of LARC in areas of low CPR and high unmet need for LARC (i.e. in most of rural Nepal). The direct provision of LARC by visiting providers (modality A) is much more cost-effective and cost-beneficial than coaching skilled birth attendants in birthing centres, mainly because modality A attracts a higher number of women. Within both modalities the provision of implants was more cost-effective, much more cost-beneficial and presented lower scale-up costs than the provision of IUCD, or the provision of both IUCD and implants.

Client satisfaction with services received. Two samples of 32 and 44 women were interviewed when exiting the service in modalities A and B respectively. While the samples were not meant to be representative, the results indicate high levels of satisfaction with the service received and with the behaviour of service providers. All women and 93% of women in modalities A and B respectively reported to have received the family planning method of their choice. While all respondents reported to have received counselling, fewer women received individual counselling in modality A – where client numbers were often very large, making individual attention by visiting providers less feasible. Most women lived within one hour of the health facilities and most considered the waiting time at the facility to be reasonable.

The quality of service was assessed through observations made by research assistants from the evaluation team and through interviews with service providers and programme managers. Issues identified that require further attention to strengthen service quality were slightly different for each modality.

- In the direct LARC provision (modality A) the main obstacles experienced by visiting providers included: contraceptive shortages; lack of adequate space in NBCs for maintaining privacy and confidentiality; long travel carrying heavy equipment, delivering services in isolation and dealing with heavy client loads on LARC clinic days. The demanding duties and poor employment conditions were reported by the visiting providers, and may partly explain the high attrition of visiting providers during the nine months pilot. Service providers also raised the need to make LARC clinics more regular and predictable in order to run a better service and better plan the mobilisation in the catchment areas. These issues, particularly the ones linked to the contracting of visiting providers, would need to be addressed in an eventual scale up of this modality, as implementing it as during the pilot would be both unfeasible and unsustainable.

- In the coaching approach (modality B) the flow of patients was lower and more evenly distributed, and the health facilities (BCs) usually had sufficient commodities and adequate space to deliver a quality service (when compared to NBCs). Issues that require attention in an eventual scale up of this modality include the need for making coaching sessions more regular and better planned, with more ongoing supervision and performance management (in terms of LARC) of the service providers being coached. For this, it may make sense to separate coaching in BCs from direct service provision in NBCs, as the two modalities often conflicted with each other and may have resulted in the coaching modality being less of a priority for the visiting providers.

Conclusions and recommendations

Chapter 6 provides a short, detailed account of conclusions and recommendations aimed at policy makers and programme managers. These include important operational connotations that cannot be summarised here without losing crucial detail. The following summarises the main, broad conclusions and recommendations:

1. Modality A is worth scaling up as it offers a rapid and cost effective way to meet the high unmet need for LARC and to attain rapid increases in CYP in areas with low CPR.

The best way to scale it up would be through a second generation intervention where the findings and recommendations from this evaluation are used to strengthen the intervention and help sustain its results.

2. Focus modality A on implants – not IUCDs – for both cost effectiveness and service quality reasons. Refer clients interested in IUCD to other facilities such as birthing centres, primary healthcare centres and district hospitals.

3. Make LARC clinics in NBCs more regular and predictable: this will help run a better service and plan client mobilisation in a more sustainable and cost effective manner.

4. Standardise the contracting of visiting providers, including better working conditions that help attract, retain and motivate them.

5. Strengthen the planning and incremental targeting of mobilisation efforts, particularly by FCHVs, so that mobilisation increasingly targets areas of higher unmet need for LARC thus avoiding 'pockets' of high unmet need for LARC within health facilities' catchment areas.

6. Improve logistical arrangements to ensure regular supply of commodities in line with demand for LARC and adequate space in the facilities where LARC clinics are run. Service provision in NBCs without adequate space to deliver a quality service (privacy, confidentiality, individual counselling, etc.) should be avoided.

7. Provide additional support to the district health offices responsible for implementing the intervention, including managerial and logistical support.

8. Improve and emphasise the need for proper recording of client data for both monitoring, district planning and programme (intervention) management purposes.

In relation to modality B and the coaching of staff in health facilities with a birthing centre where LARC should be delivered on a regular basis, our main recommendations include:

9. Ensure that training and coaching are delivered systematically, and with the required performance management and supervision of coached staff. Select visiting providers whose main or only task focuses on coaching, so that the direct provision of LARC in NBCs does not conflict with the coaching of BC staff.

10. Target mobilisation in the catchment areas of BCs, which may be helped by also making LARC clinics in BCs more regular and predictable. For instance, providing LARC services daily may not be feasible, and therefore allocating specific days each month where LARC will be provided could help BCs deliver a better service. We suspect that one of the reasons for less demand for LARC in BCs (compared to NBCs) had to do with lower mobilisation efforts in BCs, even if this could not be properly assessed with the available data.

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 this support, in 2014 DFID and USAID commissioned 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 is the report of the evaluation of one of the pilot interventions, the mobilization of Visiting Providers to expand access to Long Acting Reversible Contraception (LARC) for the population of Ramechhap district.

2.2 Justification

This section is based on a Concept Note by the Nepal Health Sector Support Programme (NHSSP) that supports and justifies this pilot.[1]

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. Nepal Demographic and Health Survey data shows that unmet need for contraceptives is very high, estimated at 27% in 2011, and increased from 25% in 2006; the overall contraceptive prevalence rate is also low, estimated at 43% in 2011 for modern methods, reduced from 44% in 2006.

LARC methods include intra-uterine contraceptive devices (IUCDs) and implants. Their advantages over short term methods include very high effectiveness, long duration of protection, relatively easy insertion, broad eligibility for women of reproductive age, high acceptability and continuation, and low cost.

IUCDs, which provide up to 12 years of reversible contraception, work by preventing fertilisation as well as implantation. They allow a rapid return to fertility after discontinuation, which makes them suitable for nulliparous women, and do not interfere with breastfeeding, which also makes them suitable for postpartum women. Contraceptive implants (flexible rods

[1] References are quoted from this source; for brevity, some references have been omitted. The concept note was prepared in early 2014 by staff from the Nepal Health Sector Support Programme, as part of its technical support to the pilot interventions, and was extensively revised. It can be accessed at www.nhssp.org.np/. The complete reference is: NHSSP (2014). Concept note: mobilizing visiting provider to expand Long Acting Reversible Contraceptives - expanding contraceptive choice for women in rural areas of Nepal through skilled visiting providers. Draft, November 2014.

inserted under the skin of upper arm of a woman) can provide a contraceptive effect for three to five years.

The Nepal Health Sector Strategic Plan II (NHSP-2) aims to ensure the provision of at least five family planning methods at every health facility, from the health post level up. This objective is echoed in the Family Planning Strategy (2012) and Costed Five Year Implementation Plan for Contraceptives. Although short term methods are available in all the country's health facilities, LARC are available only at a small proportion of these (in 18% of health posts and more scarcely so in remote locations). A study conducted in 2013 in five remote districts of Nepal found that, excluding district hospitals, only 10.5% of health facilities within eight hours distance from the district headquarters were providing the two LARC methods, resulting in very low utilization of LARC by women from hills and mountain districts (cited in NHSSP 2014). Other reported demand and supply side barriers affecting the use of LARCs include: reluctance by women to undergo the pelvic examination and procedure necessary for IUCD insertion; the fact that clients are generally more open to methods that are well known and discussed among their relatives, friends or neighbours (LARCs are less known among these groups); frequent transfer of staff trained in LARC resulting in discontinuation of services; the fact that IUCD (more than implant) insertion and removal is more labour intensive than other methods and requires more preparation and support from other facility staff (which may not be available); and the lack of counselling skills to advise on the pros and cons of LARC by many service providers (NFHP, undated). Other factors contributing to the low use of family planning (including LARC) are: high spousal separation, increased access and use of abortion services, increased use of traditional methods and increased use of emergency contraceptives (NHSSP 2014).

Against this backdrop of suboptimal access to, and demand for, LARC especially among women in rural and hill zones, there is a strong case for increasing the availability of LARC at rural health facilities. Current access to LARC is extremely low and most IUCD and implants users in mountain and hill districts receive their services from hospitals and mobile family planning camps/clinics which are available only once or twice a year. Utilisation of LARC from mobile clinics shows that there is considerable demand for LARC in rural Nepal. Consistent availability of LARC services at rural health facilities would potentially increase informed choice for women and also the contraceptive prevalence rate.

Delivery of health care services through visiting providers (VPs) can make a considerable contribution to service uptake, especially among those who have had limited access to these services (HSSP 2014, and backed by extensive research globally). Given the positive experience in other countries, and the potential for comparable results in Nepal, this pilot offered an appealing opportunity for evaluation.

2.3 The pilot and its two implementation modalities

The pilot intervention was implemented between March and November 2015 in Ramechhap, one of the hill districts of Nepal with lower than average use of family planning services and commodities.

As envisaged at design, it was an operational research intervention in which three **visiting providers** (nurses or senior auxiliary nurse midwives experienced in IUCD, implants and

coaching/mentoring) were purposely contracted for the duration of the pilot and placed in Ramechhap district. They were expected to visit eight **health facilities with birthing centres** (referred to in this document as birthing centres or BCs) and 31 **health facilities without birthing centres** (referred to in the document as non-birthing centres or NBCs).

The pilot tested two implementation modalities: modality A (direct provision of LARC by VPs in NBCs) and modality B (coaching of SBAs in birthing centres). These are briefly described below.

- **Direct provision of LARC by visiting providers in non-birthing centres**. In the 31 health facilities without birthing centres visiting providers were expected to provide LARC directly to interested clients on dates agreed with the DHO and local health facility staff, to meet local demand for these commodities. Direct provision is justified by the fact that health workers operating from these facilities have not been trained in LARC insertion and removal and are not expected to deliver LARC in these facilities. Therefore, access to LARC in the catchment areas of NBCs is, in principle, very low. Women interested in LARC would need to travel (often long distances) to access LARC in higher level health facilities such as primary healthcare centres or hospitals, or from private providers if available.

- **Coaching the existing trained staff in birthing centres**. This modality aimed to explore if training on implant insertion and coaching facility staff on IUCD insertion and removal by a visiting provider would increase uptake of LARC. In Nepal, birthing centres are expected to provide LARC as some of the staff in the facility (the auxiliary nurse and midwife, the skilled birth attendant or a paramedic) have been trained in LARC insertion and removal. However, it is a common observation across the country (see 2.2 – Justification) that birthing centres either do not provide LARC at all or very little.

- In both modalities the target beneficiaries were women of reproductive age residing in the catchment areas of the health facilities (referred to as ‘women’ or ‘clients’ throughout this report).

Each modality has a different *modus operandi* and linked standard operating procedures (SOP). Therefore, each modality was evaluated individually and the results are presented separately in this report in Chapters 3 and 4.

The Family Health Division (FHD) of the Ministry of Health (MoH)[2] through its District Health Office (DHO) and linked health facilities were responsible for implementing the pilot. The NHSSP provided technical support in terms of design, standard operating procedures, training and oversight. DFID and USAID provided financial support for implementation and evaluation. Mott MacDonald and HERD were responsible for monitoring and evaluation (M&E).

The pilot included specific arrangements to ensure consistency in implementation across facilities through an SOP manual prepared by NHSSP. The manual included specific

[2] Until 2016 and throughout the evaluation period the Ministry of Health was referred to as the Ministry of Health and Population (MoHP). We have kept the latter name and acronym in the references only.

arrangements to ensure the quality of services delivered, such as the use of a quality improvement checklist to be completed by service providers. In addition, visiting providers (in coordination with the health facility in-charge and service providers) were expected to assess the quality of LARC services delivered in all birthing centres through the use of standard family planning quality improvement tools during the intervention.

The two modalities used similar community mobilisation and promotion activities about the availability of the service and the advantages of LARC, to ensure that opting for LARC was voluntary and based on adequate information. Mobilisation activities were to be delivered mainly by Female Community Health Volunteers (FCHVs) and by Health Facility Operation and Management Committee (HFOMC) members through an orientation course on comprehensive family planning information.

In modality A in NBCs, FCHVs were expected to disseminate information and the dates the visiting provider would be in the NBCs to interested women mainly through mothers' group meetings. In Modality B in BCs, the approach was similar except that the information provided suggested that LARC would be available at the BC on a regular basis rather than pointing to a specific date.

2.4 Evaluation methodology

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

The following is 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 for evaluation. The first refers to 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, e.g. service uptake, perceived and observed quality of services and levels of user satisfaction. The second is about assessing why (or why not) the pilot met its objectives, to determine the main factors influencing results and informing potential replicability or scalability in Nepal. This required the evaluation team to perform close monitoring of the intervention in a sample of sites, as described later.

This evaluation will attempt to answer the following broad evaluation questions:

1) Does the provision of visiting providers to non-birthing centres (direct provision modality) increase the uptake of LARC?

2) Does the training in implant insertion and the coaching/mentoring on IUCD insertion and removal provided by visiting providers to existing trained service providers in birthing centres (coaching modality) enhance their LARC provision skills to the extent of enabling them to deliver LARC on their own when the visiting provider is not present? Did LARC uptake increase?

3) What is the perspective of beneficiaries/clients about the quality of services provided by visiting providers and services providers coached by the visiting providers?

4) How effective are the advocacy activities by FCHVs and HFOMC in raising awareness about the new LARC services on offer and in generating demand among women?

5) What are the main factors affecting or determining the feasibility, replicability and sustainability of the visiting provider pilot model as implemented?

2.4.2 Evaluation design and overall approach

The process of selecting an evaluation design began with assessing how to address those five questions. While experimental and quasi-experimental designs would provide a more accurate assessment of the impact of the intervention in relation to evaluation questions 1, 2, 4 and 5, these designs were ruled out from the outset in agreement with our clients and partners. The main reasons were related to: the small scale of the intervention and short duration, and the fact that the users of the new services would be self-selected, so they could not be randomly assigned to intervention and control groups. These factors made impact assessment problematic, not to mention the higher costs associated to these designs, which exceeded the budget allocated to the evaluation.

The chosen alternative was to undertake a **process evaluation** using a mix of qualitative and quantitative methods that would enable triangulation of results to propose plausible explanations for the results achieved. These methods are briefly summarised in the table below.

Table 2.1: Main study questions and evaluation methods

Main study questions	Evaluation methods
1. Direct provision modality: Does the provision of visiting providers to NBCs increase the uptake of LARC?	**Quantitative assessment:** A before and after approach was used to compare uptake of LARC during the intervention period and during an equivalent period of the previous year. However, since non-birthing centres (NBCs) at least in Ramechhap do not usually deliver LARC the uptake of LARC during the previous year was considered to be zero (baseline). The original plan was to collect the data from the reporting forms kept at the DHO. However, after looking at the consistency of various data sources (facility data, reporting data and NHSSP data) evaluators chose to use NHSSP data to measure uptake in the NBCs, as it proved more reliable (see Chapter 3). **Qualitative data** was collected from visiting providers and available service providers to explore implementation issues and perceptions on quality of services in a sample of four NBCs using endline interviews and observations from research assistants visiting the

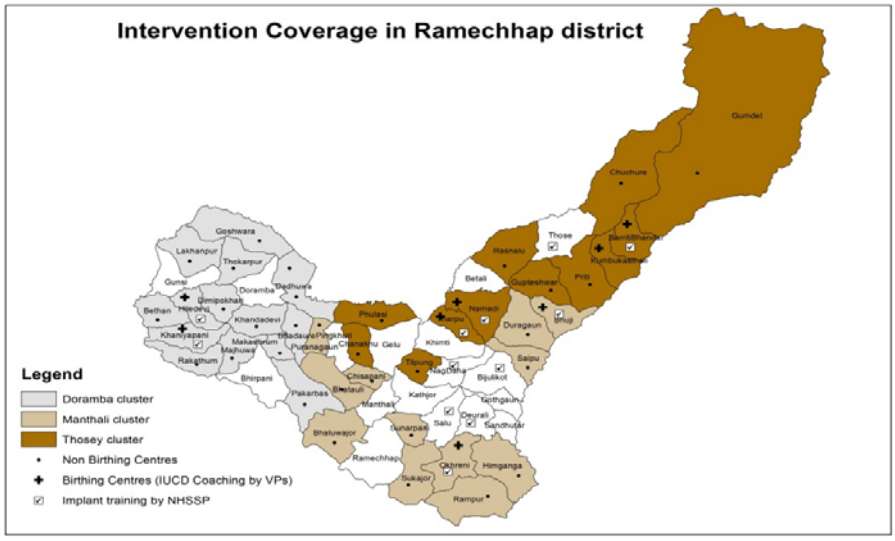
Main study questions	Evaluation methods
	health facilities (possibly on days when the visiting providers planned to deliver services in that facility).
2. Coaching modality: Does the training in implants and the coaching/mentoring provided by visiting providers to existing trained providers in BCs enhance their LARC skills to the extent of enabling them to deliver LARC on their own? Did LARC uptake increase in the BCs?	**Quantitative assessment:** A before and after approach was be used to compare uptake of LARC during the intervention period (using HMIS or facility registers) and during an equivalent period in the previous year (using HMIS data available at the facility or reported). Data from the previous year was collected by research assistants at baseline (before intervention) and then monthly from the eight birthing centres (BCs). Uptake tables by month and graphs are used to show the relationship (in real time) between coaching sessions delivered by the visiting providers and the uptake of services. **Qualitative data** was collected from visiting providers and available service providers to explore implementation issues and perceptions on quality of services in a sample of the eight BCs using endline interviews and observations from research assistants visiting the health facilities (possibly on days when the visiting providers planned to deliver coaching).
3. What is the perspective of beneficiaries/women about quality of services provided by visiting providers and service providers coached by the visiting providers?	To explore perceptions on contraceptive choice and quality of services, in both NBCs and BCs, **qualitative data** was collected from women through exit interviews on service days. In total 76 exit interviews were conducted.
4. How effective are the advocacy activities by FCHVs and HFOMC to raise awareness about the new LARC services on offer and to generate demand among women?	Quantifying or assessing accurately the effectiveness of mobilization and awareness raising by FCHVs and HFMOC would have required collection of population based data in a large number of facilities, given the relatively small number of women potentially seeking LARC and the fact that they are self-selected users. As this was not possible, as an alternative (proxy), women were 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, replicability and sustainability of the visiting provider pilot model as implemented?	Information was collected through in-depth interviews at end line with visiting providers, service providers (including those coached in the BCs), district health managers and NHSSP staff overseeing pilot implementation. This information was triangulated with information obtained for previous questions, particularly 2, 3 and 4.

2.4.3 Monitoring and evaluation sites and period

A smaller sample of 12 health facilities (eight BCs and four NBCs) were selected to generate 'rich' information to contextualise the uptake of LARC under each implementation modality. It was expected that close monitoring in 12 facilities would enable a deeper investigation with a variety of M&E techniques. Whereas only four NBCs were selected for monitoring and qualitative assessment purposes, the LARC uptake information in this evaluation refers to all the 31 NBCs included in the pilot.

Monitoring pilot implementation took place during the whole evaluation period (March to October 2015) by two research assistants in the 12 selected sites.

As stated in the implementation guide prepared by NHSSP and the DHO, the district was divided in three clusters: Thosey, Doramba and Manthali. The 31 NBCs and 8 BCs covered by this intervention were divided among these three clusters, with each cluster allocated to one visiting provider. The Thosey Cluster included 8 NBCs and 4 BCs, Doramba included 13 NBCs and 2 BCs and Manthali included 10 NBCs and 2 BCs. The detail of the BCs and NBCs in each cluster is shown in the map below.



2.4.4 Staff arrangements

This evaluation was undertaken by an evaluation team comprising HERD staff and their contracted research assistants, and technical support and oversight by the Mott MacDonald team.

HERD appointed one Senior Research Officer (SRO) based in HERD Kathmandu and two full-time field research assistants. The SRO was responsible for implementing the evaluation, ensuring compliance with the original plan of work, for the processing and analysis of qualitative data, and for triangulation with quantitative data. A Data Analyst and Data Management Officer managed quantitative data. A Communication Officer was responsible for desk-based communication with the research assistants in the field and then communicating their updates to the SRO. An Operations Manager was responsible for

overall operational and logistics management during the entire project. In order to undertake the costing work a national economist was contracted in the latter part of the evaluation.

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 Nepal – 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

A monitoring checklist was prepared and research assistants trained on its use. This checklist helped the evaluation team monitor adoption of the required SOPs in the pilot and whether continuous supply of commodities had been ensured. Research assistants also took observation notes when they visited facilities, and held formal and informal interviews with service providers, visiting providers and a small sample of FCHVs during service days. Endline interviews were held with visiting providers, service providers, NHSSP and DHO staff.

Routine monitoring was concluded by end of October 2015, when the data cleaning, data quality checks and processing of the backlog of qualitative and quantitative information began. This triggered the pre-analysis of data, i.e. the initial triangulation of data from various sources in order to bring together the results and to help prepare the endline interviews that were carried out in January and February 2016. The costing analysis also began at this time by an appointed researcher who worked under the guidance of the evaluation team's health economist.

Data analysis and evaluation report writing began in mid-February 2016, after completion of the endline interviews and costing work.

2.4.6 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. Table 2.2 shows how we converted Nepali to Western months.

Table 2.2: Western months and their equivalent Nepali 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

2.5 Factors affecting the pilot and its evaluation

Some important contextual factors affected implementation and evaluation of this pilot in ways that the risks and mitigation measures identified at design stage could not possibly predict. The specific limitations related to the application of the proposed evaluation methodology or to the availability or quality of data are discussed with the findings (Chapters 3 and 4).

On 25 April 2015 a massive earthquake hit Nepal, causing more than 8,000 deaths and immense suffering to millions. The earthquake brought the country to a halt and caused considerable destruction in Ramechhap district, were the pilot was being implemented. Concerns about conducting research amid so much suffering, the destruction of infrastructure (roads, health facilities, housing, etc) and the need for colleagues in Nepal to focus on relief operations brought pilot implementation and evaluation activities to an almost complete halt during May and June 2015. After much internal debate among implementing partners, government authorities and funding agencies and to honour the resilience of Nepal as a whole it was decided jointly with our Nepal partners to continue with implementation and evaluation, which resumed in July 2015. It is impossible to quantify the impact that the earthquake had, for example, on the uptake of family planning services and to disentangle the evaluation results from the impact of such a huge, unpredictable event.

In addition, Nepal was affected by civil unrest in the terai from August 2015 and by a blockade in the border with India that caused a severe fuel and commodities crisis from September 2015 until February 2016. The fuel crisis significantly affected pilot implementation and evaluation in several ways: service users had less access to public transport to seek health care; visiting providers could not travel to destination facilities as planned; 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; etc.

The implications – to the extent that these can be observed or guessed behind unexplained ups and downs in uptake data – are mentioned in the chapters discussing the findings. It is undeniable however that these events have seriously biased the evaluation results in ways that cannot be fully understood, particularly when compared to what a ‘business as usual’ situation would have shown.

3. Findings: Modality A – direct provision

This chapter presents the findings for the direct provision modality, in which visiting providers directly provided LARC in 31 health facilities without birthing centres (non-birthing centres or NBCs) on agreed dates. The evaluation period was March- October 2015.

3.1 Measuring uptake: methodological issues

We used NHSSP data for measuring uptake of LARC, as mentioned earlier (see 2.4.2). The original plan was to collect uptake data from the reporting forms kept at the DHO, but after looking at the consistency of various data sources (facility data, reporting data and NHSSP data) we found NHSSP data to be more reliable. Both data sets underwent routine quality checks, particularly as the total uptake figures showed significant differences (21%) – DHO reporting forms showed a total uptake of 722 implants and NHSSP data showed 912 for the same period March-September 2015. Following verification we observed that the lower uptake figures in the DHO data were caused mainly by missing data for certain facilities. This could have been caused by facility data not having been included in the reporting forms on time or not reaching the DHO office. The NHSSP data provided both uptake data and specific dates when the visits took place, so it could be verified, hence our decision to use it as the primary source for measuring uptake.

Using the NHSSP data we counted the total number of LARC delivered in the 31 NBCs in the period March-September 2015[3] rather than March-October as originally planned, for various reasons. October (Kartik) data was not available for most NBCs at the DHO when the final data collection took place in January 2016, hence we could not check the quality of the NHSSP data for that month. This period was also affected by the fuel crisis and related transport shortages, which is probably a key factor in the substantial reduction in LARC uptake measured in the NBCs by NHSSP.[4] Excluding October data was therefore considered a fairer way of assessing uptake during the pilot.

Baseline data. Given that NBCs do not and are not expected to provide LARC the assumption was for baseline LARC uptake figures for NBCs any time before the pilot to be zero. This was confirmed by data from the DHO reporting forms for the two months immediately preceding the pilot (January and February 2015), where uptake of LARC was zero. Therefore, all LARCs delivered from NBCs are considered to be additional.

[3] Or, to be precise, for the period Chaitra-Ashwin, as Ashwin ends in mid-October.

[4] According to the NHSSP uptake figures 87 implants were inserted between October and November (Kartik and Mansir) 2015. This represents a substantial drop in the LARC uptake average observed so far. In the endline interviews VPs confirmed the difficulties that they and probably clients too experienced to reach the NBCs and the fact that several LARC clinics had to be cancelled due to lack of transport.

3.2 Uptake of LARC

In the following sections we present summary tables and figures. A full set of tables and some additional charts are included in Annex 2.

3.2.1 Number and frequency of LARC clinics

According to NHSSP records, between March and September 2015 visiting providers made a total of 77 visits to the 31 NBCs. The frequency of visits (also referred to as 'LARC clinics' in this report) is summarised in Box 3.1, and the number of LARC clinics per month in Box 3.2. Details of LARC clinics conducted in each NBC are shown in table A3-1, Annex 2.

Box 3.1: Frequency of LARC clinics (Visits by VPs)

How many LARC clinics?	In how many NBCs?
A single LARC clinic	5
2 LARC clinics	13
3 LARC clinics	7
4 LARC clinics	5
5 LARC clinics	1
Total LARC clinics held	**77**
Mean (clinics per NBC)	2.48
Source: *NHSSP*	

Box 3.2: LARC clinics per month

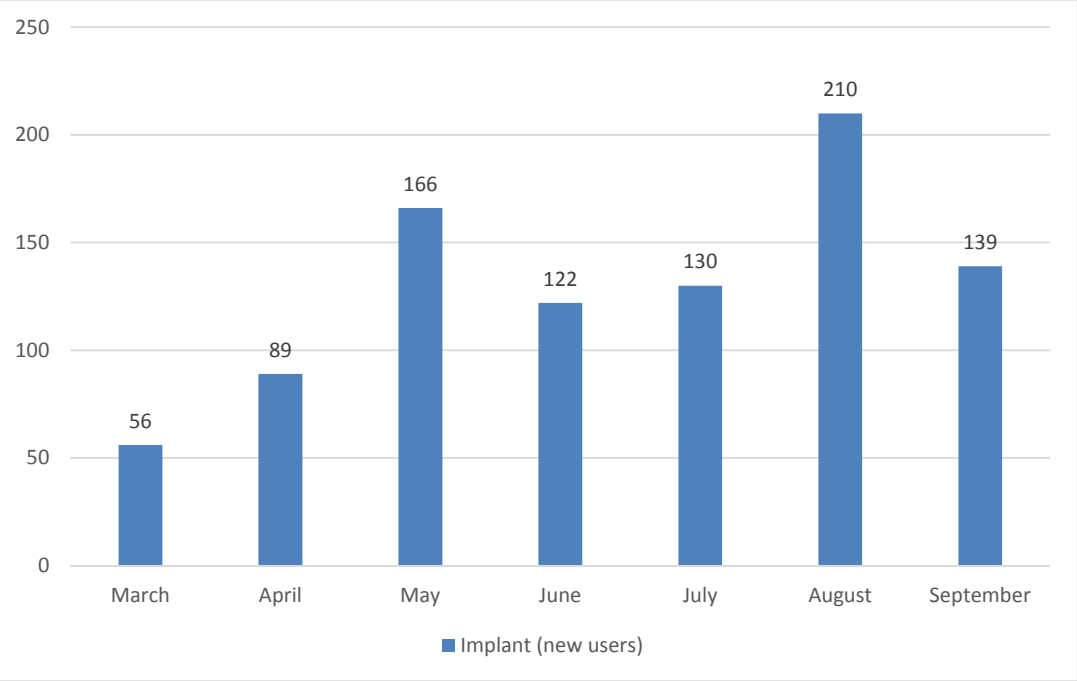
March	5
April	13
May	11
June	13
July	7
August	18
September	10
Total LARC clinics	**77**
Mean (clinics per month)	11
Source: *NHSSP*	

While the average number of LARC clinics per month is 11, the frequencies and periodicity illustrate that not all the NBCs received the same number of visits or around the same time, and that the uptake of LARC in different facilities was achieved with different levels of effort. Decisions on where and when LARC clinics should take place were made jointly by visiting providers and the DHO based on parameters such as the expected demand for the service (based on the previous visit) and other logistical considerations.

3.2.2 Uptake of Implants

According to NHSSP data, between March and September 2015 visiting providers inserted 912 implants (Fig. 3.1). According to DHO reporting forms, 99% of implants were delivered to women aged 20 years or more. Data for January and February confirms that no LARCs were delivered in these facilities before the pilot (with the exception of one LARC clinic held in Khadadevi in February 2015 in preparation for the pilot, which has not been counted).

Figure 3.1: New users of implants in 31 NBCs, 2015



Source: NHSSP data

An average 11.8 implants were delivered per LARC clinic (see Table 3.1), which represents a substantial uptake throughout the pilot, including during the second quarter of 2015 when the earthquake hit Nepal. Uptake peaked during the third quarter of 2015, with a maximum average uptake of 18.5 implants per LARC clinic measured in July 2015.

Table 3.1: Summary uptake of implants in 31 NBCs, 2015

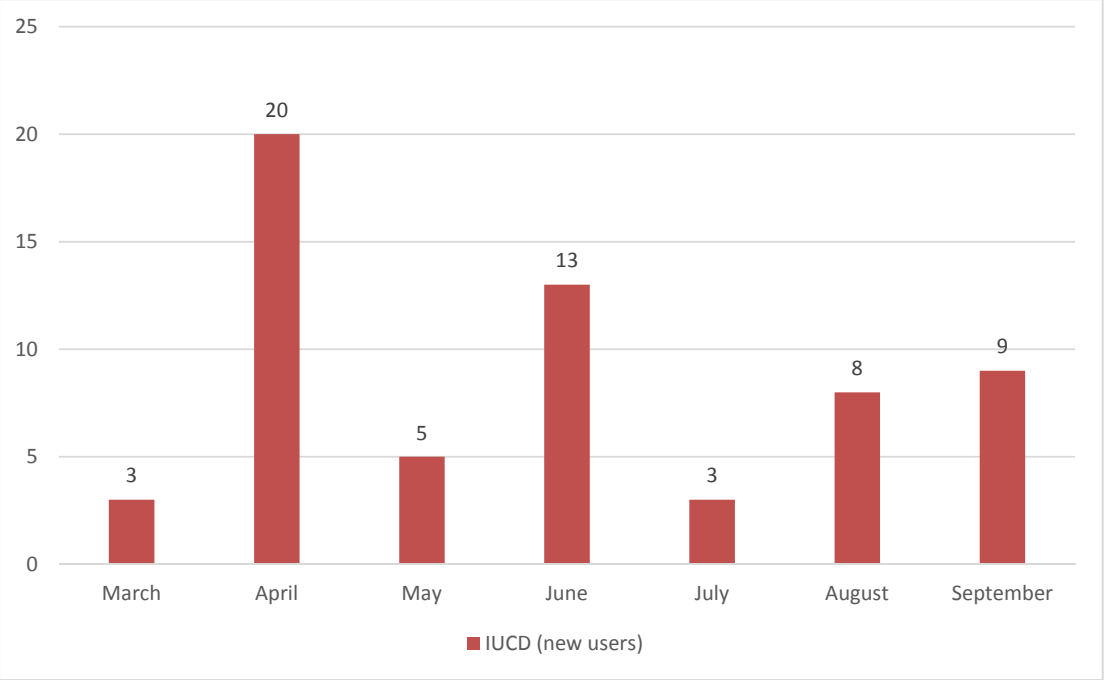
	March	April	May	June	July	August	September	Total
Implants per month	56	89	166	122	130	210	139	912
Nº of LARC clinics	5	13	11	13	7	18	10	77
Average uptake per clinic	11.2	6.84	15	9.38	18.5	11.6	13.9	11.8

Source: NHSSP data

3.2.3 Uptake of IUCD

Between March and September 2015, visiting providers inserted 61 IUCDs through 77 LARC clinics (Fig. 3.2). All IUCDs were inserted to women aged 20 years or more.

Figure 3.2: New users of IUCD in 31 NBCs, 2015



Source: NHSSP data

The data (table 3.2) also allows the following observations:

- The uptake of IUCD was 15 times lower than that observed for implants. For every 16 women (15.95) adopting LARC (n=973) only one (6%) chose IUCD as the LARC method of choice.
- On average, less than one IUCD (0.79) was inserted per LARC clinic. In fact, no IUCDs were inserted in 55 out of 77 LARC clinics conducted.
- The average number of IUCDs inserted per month across all 31 NBCs was 8.71.

Table 3.2: IUCD (new users) in 31 NBCs, 2015

	March	April	May	June	July	August	September	Total
IUCDs per month	3	20	5	13	3	8	9	61
Nº of LARC clinics	5	13	11	13	7	18	10	77
Average uptake per clinic	0.6	1.53	0.45	1	0.42	0.44	0.9	0.79

Source: NHSSP data

3.3 Quality of LARC services

We assessed the quality of services in two ways: a) through direct observation of LARC services delivered in a sample of four NBCs using an observation checklist and b) by asking a sample of 32 women exiting the four NBCs about their perceptions on the quality of the service received. This section also includes findings from key-informant interviews (KII).

Research assistants made two rounds of observation visits to each of the four NBCs, except for Rasnalu (one observation round only). A total of seven clinics were observed, using a checklist and making observation notes.

To complement observations and views from clients, a range of key informants were interviewed during monitoring and then at endline to explore their perceptions on the quality of LARC services delivered and the types of issues or barriers they experienced. The in-charges of all four NBCs, six visiting providers, two staff (District Health Officer and FP Supervisor) from the District Health Office (DHO) and the district coordinator of NHSSP were interviewed. The information from these interviews is presented next.

3.3.1 Availability of commodities

Short-term methods (condoms, pills and depo) were found to be generally available during all the observation visits to the four NBCs. However, the stock of LARCs was more irregular as visiting providers had to carry the contraceptives with them based on a rough estimation of likely demand, which sometimes was higher than expected. (Source: observation notes)

The majority of the six visiting providers interviewed reported that occasionally the commodities that they carried became insufficient due to heavy client flows in the health facility, at times higher than expected. To ensure uninterrupted service delivery in such cases they asked the nearest birthing centre, but it is not known if the approach actually worked, or how often. (Source: KII with VPs)

Shortage of commodities in the district was more noticeable after the April earthquake when a shortage of implants was experienced in the majority of health facilities, in the DHO and at central (national) level. To manage this shortage, the DHO asked the health facilities with commodities in stock to supply them to the facilities with no stock. DHO staff also reported that they received supply of commodities from other organizations or from the Logistics Management Division (who had been alerted of the need by NHSSP staff). It should be noted that family planning commodities are generally supplied by the central level of the MoH based on the targets set by the district, so the supply available in Ramechhap was not sufficient to cover the needs of the intervention, which aimed to increase the number of users beyond any targets set so far. (Source: KII with DHO staff)

3.3.2 Availability of equipment and physical infrastructure

Availability of equipment was found to be a major issue in NBCs. Visiting providers reported that NBCs did not have the materials required for inserting LARC, including IUCD sets, gloves, gauge, torch light, Betadine, etc, given these health facilities are not expected to deliver LARC. In most cases this meant that these items were not available before the

intervention, and visiting providers had to carry them to the NBCs. Visiting providers also reported they often had to carry equipment to boil surgical equipment with them where the NBC did not have autoclave or a working boiler. Visiting providers stated that they tried their best to maintain infection prevention steps as far as they could. (Source: KII, observation notes)

Availability of space was found to be another problem. Two of the four NBCs monitored did not have a separate room for counselling; in these facilities it was observed that counselling was provided in the same room where family planning services were being delivered to other clients. In many directly observed LARC clinics information on family planning methods was provided through a group information session rather than individual counselling. (Source: observation notes)

During KIIs visiting providers stated that enough rooms were available in most of the 31 NBCs before the earthquake, so maintaining privacy was not a problem then. After the earthquake, which destroyed many buildings thus limiting space for service provision, they were not able to maintain client privacy because there were no separate rooms. One of the visiting providers said she had used a simple curtain for privacy where possible. (Source: KII).

3.3.3 Working modality of visiting providers

When asked about their working modality in NBCs, all interviewed visiting providers reported that they used to contact the health facility in-charge by phone, fix a date for the visit and ask the facility staff to gather clients for LARC. However, this approach did not always work as planned; they reported of several occasions when they could not contact any of the facility staff to estimate the number of likely clients and quantify the number of commodities to carry. They also reported that occasionally they had to extend the stay in a particular NBC either because the number of clients was higher than expected or because there were no clients on the agreed date, but were told to expect them on the following day. Extending their stay in those NBCs directly affected their work plan/schedule to visit other facilities. (Source: KIID with VPs)

We also tried to understand factors affecting the frequency of visits to NBCs. The interviewed visiting providers stated that geographical location was one of the factors that affected the number of visits, i.e. a facility with difficult geographical location and with less access to transportation was visited less often than NBCs with easier access. Client flow was also considered, in the sense that facilities with high client flow were visited more often. They also added that the dropout of the visiting provider from another cluster also affected the frequency of visits to some NBCs, because it increased their workload and had an impact on the work plan for their own cluster. (Source: KII with VPs)

3.3.4 Service delivery process

Visiting providers were observed to be confident in inserting LARC. Research assistants noted that they were doing everything on their own, from recording in the face sheet to providing counselling and inserting LARC. When interviewed, they said they were satisfied with their work, stating that they provided service to 12-13 clients in a single day on average.

They also said that the workload was at times very high and could reach up to 20-40 clients, with the visiting provider having to do everything on her own: counselling, inserting LARC and recording.

One visiting provider admitted that heavy client flow affected their ability to deliver proper counselling, as there simply was not sufficient time for it. Since health workers of NBCs were not trained to provide counselling on LARC, visiting providers did not get support from NBC staff for counselling (unlike in the case of BCs – see Chapter 4). The dropout of a visiting provider from another cluster added to their workload as they had to cover an additional cluster and visit 24-25 facilities in a month, which was challenging. (Source: KII with VPs and Observation notes)

3.3.5 Dissemination of information about the new LARC service

All the key informants reported that the main source of information dissemination was through mobilization of FCHVs, and most of them believed that FCHVs had been actively involved in information dissemination.

In the original plans NHSSP intended to disseminate information through FM/radio; this was not done during the intervention for reasons unknown to evaluators. (Source: KII and observation notes)

Research assistants also interviewed five FCHVs during monitoring visits. FCHVs reported that they disseminated information mainly through mothers' group meetings or by informing women when they met casually. (Source: KII with FCHVs)

Given the high turnout of clients to many of the LARC clinics and the evidence provided through exit interviews about the source of information on LARC clinics (see 3.3.2) it would appear that the means of dissemination worked reasonably well and that FCHVs were key in enabling high turnout of clients.

3.4 Client satisfaction

In total, 32 exit client interviews were conducted in the four NBCs selected for monitoring purposes. Research assistants used a structured questionnaire to interview women who had received LARC on a day when the research assistant was present. Table 3.3 shows the distribution of exit interviews over time.

User satisfaction with the services received 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. However information presented in this section of the report should be seen as *indicative rather than statistically representative* because only four of 31 NBCs were monitored by the evaluation team, and because the number of exit interviews represents only 18% of the total number of LARC delivered in the four NBCs.

Table 3.3: Distribution of exit interviews over time in the four NBCs monitored

	March	April	May	June	July	August	September	October	November	Total
Non Birthing Centres										
Rasnalu		4		0						4
Bhatauli				4					2	6
Khadadevi						10			2	12
Pakarbas						8			2	10
Total										**32**

Note: 0 means that no interviews were conducted during the monitoring visit because no women were available for interview.

3.4.1 Received the family planning method of choice

All the interviewed women (N=32) stated that they had received the family planning method of their choice, in this case LARC (those who received another commodity were not interviewed, so it is not possible to know if they also received the method of choice).

3.4.2 Source of information about availability of LARC

Women were asked how they had heard about the new LARC service in NBCs. Of these, 21 (65%) identified the FCHV as the main source of information (Table 3.4); other sources included health workers (1), friends (4), neighbours (4) and teachers (1). Note that the totals for sources of information exceed the numbers of interviews because some women mentioned more than one source of information.

Table 3.4: Source of information about the new LARC service availability

	Non-Birthing centres				
	Rasnalu	**Pakarbas**	**Bhatauli**	**Khadadevi**	**Total**
FCHV	2	9	3	7	21
Health worker	0	1	0	0	1
Friends	1	1	1	1	4
Neighbours	2	0	0	2	4
Teachers	0	1	0	0	1

Source: Exit client interviews.

3.4.3 Distance to health facility

The majority (87.5%) of women interviewed could reach the health facility in less than one hour; it took 1.2 hours for the remaining four women (Table 3.5). This suggests that the LARC clinics were conveniently located for the large majority of clients, who stated that distance to health facility had not been a major issue for them.

Table 3.5: Time taken to reach the health facility

	Non-Birthing centres				
	Rasnalu	**Pakarbas**	**Bhatauli**	**Khadadevi**	**Total**
< 30 mins	3	2	5	6	16
30 mins to 1 hr	1	5	1	5	12
1-2 hours	0	3	0	1	4
Total	**4**	**10**	**6**	**12**	**32**

Source: Exit client interviews

3.4.4 Waiting time

Around 60% of women interviewed after receiving the service perceived that they did not have to wait for a long time (i.e. that the waiting time was reasonable – Table 3.6). Among the 40% who reported a longer waiting time this was estimated to be 1-2 hours by more than half of them (8 out of 13). The most common reason reported for the delay was the heavy client flow in the facility.

Table 3.6: Waiting time at the facility

	Non-Birthing centres				
	Rasnalu	**Pakarbas**	**Bhatauli**	**Khadadevi**	**Total**
Had to wait					
Yes	1	8	1	3	13
No	3	2	5	9	19
Total	**4**	**10**	**6**	**12**	**32**
Waiting time					
< 30 mins	0	0	0	0	0
30 mins to 1 hr	0	2	0	3	5
1-2 hour	1	6	1	0	8
Total	**1**	**8**	**1**	**3**	**13**

Source: Exit client interviews

3.4.5 Counselling

All the women interviewed reported that they had received counselling (Table 3.7). Most of them (62%) reported that counselling was provided before the service, while the remaining 38% reported to have received counselling both before and after the service.

Table 3.7: When did clients receive counselling?

	Non-Birthing Centres				
	Rasnalu	**Pakarbas**	**Bhatauli**	**Khadadevi**	**Total**
Only before receiving the service	3	7	6	4	20
Only after receiving the service	0	0	0	0	0
Both, before and after	1	3	0	8	12
Total	**4**	**10**	**6**	**12**	**32**

Source: Exit client interviews

Researchers also asked where the counselling took place to assess if privacy and confidentiality were maintained (table 3.8). Only seven women (22%) reported to have received counselling in a separate room. The majority (75%) of the interviewed women (24 out of 32) had received counselling in the same room where they were examined and the service delivered, and half of them (or 32% of all clients interviewed) reported to have received information in a group session, as opposed to individually.

Table 3.8: Where did clients receive counselling?

	Non-Birthing centres				
	Rasnalu	**Pakarbas**	**Bhatauli**	**Khadadevi**	**Total**
In a separate room	1	5	0	1	7
In a room separated by curtain	1	0	0	0	1
In the same room where examined and received service	2	2	4	4	12
In a different corner of the room	0	0	0	0	0
Group information session (location not specified)	0	3	2	7	12
Total	**4**	**10**	**6**	**12**	**32**

Source: Exit client interviews

The fact that all clients were provided counselling before the service reflects well on the level of effort by visiting providers to deliver a quality service in spite of often demanding circumstances. As explained earlier (see 3.2.2) VPs could not always provide proper counselling due to either heavy client flow (linked to lack of supporting staff) or lack of suitable space.

3.4.6 Satisfaction with service provider and service received

The majority of the women interviewed (93%) rated the behaviour of the service provider good or very good, and only two reported it just satisfactory (Table 3.9). No women complained about provider behaviour, a common problem reported in many parts of Nepal.

Table 3.9: Overall rating of service provider behaviour

	Non-Birthing centres				
	Rasnalu	**Pakarbas**	**Bhatauli**	**Khadadevi**	**Total**
Very good	0	2	2	1	5
Good	3	7	4	11	25
Satisfactory	1	1	0	0	2
Not good	0	0	0	0	0
Very bad	0	0	0	0	0
Total	**4**	**10**	**6**	**12**	**32**

Source: Exit client interviews

We also asked women to rate the overall service that they received from the health facility. All rated the overall service good or very good (Table 3.10).

Table 3.10: Overall rating of the service received from the facility

	Non-Birthing centres				
	Rasnalu SHP	**Pakarbas SHP**	**Bhatauli SHP**	**Khadadevi SHP**	**Total**
Very good	0	2	1	4	7
Good	4	8	5	8	25
Satisfactory	0	0	0	0	0
Not good	0	0	0	0	0
Very bad	0	0	0	0	0
Total	**4**	**10**	**6**	**12**	**32**

Source: Exit client interviews

Again, these findings reflect very positively on the professionality of the visiting providers and NBC staff, and their effort to provide a quality service, often in challenging circumstances. The levels of satisfaction are well above those often reported for government health services in other user satisfaction surveys conducted in the recent past (see for example Paudel et al, 2015, among others).

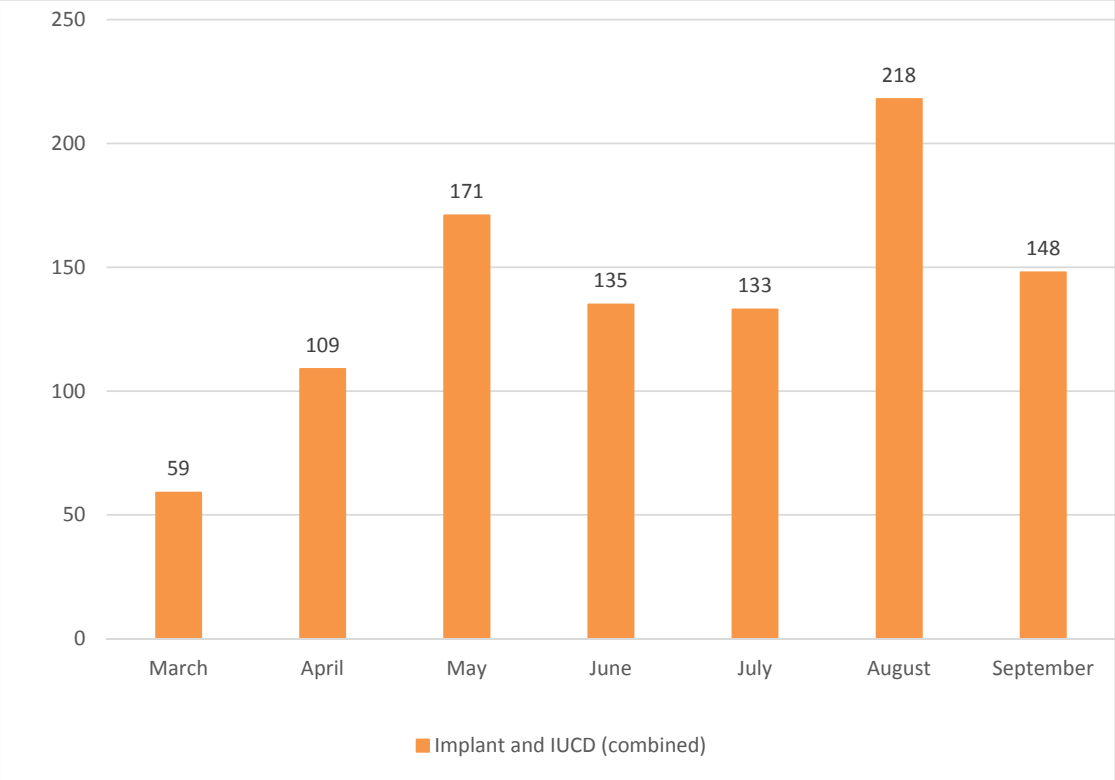
3.5 Brief discussion of findings

This section summarises the main findings for modality A by briefly addressing the five evaluation questions included in 2.4.1. A more contextualised discussion focusing on replicability and scalability of this modality as well as of the visiting provider intervention as a whole is provided in Chapter 6.

3.5.1 Did the uptake of LARC increase?

The uptake of LARC increased markedly, suggesting high unmet need for LARC that was met – at least in part – by the pilot intervention. Uptake was much higher for implants and more consistent across both health facilities and time than in the case of IUCD, where uptake was 15 times lower and where the pattern of demand was much less regular or consistent.

Figure 3.3: New users of LARC (IUCD + implant) in 31 NBCs, 2015



Source: NHSSP data

Our interpretation of the uptake figures is that when availability and access to LARC were ensured through the pilot, women exercised their choice and opted for LARC, and particularly implants. It is reasonable to assume that uptake would likely have been even higher without the earthquake and fuel shortages that hit the country during pilot implementation as these made access to health facilities more difficult for many potentially interested women and service delivery more challenging for visiting providers.

To what extent did the provision of LARC during the pilot meet the unmet need for LARC in the catchment areas of the VDCs or in Ramechhap district? This question might help decide if additional LARC clinics should be held with *some guarantee* that additional clients would continue to come to the LARC clinics in selected NBCs. While it is not possible to answer this question with the available data, we assessed 'continuous demand in successive LARC clincs' as a proxy by looking at whether the uptake pattern for implants was increasing or declining as successive LARC clinics were held. We counted the number of NBCs (from the 14 NBCs that received 3 or more LARC clinics during the pilot) where the last one or two clinics delivered equal or a higher number of implant acceptors than the average of the first two LARC clinics. The analysis revealed that in 8 out of 14 NBCs the uptake of implants was the same or higher than for the two first LARC clinics. This proxy proportion would indicate that considerable unmet need for LARC still remains even in VDCs that received three LARC clinics or more.

3.5.2 Perspectives from beneficiaries

What is the perspective of beneficiaries/clients about the quality of services provided under this modality? The 32 exit client interviews conducted suggest high levels of user satisfaction with the services received, over and above satisfaction levels expressed in other studies exploring general satisfaction with government health services. However, the sample of clients interviewed is not a representative sample, so all results summarised herewith should be seen as indicative, not representative. The main findings were:

- All clients reported to have received the LARC method of choice and rated the service received as good or very good.
- Most clients (60%) reported short or no waiting times to get the service.
- All the women interviewed reported to have received counselling. For one third of women counselling was provided through a group session, which technically speaking should not be called counselling but information session. While group counselling can work where counselling staff are not available in sufficient numbers a one to one approach remains the standard as it enables discussing the best option for each client.
- For at least one third of women interviewed counselling was provided in the same room where the LARC insertion took place. Lack of adequate space in NBCs or the fact that the visiting provider had to deliver the service alone, without another person delivering the counselling were the main reasons for this finding.
- The majority of the women (93%) rated the behaviour of the service provider good or very good. No women complained about provider behaviour.
- The majority of clients (87%) took one hour or less to reach the facility, which confirms high unmet need for LARC at very short distance from government health facilities.

3.5.3 Effectiveness of mobilisation

How effective were the advocacy activities in raising awareness about the new LARC services on offer and in generating demand among women? The effectiveness of information and mobilisation activities was evaluated only indirectly, by looking at the uptake of LARC and by asking a relatively small number of clients, so the information provided in this section is indicative rather than representative of all clients.

Overall the mobilisation effort worked very well, in the sense that most of the time clients attended the NBC on the correct day to receive the LARC service as per the information received. In most cases (65%) information was provided by FCHVs, which confirms the high potential of this cadre of workers to mobilise potential users for family planning services.

3.5.4 Factors affecting results and issues requiring further attention

There are several important issues that need further attention by policy makers and programme managers before a decision to scale up this modality can be made. In the opinion of the evaluators the implementation period (9 months) was sufficient to test the hypothesis that increased supply of LARC through visiting providers in NBCs can increase the uptake of LARC substantially, cost-effectively and rapidly. However, there is some way to go before a decision to scale up this intervention can be made with guarantees that similar results would be obtained.

We have summarised some of the main factors affecting this modality in the conclusions and recommendations (chapter 6).

3.6 Limitations: what could not be evaluated

Natural disasters and fuel crisis aside, the evaluation of this modality faced a number of challenges, some methodological and some practical. Most issues relate to the inaccurate and/or incomplete recording and reporting of data on the uptake of LARC that are part of the HMIS, which is the reason why NHSSP sources were used for uptake as they were far more reliable than the reporting forms.

Examples of missing, incomplete or unreliable information that prevented evaluators answering some questions included the following:

- **Characteristics of service users**. Background data on service users (including on their family planning history) was not collected by visiting providers in most NBCs. The main justification for not collecting such data was that, on most occasions, the visiting provider herself was expected to register the client and deliver both counselling and the LARC service, which was already burdensome, even when NBC staff were able to assist. Research assistants did collect background data from the 32 women interviewed when exiting the service, but the sample is too small to represent LARC users as a whole. Absence of patient background data prevents us from answering certain questions that were included in the original evaluation design, such as:

- Among the users of family planning services (LARC) what proportions were new users and existing users?
- How many switched family planning methods?
- What method did they switch to? (and reasons for the shift)

It would have been useful to use this opportunity to assess the ethnicity and socio-economic status of users, to know if the intervention drew women across the spectrum or instead benefitted some groups more than others.

- **Reporting and recording forms and processes.** Since NBCs in Ramechhap do not usually deliver LARC, the standard Implant and IUCD register (HMIS 3.3) used for example in Birthing Centres was not available in NBCs, neither were the reporting systems in place to ensure effective compilation and reporting of LARC at the DHO. These systems had to be improvised and supported by the NHSSP team. For instance, recording was done in a photocopy of the register, which was at times insufficient to capture the client flow of the day. In general, recording information in the right way was observed to be a major problem in the district. From the research assistants' observation notes we know that the NBC staff were unaware of the correct ways of recording in HMIS registers. Poor recording and use of parallel systems was an obstacle to the standard data verification and data quality assurance checks that are customary in evaluation.

3.7 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 (March 2016). Hence the two months delay in submission of this report.

4. Findings: Modality B – coaching

This chapter presents the findings for the coaching modality, in which visiting providers coached existing staff in eight health facilities with birthing centres (BCs) on the use of LARC. The evaluation period was March-October 2015.

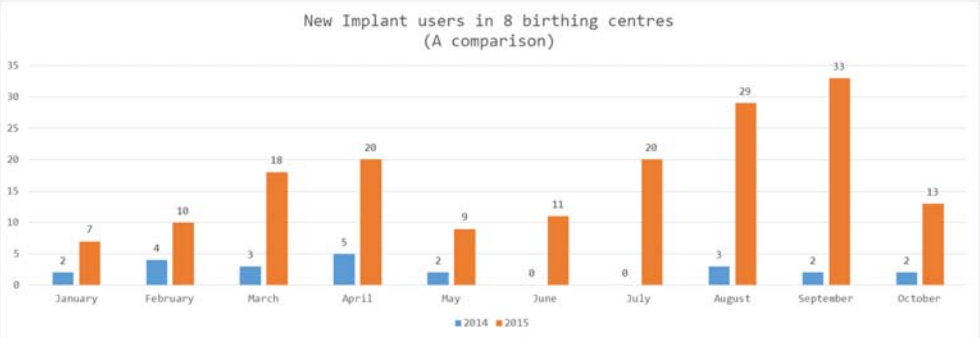
4.1 Uptake of LARC

The total number of LARC delivered in the eight birthing centres were counted using the reporting forms from the DHO. This chapter presents summary tables and figures; detailed tables and figures for uptake in each BC can be found in Annex 3. Please note that issues relating to the quality and incompleteness of reported data (summarised in 4.2) affected the measurement of uptake and the interpretation of related findings.

4.1.1 Uptake of implants

Between March and October 2015 the eight BCs in Ramechhap district delivered 153 implants, against 17 implants during the same period of 2014 (Fig. 4.1 and Table 4.1). The fact that the uptake of implants during the pilot is almost ten times higher than in the same period of the previous year, or that 136 additional implants (153 – 17) were delivered during the pilot suggests that the training that was provided to BC staff at the beginning of the pilot enabled some BCs to increase the delivery of implants. While full attribution of the increase to the intervention is not methodologically feasible, it can be stated with some certainty that the increase was largely caused by the intervention, given that most remaining conditions in the BCs during 2014 and 2015 were quite similar (staffing levels, supply of commodities, etc). Furthermore, it can be safely assumed that in the absence of the earthquake, and later the fuel crisis, uptake figures during the pilot would have probably been higher.

Figure 4.1: Uptake of implants in 8 birthing centres in 2014 and 2015



Source: HMIS reporting forms

Table 4.1: Summary uptake of implants in 8 birthing centres 2014 and 2015

	2014											2015										
	J	F	M	A	M	J	J	A	S	O	Total	J	F	M	A	M	J	J	A	S	O	Total pilot
Totals per month*	2	4	3	5	2	0	0	3	2	2	17	7	10	18	20	9	11	20	29	33	13	153
Number of coaching sessions														4	2	1	2	1	3	1	2	16

** Shaded cells show the periods being compared for evaluation purposes*

Source: HMIS reporting forms

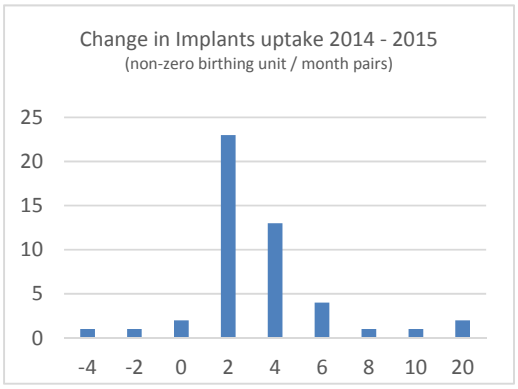
A statistical analysis using a paired t-test (see box) indicated that the differences between 2014 and 2015 were statistically significant. This was true both for all the unit / month pairs investigated and for those month pairs which were non-zero in 2014 and 2015. A histogram for the difference between the two years for the 64 birthing unit / month pairs and the 48 non-zero pairs are set out in the charts below. Whilst not large, the differences are clearly seen as being positive. Note that these results relate only to the birthing centres reviewed and for the months specified and may not be generalizable outside of these parameters as the selection process was non-random. Note also that this significant effect does not automatically prove cause and effect between the coaching sessions and the increase in implants undertaken; although in the absence of any other change in circumstances this does seem to be a plausible explanation.

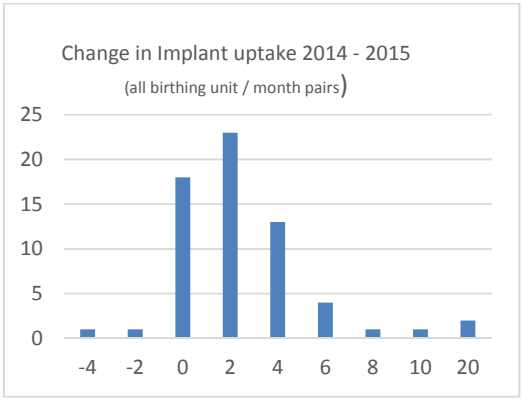
Statistical testing

This test treated each birthing centre's results for each month as an individual sampling unit and compared the figures for 2014 with those for 2015 as a matched pair. This approach removed any seasonal and / or geographical effect but would not remove the impact of the earthquake.

Two tests were carried out, one that included all months (ie 64 month pairs) and one that compared only those month / birthing units pairs that has at least one non-zero value (48 pairs). The argument for the second comparisons is that units which had zero values in both years may not carry out implants for reasons other than the expertise of available staff.

The analysis was carried out on women aged 20 and over only.





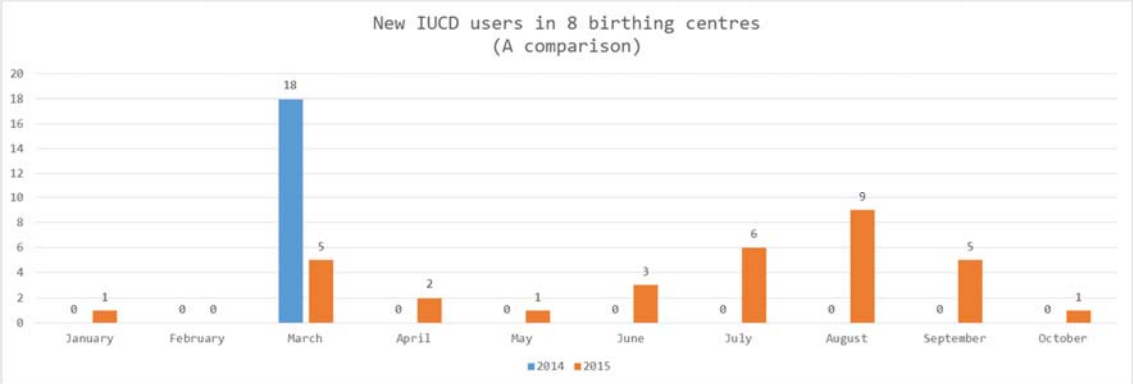
The following observations can be made to put these results in context:

- All but four new users of implants (149 out of 153) during the pilot were women above 20 years of age. The results for 2014 show an average of two implants inserted per month, and confirm the common observation that many, or most birthing centres, deliver very few implants (or LARC) on a regular basis.
- The results from 2015 indicate that an average of 19 implants were inserted every month, or 2.3 implants per birthing centre per month.
- The difference between 2014 and 2015 is statistically significant.
- While uptake measured in 2015 is clearly higher than in 2014 results continue to point to a very modest supply of implants in birthing centres.

4.1.2 Uptake of IUCD

Between March and October 2015 the eight birthing centres in Ramechhap district received 16 coaching sessions by visiting providers and delivered 32 IUCD, against 18 IUCD during the same period of 2014 (Fig. 4.2 and Table 4.2). The uptake of IUCD during the pilot is less than double than in the previous year, equivalent to less than 14 'additional' IUCD delivered during the pilot. These results suggest that the coaching performed by visiting providers had a very limited effect on the uptake of IUCD.

Figure 4.2: Uptake of IUCD in 8 Birthing Centres in 2014 and 2015



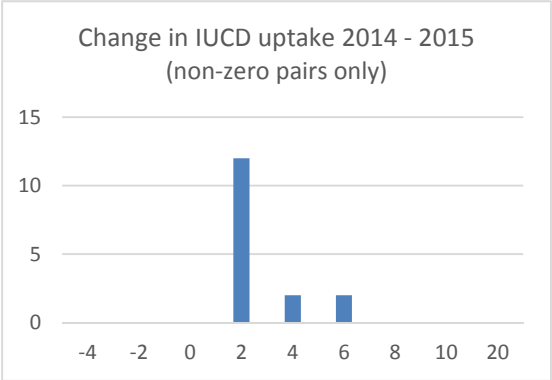
Source: HMIS reporting forms

Table 4.2: Summary of new IUCD users in 8 birthing centres 2014-2015

	2014											2015									
Birthing centres	J	F	M	A	M	J	J	A	S	O	Total	J	F	M	A	M	J	J	A	S	O	Total
Totals	0	0	18	0	0	0	0	0	0	0	18	1	0	5	2	1	3	6	9	5	1	32
Number of coaching sessions														4	2	1	2	1	3	1	2	16
Uptake data for Namadi (from July to October 2014) was not available.																						

Source: HMIS reporting forms

Statistical significance tests similar to the ones performed for implants were carried out for IUCD uptake figures comparing 2014 and 2015 data pairs (see chart). The t-tests showed significant differences, although the level of significance was less than for implants. As explained above the significance here does not automatically translate to a wider population of birthing units; neither can one assume cause and effect although in the absence of other explanations the coaching sessions would appear to be the most plausible driver. Please note that in carrying out the statistical analysis the anomalous result for Kubukasthali in March 2014 where 17 IUCD's were recorded as inserted in under 20 year old's has been excluded as it is clearly an outlier, whether factually correct or an administrative error. The analysis was also restricted to women aged 20 and over as apart from this anomalous result no other IUCDs were administered to those aged under 20.



To put these results into context:

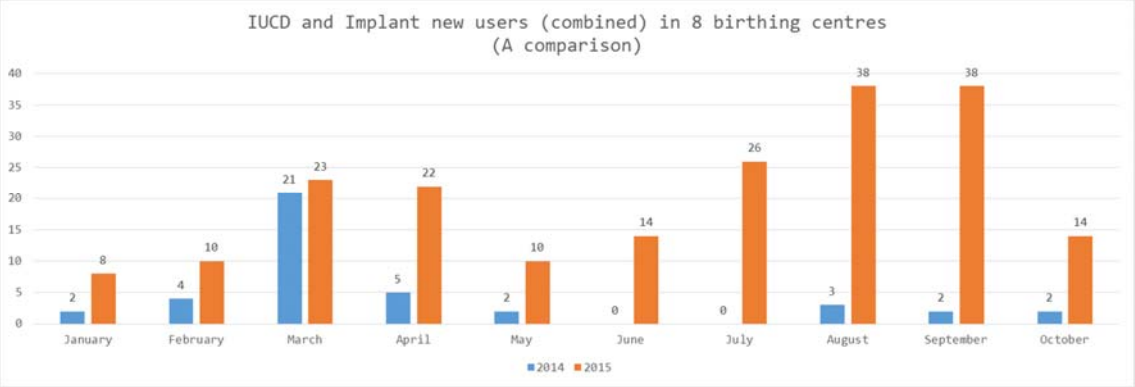
- All new users of IUCD during the pilot were women above 20 years of age.
- The differences in uptake measured in 2014 and 2015 were statistically significant, although to a lower degree when compared to implants.
- Demand for IUCD was five times lower than for implants. The results from 2015 indicate that 4 IUCD were inserted on average every month in the 8 BCs, or 0.5 IUCD per BC per month. In fact, 5 BCs delivered three or less IUCD over 8 months. Furthermore, a closer look at uptake data (see Table A4-1 in Annex 3) shows that not a single IUCD was inserted in any birthing centre for 62 months out of the 64 months covered during the pilot (8 months x 8 birthing centres = 64 birthing centre/months). These results confirm the common observation that many or most birthing centres deliver few, if any, IUCD (or LARC) on a regular basis.

4.1.3 Discussion

The total number of LARC (implants and IUCD) is shown in Fig 4.3. When uptake during the evaluation period is compared with 2014 the number of additional implants was 150 and 14 additional IUCDs giving a total of 164 additional LARC. While the uptake figures show a statistically significant increase for implants (and less so for IUCD[5]) the results of modality B should be considered modest, particularly in comparison with modality A.

[5] The statistical analysis considered that the 18 IUCDs delivered in a single month for the whole of 2014 were an outlier. This is the only reason why the difference in uptake of IUCDs between 2014 and 2015 is also statistically significant, although weakly so.

Figure 4.3: Uptake of LARC (IUCD + implants) in 8 birthing centres, 2014 and 2015



Source: HMIS reporting forms

It is probable that these results would be replicated elsewhere in the region but we cannot prove this with the evidence we have. Neither can we assess the long term impact once coaching sessions are withdrawn without further investigation.

Table 4.3: Paired t-Test significance testing, results

	Implants	**IUCD's**
	t-value (number of pairs)	t-value (number of pairs)
All birthing centre / monthly pairs	5.3 (64)	3.4 (64)
Pairs with at least one non-zero value	5.7 (48)	4.9 (16)

NB. Assumes a two-tailed test, all results significant at greater than 99%

The modest rise in uptake measured in birthing centres is in sharp contrast with the substantial uptake of LARC measured in the 31 non-birthing centres discussed in Chapter 3. Such differences in uptake bear another important question: are the results achieved under this modality worth scaling up? This question will be the primary focus of the costing analysis presented in Chapter 5 and of the overall evaluation conclusions and recommendations in Chapter 6.

Why did women living near the BCs not respond to LARC service availability in the same way as in the case of NBCs? It is not possible to answer this question with the available data but the following considerations may help interpretation:[6]

- We would assume that the high unmet need for LARC demonstrated in NBCs would be roughly similar for women living closer to BCs, so the differences between the two modalities are unlikely to be caused by a different LARC demand pattern in the catchment areas.

[6] The only way to answer this question would have been to use a large sample of users and non-users in both NBC and BC catchment areas, which was ruled out at design due to the high costs involved (see Chapter 2).

- Lower LARC demand in modality A may have been influenced by differences in the intensity of mobilisation efforts made, or in the way in which the information was interpreted by potential clients under each modality. This is discussed later in this chapter (see 4.5.5).

- Linked to the previous point, people often respond better to 'campaign' type approaches (where a specific service is offered on a particular day) because it helps them plan and prepare for the service and gives them time to decide if they want such a service. This argument is supported by the international literature comparing the pros and cons of vaccination campaigns versus static, regular delivery of immunization.

There are other important issues relating to uptake that will be discussed later in this chapter: How many coaching sessions were needed for BC staff to apply their LARC skills? Was BC staff competence the main reason for low LARC delivery in birthing centres before the intervention or were there other factors? And was the competence and confidence of BC staff the main obstacle that visiting providers had to address in BCs? Were the coaching sessions properly planned and managed?

4.2 Limitations and data issues

The intention in the original evaluation design was to compare uptake of LARC during the evaluation period with the equivalent period in 2014, in order to provide a *rough estimate* of whether the provision of LARC services had increased as a result of coaching by visiting providers. This assessment was always going to be a proxy indicator for additionality of services resulting from the intervention, as the only manner to measure increases in uptake with any level of accuracy would have been to use experimental or quasi-experimental designs with control groups which, as explained in Chapter 2, were discarded at design due to their high costs. In proposing such design we had hoped that the frequency tables, averages and standard deviations from the 2015 and 2014 data would show statistically measurable differences that could be used for comparison.

LARC uptake data (new users) from March-October 2015 and 2014 was collected as planned from the HMIS reporting sheets kept at the DHO office that all health facilities use for monthly reporting. When we performed quality checks on the 2014 HMIS data collected at the beginning of the pilot, we found the data to be highly unreliable. For example: data was missing for complete months in certain birthing centres; high volumes of null values were recorded; there were unexplained 'jumps' in the number of current users that did not match either previous current users or new users; and there was a complete absence of reporting for LARC (and for other commodities) in certain months of the year.

The same limitations in the quality of data from 2014 are likely to have affected data for 2015. Unfortunately, unlike in the case of the NBCs (where we could use NHSSP data) evaluators did not have an alternative data source to check the reliability of DHO data because visiting providers, NHSSP staff and research assistants were not present when birthing centre staff delivered LARCs, as LARCs could be delivered any day in the week

over a period of nine months.[7] Even though data entries during the pilot intervention were subject to some level of scrutiny by NHSSP staff and by the research assistants, such scrutiny was limited to the few days when these staff and researchers happened to be present in the facilities. In addition, the degree of data scrutiny was severely affected by the aftermath of the earthquake and by the fuel crisis, which restricted the ability of evaluators to travel to the BCs.

4.3 Quality of LARC services

Quality of services in BCs was assessed in a similar way as in the NBCs, that is: a) through direct observation of coaching sessions delivered and b) by asking a sample of 44 LARC clients about their perceptions of quality of the service received.

To complement client observations a range of key informants (KII) were also interviewed; they included the in-charges of the eight BCs and seven coached skilled birth attendants (SBAs). In addition, as already mentioned in Chapter 3, the following informants were interviewed: six visiting providers, two staff from the DHO (the District Health Officer and the Family Planning Supervisor) and the district coordinator of NHSSP. Most of these informants were interviewed twice, during monitoring and at endline. The information provided by these informants with respect to BCs is included in the following sections.

Research assistants made a total of 28 visits to the BCs, or approximately 3-4 visits to each BC. Whenever possible their visits coincided with the planned visit by the visiting provider for the coaching session (as shown in the shaded cells in Table 4.4 below), but this was not always possible because of some last minute changes in the visiting provider schedule. During their visits, research assistants used an observation checklist, took observation notes and interviewed LARC clients when they were available.

4.3.1 Distribution of coaching sessions

Table 4.3 shows when the coaching sessions took place. Several interesting features relating to the frequency and periodicity of the coaching sessions conducted by the visiting providers are worth noting, for example:

a) Only five BCs received coaching during the first two months of the intervention. The remaining BCs only received coaching after the fourth month (June) or later. One BC (Bhujee) received only one coaching session towards the end of the pilot because there was not an SBA in post during most of the pilot (which may explain why uptake of LARC in Bhujee was zero until September 2015).

b) Only one BC received three coaching sessions. The remaining BCs received two coaching sessions at most, and these took place quite far apart in time.

[7] Faced with unreliable data in the reporting forms, we attempted to collect the same data directly from the health facilities, where the same issues found in the reporting forms were observed. Furthermore, several 2014 facility registers were missing from the birthing centres.

c) There does not seem to be a pattern of continuity or regularity in the dates of coaching sessions, some of which were separated by four months in Namadi, Pharpu and Bamti. The long time that elapsed between the first and the second coaching visits raises concerns that coached SBAs did not receive sufficient or regular supervision by visiting providers after the first coaching session.

d) While the earthquake and the fuel crisis did affect the feasibility of visits, it is interesting that the periodicity of visits to BCs was much lower than that observed for several NBCs (see Chapter 3). For example, fourteen NBCs were visited three times or more by the visiting provider in a seven month period. Does this imply that the direct provision modality was prioritised by visiting providers at the expense of the coaching modality?

Table 4.4: Coaching sessions held by visiting providers in the 8 BC, 2015

Birthing Centre	March	April	May	June	July	August	September	October
Namadi	Sarita					Hemkala+Sarita		
Khaniyapani	Khamba		Khamba (10)		Saraswoti			
Pharpu	Sarita						Hemkala	
Bamti	Sarita	Sarita +Saraswoti						Hemkala
Kubukasthali		Sarita +Saraswoti				Hemkala		
Okhreni				Saraswoti		Sarita		
Hiledevi					Saraswoti			
Bhujee								Hemkala

Note: coloured cells indicate when the Research Assistant accompanied the visiting provider to observe the coaching session. The names in the boxes indicate which visiting provider delivered the coaching. There are more than three names of visiting providers because some of them resigned and had to be replaced.

4.3.2 Availability of contraceptives

LARC were reported to be generally available, although lack of implants was reported in some BCs, and the earthquake and fuel crisis affected the supply of commodities in some health facilities. For example, SBAs from Kubukasthali and Namadi reported that 3-4 women who came for implant had to be given with pills and condoms instead due to stock out of implants. (Source: KII with SBAs)

DHO staff reported that it was problematic to deliver commodities on time to some more remote BCs and that at some point the stock of commodities in the district was zero as the

central stores in Kathmandu had also run out of commodities. DHO staff were of the opinion that the piloting organization should have delivered the supplies. In fact, NHSSP did supply commodities, instruments and IEC materials on occasion, whenever stock shortages were reported. (Source: KII with DHO and NHSSP)

4.3.3 Availability of equipment and infrastructure

Lack of an autoclave was reported in some BCs, which made infection prevention more difficult. One SBA reported that it was difficult to maintain proper sterilization of the equipment at times of high client flow and that this sometimes caused longer waiting times.

The majority of key informants reported that in general BCs had enough space and rooms to ensure a proper service and maintain privacy and confidentiality. However room availability became problematic in some BCs after the earthquake, when part of the infrastructure was destroyed. Where this was the case a simple curtain was used to maintain some privacy. The SBAs reported that because of unavailability of rooms or due to high client flow, they delivered group information sessions rather than individual counselling. However, the justification based on high client flow seems to be at odds with the limited uptake of LARC measured in BCs. (Source: KII with SBAs, VPs and Observation Notes)

4.3.4 Orientation/training on counselling

The interviewed SBAs said they had received no training on counselling before the pilot, except for the training on counselling during the basic SBA training, which was a small portion of the total training. Moreover, most of them stated that they did not receive orientation on counselling from visiting providers during the coaching, and that they learned about counselling by observing them deliver counselling to clients. (Source: KII with SBAs)

4.4 Effectiveness of coaching

4.4.1 Quality of coaching and barriers

All the interviewed SBAs reported that coaching from visiting providers had developed their skills to insert and remove an IUCD and helped build up their confidence. They also mentioned that coaching had improved their recording skills, suggesting that some of them only realised at that point that they had not been completing records properly. Most SBAs and BC in-charges were satisfied with the coaching offered by visiting providers, which they found of good quality. In the few cases where visiting providers also trained SBAs in counselling they used IEC materials to show the advantages and disadvantages of LARC. (Source: KII with SBAs and In-charges)

We also asked visiting providers about their experience of coaching and any issues. All six visiting providers interviewed reported that limited transportation to reach remote locations was the main barrier, as it forced them to walk long distances alone, even at night. Another issue was the lack of clients or even the absence of the SBA from the facility at the date of the coaching session, which had to be rescheduled. Visiting providers confirmed that SBAs often lack confidence, particularly with IUCD insertion, and that many SBAs tended to

neglect basic infection prevention measures and lacked counselling skills to properly explain to women the advantages and disadvantages of LARC. (Source: KII with VPs)

4.4.2 Ability of coached SBA to insert IUCD

Visiting providers were expected to coach SBAs on the insertion of both implants and IUCD (although the focus was greater on IUCD). Interviews with visiting providers seem to suggest that the main problem for SBAs was the insertion and removal of IUCDs. Seven SBAs (Bamti BC did not have an SBA from the beginning of the intervention) received coaching on this. Four SBAs inserted at least one IUCD after the coaching and the remaining three (Khaniyapani, Bhujee and Hiledevi) inserted none[8], which they attributed to their lack of confidence (1 SBA), lack of IUCD sets (1 SBA), or the lack of interested clients (2 SBAs).

Nearly all the SBAs interviewed stated that one coaching session of two days was not enough for them to start providing IUCDs and stressed the need of a week-long session during which they could practice insertion in more than one client (suggesting that coaching sessions included one IUCD insertion at best, which is supported by the uptake data for individual facilities). (Source: KII with SBAs, VPs and Observation)

4.4.3 Supervision from visiting provider

All SBAs interviewed emphasised the importance of regular supervision to put the skills taught by visiting providers into practice, and that regular supervision had not been provided during the pilot. Most SBAs reported that the visiting providers had been to their birthing centre once every two or three months, which they did not consider to be enough. When asked about this in the endline interviews, visiting providers said that the frequency of visits were determined mainly by the geographical location of the health facilities (BCs and NBCs) and by factors such as client load and demand for LARC in the facilities. Information from the dates of coaching (Annex 3, uptake charts for each BC) also suggests that many BCs received their first coaching session half way through the pilot or even later than that.

As noted in section 4.3.1 (Distribution of coaching sessions), early, regular supervision of the SBAs in the BCs was not a primary consideration among the visiting providers. These aspects should perhaps be revisited in future (should this modality be scaled up) in order to ensure that all BCs are visited and their staff coached at the beginning of the intervention, and that regular supervision visits (and more coaching) take place more frequently. Without regular supervision, visiting providers and pilot managers cannot assess the effectiveness of coaching or whether coaching has addressed the most important barriers faced by each individual SBA in terms of delivering more LARC.

[8] If these SBAs did not insert IUCDs after the coaching it would mean that the IUCDs inserted in Khaniyapany (2) and Hiledevi (2) according to uptake data by facility (Annex 3) must have been inserted by the visiting provider herself during the coaching session.

4.5 Client satisfaction

4.5.1 Generalisability of results from exit interviews

A total of 44 exit interviews were undertaken with women who had been inserted LARC in the BCs on days when the research assistants were present in the facility. Table 4.5 shows the number and distribution of exit interviews conducted.

The main purpose of collecting data through exit interviews was to quickly assess client satisfaction. 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 LARC users in each facility. This was not feasible for operational and budget constraints. Therefore, all the information presented in this section should be seen as *indicative rather than representative* of the satisfaction of service users across the eight BCs, and while frequencies will be used to show how many interviewees provided a particular answer, these frequencies cannot necessarily be generalised to all LARC adopters. Limited generalisability is not in this case linked to a small sample size of exit interviews: roughly, 23% of all LARC adopters in the BCs were interviewed, i.e. a very good sample size by any standards. The problem is related to the skewed distribution of exit interviews vis-a-vis the number of LARC adopters in each of the 8 BCs, as shown in the last column of Table 4.4. Similarly, exit interviews are not evenly distributed across months or clinic days, which could also be a potential source of bias.

Table 4.5: Distribution of exit interviews in Birthing Centres during the pilot

	March	April	May	June	July	August	September	October	Total Interviews	Total LARC users	% LARC users interviewed
Okhreni		0					3	5	8	21	38%
Pharpu				0			3		3	8	42%
Hiledevi					2		0	0	2	16	12%
Khaniyapani					0		2	4	6	54	15%
Kubukasthali					0	5		4	9	22	40%
Namadi						4	4		8	26	15%
Bamti							1	0	1	27	3%
Bhujee							5	2	7	11	63%
Total	0	0	0	0	2	9	18	15	44	185	23%

Note: 0 means that no interviews were conducted due to unavailability of clients during the monitoring visit by the research assistant.

Source: Research Assistants from HERD

4.5.2 Received the family planning method of choice

Among the women interviewed, 41 (93%) stated that they had received the family planning method of their choice. Three women from two BCs (two from Khaniyapani and one from Hiledevi) did not get the desired method: they said they wanted an IUCD but received an

implant instead, which had been explained by the service provider as ‘due to problem in the uterus’.

4.5.3 Previous family planning history

Among 44 women interviewed (Table 4.6), 37 (84%) stated that they had used a contraceptive method in the past (so they were ‘ever users’), while the remaining 7 said they were using a contraceptive for the first time ever (so they were ‘new users’); 30 were inserted an implant and 14 an IUCD.

Table 4.6: Ever used family planning method before

	Birthing Centres								
	Bhujee	**Namadi**	**Kubukasthali**	**Khaniyapani**	**Bamti**	**Okhreni**	**Pharpu**	**Hiledevi**	**Total**
Yes	5	6	8	6	0	8	3	1	37
No	2	2	1	0	1	0	0	1	7
Total	7	8	9	6	1	8	3	2	44

Source: Exit interviews

We enquired with the ‘ever users’ if they were using a family planning method at the time of coming to the BC, and if so which method (Table 4.7). Of these, 34 (91.8%) reported to be using Depo and the remaining three reported to be using pills and IUCD. Therefore, all the ever users had actually switched methods.

Table 4.7: How many clients switched family planning methods?

	Birthing Centres								
	Bhujee	**Namadi**	**Kubukasthali**	**Khaniyapani**	**Bamti**	**Okhreni**	**Pharpu**	**Hiledevi**	**Total**
Last used FP method									
Pills	1	0	0	0	0	0	0	0	1
Depo	4	6	7	6	0	8	2	1	34
IUCD	0	0	0	0	0	0	1	0	1
Male sterilization	0	0	1	0	0	0	0	0	1
Total	**5**	**6**	**8**	**6**	**0**	**8**	**3**	**1**	**37**
LARC method adopted on day of interview									
IUCD	3	4	5	0	1	0	0	1	14
Implant	4	4	4	6	0	8	3	1	30
Total	**7**	**8**	**9**	**6**	**1**	**8**	**3**	**2**	**44**

Source: Exit interviews

When asked about the reasons for switching, 20 (54%) replied that they chose LARC because it works for a longer period than the one they were using before and eight because of the side effects of the method previously used (Table 4.8).

Table 4.8: Reasons for switching family planning method

	Birthing Centres							
	Bhujee	**Namadi**	**Kubukasthali**	**Khaniyapani**	**Okhreni**	**Pharpu**	**Hiledevi**	**Total***
LARC works for long period	5	5	6	6	6	2	0	**30**
Method used previously was not effective/ led to pregnancy	0	0	1	0	0	0	1	**2**
Easy to insert / remove	0	1	0	0	0	0	0	**1**
Side effects of the method used previously	0	2	1	0	3	2	0	**8**
Total	**5**	**6**	**8**	**6**	**8**	**3**	**1**	**37**

* Frequencies may be larger than sample as respondents could choose more than one answer.

Source: Exit interviews

4.5.4 Source of information about the availability of LARC

Clients of the LARC service were asked if they had heard about the LARC service before visiting the BC. The intention was to indirectly assess whether they had made the decision to adopt LARC before coming to the BC or during their visit to the BC, which they might have visited for reasons other than contraception. Among the 44 women interviewed, 32 (72%) said that they had heard about the availability of LARC services in the BC before their visit, implying that this was the primary reason for coming to the health facility. The remaining 12 women interviewed said that they had not heard about the service before coming to the facility (Table 4.9).

Table 4.9: Had clients heard about the availability of LARC before visiting the BC?

	Birthing Centres								
	Bhujee	Namadi	Kubukasthali	Khaniyapani	Bamti	Okhreni	Pharpu	Hiledevi	Total
Yes	5	8	4	4	1	6	3	1	32
No	2	0	5	2	0	2	0	1	12
Total	**7**	**8**	**9**	**6**	**1**	**8**	**3**	**2**	**44**

Source: Exit interviews

The 32 women who had heard about the availability of the service were asked about their source of information (Table 4.10). About half (18) had heard from the FCHV; 16 had learnt about it from a health worker in a health facility, and nine from friends and/or neighbours.

Table 4.10: Source of information about availability of LARC

	Birthing Centres								
	Bhujee	Namadi	Kubukasthali	Khaniyapani	Bamti	Okhreni	Pharpu	Hiledevi	Total
FCHV	3	5	2	2	0	5	1	0	18
Health personnel	3	3	3	2	1	2	2	0	16
Friends	1	0	3	1	0	0	0	1	6
Neighbour	0	0	0	2	0	0	0	1	3
Total	**5**	**8**	**4**	**4**	**1**	**6**	**3**	**1**	**32**

Source: Exit interviews

4.5.5 Effectiveness of mobilisation

While both modalities (A and B) used a similar approach to community mobilisation, the two tables above (4.9 and 4.10) provide interesting perspectives on the intensity and nature of information provided under each modality.

- All clients who took up LARC under modality A had heard about the service before it was offered and travelled to the NBC in order to get the service. By contrast, 12 LARC clients interviewed in birthing centres (modality B) had not heard about the LARC service before showing up at the BC, implying that they were possibly visiting the facility for other purposes and the health workers approached and convinced these women about opting for LARC.

- The message delivered during mobilisation was also different for each modality. In modality A, women were told (mainly by FCHVs) that LARC services would be provided on one particular day at a specific NBC. In contrast, clients for modality B were simply told that the LARC service would be available at their closest BC, so women could chose when to go. Perhaps the absence of a particular date is what made some potential users not plan a specific day for visiting the BC and to end up not using the LARC service.

These findings suggest that the mobilisation effort at community level made in modality B was less intense than for modality A, which may explain in turn why fewer clients turned up for LARC services in the BCs than they did in the NBCs.

4.5.6 Distance to health facility

Table 4.11 shows the time to reach the health facility as reported by the interviewed women on the day of their visit. Twenty seven (61%) had reached the BC in less than 30 minutes and 16 (36%) in between 30 minutes and one hour. Only one woman said it had taken her more than one hour. These findings suggest that most women lived in the vicinity of the BCs, at one hour's walking distance or less.

Table 4.11: Time taken to reach the health facility

	Birthing Centres								
	Bhujee	Namadi	Kubukasthali	Khaniyapani	Bamti	Okhreni	Pharpu	Hiledevi	Total
< 30 mins	5	5	7	0	1	6	3	0	27
30mins to 1hr	2	3	2	6	0	2	0	1	16
1-2 hours	0	0	0	0	0	0	0	1	1
Total	**7**	**8**	**9**	**6**	**1**	**8**	**3**	**2**	**44**

Source: Exit interviews

4.5.7 Waiting time

The majority of women interviewed (77%) felt that they had not waited a long time to receive the service, and only 12 said that they had to wait what they considered a long time (Table 4.12). Among these 12, waiting time ranged from less than one hour (10) – which is not an unreasonable waiting time - to between one and two hours (2). The most commonly reported reason for the delay was the heavy client flow in the facility on that day (8), followed by lack of commodities (3) and late arrival of the service provider (1). The results suggest that no waiting or a reasonable waiting time was achieved in most cases.

Table 4.12: Waiting time to receive the service

	Birthing Centres								
	Bhujee	Namadi	Kubukasthali	Khaniyapani	Bamti	Okhreni	Pharpu	Hiledevi	Total
Had to wait									
Yes	1	1	3	1	0	3	2	1	12
No	6	7	6	5	1	5	1	1	32
Total	**7**	**8**	**9**	**6**	**1**	**8**	**3**	**2**	**44**
Waiting time									
< 30 mins	1	0	3	0	0	2	0	0	6
30 mins-1 hr	0	0	0	1	0	1	2	0	4
1-2 hour	0	1	0	0	0	0	0	1	2
Total	**1**	**1**	**3**	**1**	**0**	**3**	**2**	**1**	**12**
Reasons for waiting									
Provider arrived late	0	0	0	1	0	0	0	0	1
Many clients	1	1	3	0	0	3	0	0	8
Lack of commodities	0	0	0	0	0	0	2	1	3
Total	**1**	**1**	**3**	**1**	**0**	**3**	**2**	**1**	**12**

Source: Exit interviews

4.5.8 Counselling

All the interviewed women reported to have received counselling during their visit to the health facility (Table 4.13); 45% of them had received counselling before the LARC service, and 50% reported to have received counselling both before and after the LARC service. Two women said they had received counselling only after receiving the service (this suggesting that they confused counselling with being told about the side effects or possible complications of the LARC service received).

Table 4.13: Was counselling provided and at what point during the LARC service?

	Birthing Centres								
	Bhujee	Namadi	Kubukasthali	Khaniyapani	Bamti	Okhreni	Pharpu	Hiledevi	Total
Only before the LARC service	2	4	5	6	0	2	0	1	20
Only after the LARC service	1	0	0	0	0	1	0	0	2
Both, before and after the LARC service	4	4	4	0	1	5	3	1	22
Total	**7**	**8**	**9**	**6**	**1**	**8**	**3**	**2**	**44**

Source: Exit interviews

To assess privacy and confidentiality, exiting women were asked where they had received the counselling, and whether it had been offered one-to-one or in a group session. Table 4.14 shows that 90% of women received individual counselling (which should be the standard for family planning counselling) and only four had received counselling within a larger group. These findings show that individual counselling was provided much more often in the BCs than in the NBCs (Chapter 3), probably because the flow of patients to BCs was more evenly spread than in the NBCs, where visiting providers often experienced heavy client loads on the day of the LARC clinic.

Among those counselled individually, 50% reported to have received counselling in a separate room, and 45% in the same room where they were examined and where service was delivered. The fact that 45% of clients did not receive counselling in a separate room shows that the availability of space (rooms) to provide a quality service in BCs was lower than stated by the service providers, most of whom thought that BCs had enough space and number of rooms to ensure a proper service in terms of privacy and confidentiality (see 4.3.3).

Table 4.14: Place of counselling

	Birthing Centres								
	Bhujee	Namadi	Kubukasthali	Khaniyapani	Bamti	Okhreni	Pharpu	Hiledevi	Total
In a separate room	5	0	4	6	1	3	0	1	20
In a room separated by curtain	0	0	5	0	0	0	0	0	5
In the same room where examined and received service	2	4	0	0	0	5	1	1	13
In a different corner of the room	0	0	0	0	0	0	2	0	2
Group Counselling (location not specified)	0	4	0	0	0	0	0	0	4
Total	7	8	9	6	1	8	3	2	44

Source: Exit interviews

4.5.9 Client satisfaction

All the women interviewed rated the behaviour of the service provider (table 4.15) and the quality of the service received (table 4.16) as good or very good. As in the case of NBCs (Chapter 3), these findings reflect very positively on the professionality of the SBAs, visiting providers and BC staff and on their effort to provide a quality service, often in challenging circumstances.

Table 4.15: Overall rating of behaviour of the service provider

	Birthing Centres								
	Bhujee	Namadi	Kubukasthali	Khaniyapani	Bamti	Okhreni	Pharpu	Hiledevi	Total
Very good	2	3	5	5	0	1	0	1	17
Good	5	5	4	1	1	7	3	1	27
Satisfactory	0	0	0	0	0	0	0	0	0
Not good	0	0	0	0	0	0	0	0	0
Very bad	0	0	0	0	0	0	0	0	0
Total	**7**	**8**	**9**	**6**	**1**	**8**	**3**	**2**	**44**

Source: Exit interviews

Table 4.16: Overall rating of the service received

	Birthing Centres								
	Bhujee	Namadi	Kubukasthali	Khaniyapani	Bamti	Okhreni	Pharpu	Hiledevi	Total
Very good	2	3	5	5	0	1	0	1	17
Good	5	5	4	1	1	7	3	1	27
Satisfactory	0	0	0	0	0	0	0	0	0
Not good	0	0	0	0	0	0	0	0	0
Very bad	0	0	0	0	0	0	0	0	0
Total	**7**	**8**	**9**	**6**	**1**	**8**	**3**	**2**	**44**

Source: Exit interviews

4.6 Brief discussion of findings

This section summarises the main findings for modality B by briefly addressing the evaluation questions included in 2.4.1. A more contextualised discussion focusing on replicability and scalability of this modality as well as of the visiting provider intervention as a whole is provided in Chapters 5 (Costing analysis) and Chapter 6 (Conclusions and recommendations.

4.6.1 Did the uptake of LARC increase?

During the evaluation period (March-October 2015) the uptake of LARC in the 8 birthing centres increased by 150 implants and 14 IUCDs when compared to the same period of 2014, during which 35 implants and 18 IUCD had been delivered. While the uptake figures show a statistically significant increase for implants (and less so for IUCD) the results of modality B should be considered modest, particularly in comparison with modality A. Why did women living near the BCs not respond to LARC service availability in the same way as in the case of NBCs? It is not possible to answer this question with the available data but several possible explanations have been discussed, including the difference in the approach to mobilisation and in the messages delivered to the population under each modality.

The modest rise in uptake measured in birthing centres is in sharp contrast with the substantial uptake of LARC measured in the 31 non-birthing centres discussed in Chapter 3. Such differences in uptake bear an important question: are the results achieved under this modality worth scaling up? This question will be the primary focus of the costing analysis and of the overall evaluation conclusions and recommendations.

4.6.2 Perspectives from beneficiaries

How did beneficiaries respond to the LARC service availability? Research assistants conducted 44 exit client interviews with women who had been inserted LARC in the BCs on days when the research assistants were present in the facility. Findings from exit interviews should be seen as indicative rather than representative because the sample of interviewed women is not proportionate to either the case load in each facility or evenly distributed across time. Main results can be summarised as follows:

- All the women interviewed rated the behaviour of the service provider and the quality of the service received as good or very good.
- In terms of access to the service, 97% of clients interviewed took less than one hour to reach the facility, suggesting that most women lived in the vicinity of the BCs.
- As for waiting time, the majority of women (77%) felt that they had not waited for a long time to receive the service (i.e. that the waiting time was reasonable). Those who had to wait reported waiting for less than an hour.

- All the interviewed women reported to have received counselling during their visit to the health facility. In difference with modality A (where group counselling was reported by at least one third of respondents) 90% of women in modality B reported to have received individual counselling (as is the norm). 50% reported to have received counselling in a separate room and 45% in the same room where they were examined and where the LARC was inserted.

- 93% of women stated that they had received the family planning method of their choice - 84% of women had used a contraceptive method in the past, so only 16% were new contraceptive users. 91.8% of the ever users reported to be using Depo before switching to LARC.

- 32 women (72%) had heard about the availability of LARC services in the BC before their visit, implying that this was the primary reason for coming to the health facility. The remaining 12 women interviewed said that they had not heard about the service before coming to the facility. About half of the women (18) who had heard about the service before the visit had been informed by the FCHV and 16 others were informed by health workers. These findings are differed from those obtained for modality A (where all clients had heard about the service before visiting the health facility) and suggest that the intensity and nature of mobilisation provided under each modality were different. These differences may partly explain why fewer clients turned up for LARC services in the BCs than they did in the NBCs.

4.7 Factors affecting results and issues requiring further attention

This chapter summarises issues that need further attention by policy makers and programme managers before a decision to scale up this modality can be made. Some of these issues will be captured again in the conclusions and recommendations chapter 6.

4.7.1 Factors that are common for both modalities

Several issues discussed for modality A (see 3.6) are similar for modality B. These are briefly outlined next. Please refer to section 3.6 for further detail.

Retention of visiting providers. The temporary nature of employment under the pilot as well as the need for a more reasonable workload, greater job security and more work satisfaction of visiting providers deserves close analysis and attention, should the pilot be replicated.

Supply of contraceptives to NBCs. There were less issues reported in birthing centres on the availability of equipment and commodities because – unlike in NBCs - BCs are expected to provide LARC on a regular basis. Nevertheless the DHO would need to pay close attention to additional requirements linked to a predictable increase in demand for LARC during the intervention in BCs.

Regularity and predictability of LARC clinics. While LARC services should be theoretically available at any BC at any time, policy makers should consider the pros and cons of ring-fencing certain days or weeks in BCs during which LARC services can be provided, perhaps once or twice every month. The advantage of this approach would be to help FCHVs and other health workers better mobilise LARC clients on the days when the service will be available and to help BC staff deliver a better coordinated service on those days. One lesson from the pilot is that telling women that the service will be available 'any time, any day' may be less effective than telling them that they should go for the service at a particular time.

Distance to the health facilities. The majority of LARC service users lived in the vicinity of the BCs at one hour travel distance or less. This means that in order to maintain demand for LARC across the catchment areas over time mobilisation should increasingly cover more distant areas where potential clients may live, and who are often targeted less often by FCHVs.

Recording information from clients. The same issues about poor recording of patient data observed in NBCs were also experienced in BCs, this resulting in loss of valuable information for programme and policy purposes. Lack of client data is the main reason why the evaluation could only partially answer some important questions and why service delivery often fails to tailor services equitably across catchment areas, because they lack detailed information about (a) which parts of the catchment areas are more or less reached by services, (b) is there a focus on poor households, etc. We strongly recommend that if this modality of provision is replicated then much more attention and investment is devoted to proper recording of user data.

Support to the DHO. In scaling up this modality, one should consider the additional support provided by NHSSP staff for the planning and coordination of this modality. While the need for support is likely to be less intense for modality B than it is for modality A the case for identifying and perhaps contracting additional support to help the DHO manage the initiative should be considered by policy makers. Without such support the 'business as usual' is likely to cause insufficient attention to those BCs where LARC uptake is lowest and therefore where coaching of SBAs is more necessary.

4.7.2 Programme issues specific to modality B

Most of the following issues originate in the observation notes from research assistants and in key informant interviews.

Was coaching delivered professionally? The frequency, regularity and periodicity of coaching sessions should be improved as these patterns were very uneven during the pilot (see 4.4.1 – quality of coaching and barriers). Some BCs received too few visits by visiting providers, often widely spaced or very late during the life of the pilot. Coaching and mentoring should be provided early and regularly over a period of time and include regular supervision in order to tailor coaching to the specific competence or other issues faced by the SBAs. Coaching should also have greater focus on developing the counselling skills of SBAs and perhaps of other staff in the BCs, a point that was raised in the interviews with visiting providers. In other words, the coaching of SBAs should be delivered as a

professional service with targets being set over time for SBAs to address their insecurity or competence needs. Coaching should also be better linked to mobilisation, in order to enhance the chances that clients will turn up on coaching days (see last point in this section on mobilisation).

Who should provide the coaching to SBAs? There is no reason why the same visiting providers delivering services in NBCs should be the ones delivering coaching in BCs. In fact, it would probably work better if both activities (coaching in BCs and delivering LARC in NBCs) were provided by different individuals, so that the logistics of both modalities do not impact on one another as was the case during the pilot. We recommend to test this revised modality in a second generation pilot and to compare results with a view to future policy.

Should IUCDs be delivered in BCs? We have argued for not inclusion of IUCDs in modality A on cost effectiveness grounds and for other reasons. However, there is no reason to discontinue IUCD supply in modality B in spite of lower demand and less cost effectiveness than implants because maintaining IUCDs in BCs is not only the national policy but it does not incur significant additional costs (since the set up costs are already covered).

Mobilisation in catchment areas of BCs. While we are unable to prove it, there are several reasons to believe that the mobilisation approach used in modality B did not so effectively address unmet need for LARC as it did in NBCs. For example, in relation to coaching of SBAs, observation notes highlight that coaching sessions could not be run at times because there were not women interested in taking up LARC on that particular day. This is an interesting observation for replicability, that unless potential LARC adaptors are mobilised on specific dates there may not be subjects on whom to develop the LARC insertion skills of SBAs. Some of the suggestions made in 4.2.1 to make the LARC service in BCs more predictable would also help mobilisation of clients interested in LARC. Clearly, the ‘business as usual’ approach of telling women to come to the health facility whenever they want did not work as well as giving these women a specific time during which the service will be available. In any case, the whole issue of mobilisation in catchment areas of BCs should be revised and strengthened given the high investment that has been made for LARC to be delivered in BCs (staff, training, commodities, space, etc) and the poor uptake registered before the pilot and the modest uptake achieved during the pilot itself.

5. Costing analysis

This chapter is a summary of a full costing analysis report submitted separately. Most tables and figures from the original report have been excluded from this chapter in order to keep this evaluation report to a reasonable length.

The main purpose of undertaking a separate costing analysis was to complement the findings of the evaluation of the visiting provider (VP) pilot. During the evaluation period and after discounting the uptake figures corresponding to a similar period of the previous year, the intervention resulted in additional uptake of services by 1,123 new LARC users, out of which 1,048 were implant users and 75 were IUCD users. This investment in the pilot provided 4,327 couple years of protection (CYP).

5.1 General findings

The total cost of implementing the pilot is estimated to be NPR 6.55 million (USD 63,860) over the evaluation period (see table 5.1). The share of modality A in the total costs was 70%, and 30% for modality B. Costs were also broken down by type of method provided, the breakdown informed that 57% of the total costs have been incurred for providing implant services and 43% for IUCD services. 64% of costs were identified as variable costs, as opposed to fixed costs.

Table 5.1: Detailed costs used for costing calculations

Sr. No.	Details	Cost (NPR)				
		Total	Direct	Allocable	Modality B	Modality A
1	Costs of conducting QI and health facility assessments	193,375	-	193,375	39,667	153,708
2	Costs of district level orientation, consultation and planning meetings	140,963	-	140,963	70,482	70,482
3	Costs of FP equipment and instruments provided (including transportation costs)	342,216	342,216	-	-	342,216
4	Costs of IEC materials and other awareness raising activities	188,950	-	188,950	25,238	163,712
5	Costs of monitoring, supervision and quality assurance	416,295	-	416,295	85,394	330,901
6	Costs of providing equipment and work aids to VPs	14,150	-	14,150	2,903	11,247
7	Costs of trainings	712,395	712,395	-	712,395	-
8	Costs related to district	321,892	-	321,892	160,946	160,946

Sr. No.	Details	Cost (NPR)				
		Total	Direct	Allocable	Modality B	Modality A
	management office including salaries					
9	Costs related to selection and recruitment of staff	11,950	-	11,950	5,975	5,975
10	Field visit expenses of VPs	514,968	514,968	-	-	514,968
11	Orientation costs of FCHVs and HFOMC	809,850	-	809,850	166,123	643,727
12	Payments to contracted VPs	1,511,517	-	1,511,517	260,046	1,251,471
13	Costs of coaching BC providers	295,083	295,083	-	295,083	-
14	Costs of commodities and supplies	1,075,902	1,075,902	-	140,148	935,754
	Total cost of running the pilot - NPR	6,549,505	2,940,564	3,608,942	1,964,399	4,585,107
	Total cost of running the pilot - USD	*$ 63,860*	*$ 28,671*	*$ 35,188*	*$ 19,153*	*$ 44,706*
					30%	70%

We found that the additional cost for reaching one additional LARC user under modality B is almost 3 times higher than for modality A. While in absolute terms the costs incurred for modality A are higher, in relative terms the respective unit costs of both IUCDs and implants for modality A are much lower due to the higher uptake measured in modality A, and because a substantial amount of unit costs are fixed, and therefore unit costs decrease with increased uptake of services.

There was wide variation found in the cost per IUCD user between the two modalities. The cost per IUCD user was more than double under modality B (USD 636 per IUCD user) in comparison to modality A (USD 300 per IUCD user). The costing study also found that for the pilot overall (both modalities combined), the cost per IUCD user was more than 10 times higher than the cost per implant user. Backward modelling, based on the assumption that IUCDs was not included in the pilot project, suggests that the overall costs per LARC user could have been 63% less as compared to the costs estimated in this study.

The cost per capita (cost per person) in the pilot project catchment area for the overall project was found to be NPR 42 (USD 0.5).

Both modalities of the pilot intervention were found to be highly cost-effective when compared with the WHO benchmark of costing less than the per capita GDP. However, comparison of the modalities suggests modality A being much more cost-effective than modality B. When comparing cost-effectiveness by contraceptive method, implants are much more cost-effective than IUCDs. This can be illustrated by the fact that cost per DALY averted for IUCD is 8.5 times higher than the cost per DALY averted for implants.

The cost-benefit analysis results suggest high return on investment for the pilot as a whole and for modality A in particular. One NPR invested in this project is likely to produce a return

of 6 NPR. In the case of modality A, one NPR produced a return of NPR 7.4 as compared to NPR 2.7 for modality B.

An economic model was developed to assess the likely costs of scaling up the intervention in other health facilities. The analysis found that, using the existing mix of services, the fixed costs required per facility per annum will be NPR 64,007 for modality A and NPR 70,112 for modality B. The variable cost per new LARC user will be NPR 3,115 and NPR 7,869 for modalities A and B respectively.

5.2 Main conclusions

This costing study provides crucial information on the costs of providing FP services – more specifically LARC - through the use of visiting providers under two different modalities: direct service provision by VPs in non-birthing centres (modality A) and coaching of SBAs by VPs in birthing centres (modality B).

Overall, the pilot intervention was highly cost-effective. However, modality A was much more cost effective than modality B, largely because the uptake of LARC in the 31 NBCs by three visiting providers was five times higher than the uptake registered in the 8 birthing centres. The provision of implants was far more cost-effective than the provision of IUCDs, in both modalities, largely because implants outnumbered IUCDs as the LARC method of choice: for every IUCD user eleven clients chose implants.

The much higher cost-effectiveness of modality A was further confirmed by lower average and unit costs per new LARC user, by lower per capita costs and by much more favourable cost per DALY averted. In all cases – for both modalities - the provision of implants proved more cost-effective than IUCD provision. The cost-effectiveness of implant over IUCD provision was further confirmed through backward modelling, which showed that the average unit cost of reaching an additional LARC user by the intervention overall (both modalities combined) would have been reduced by 48% if only implants are delivered (as opposed to delivering both implants and IUCDs).

The cost-benefit analysis confirmed all the findings above by showing that the highest return for every rupee invested was achieved by implants, which returned 11.7 and 4.5 rupees under modalities A and B respectively. In contrast, the return achieved for IUCDs was 1.3 and 0.6 rupees under modalities A and B respectively, suggesting lower value for money.

The scale up costs that we estimated also suggested that it would cost 38% (fixed costs) or 60% (variable costs) less to scale up modality A when compared to modality B.

5.3 Brief discussion

These findings have policy and programme implications: the following preliminary conclusions will be further contextualised in Chapter 6.

- The visiting provider intervention is a cost-effective way to substantially increase the uptake of LARC in areas of low CPR and high unmet need for LARC, which means in most hill and mountainous rural areas of Nepal.

- Modality A – direct LARC provision by visiting providers in health facilities without a birthing centre – is much more cost-effective and cost-beneficial than coaching SBAs in birthing centres, mainly because modality A attracts a higher number of clients.

- Within both modalities the provision of implants was more cost-effective, much more cost-beneficial and presented lower scale-up costs than the provision of IUCD or the provision of both IUCD and implants.

- These findings, while conclusive, should be interpreted and used carefully in order to align to current family planning policy in Nepal. For example:

  - If modality A is adopted, it would be preferable to offer only implants and not IUCD. Delivery of IUCD under modality A is not only of lower cost effectiveness and of dubious value for money but it also presents with specific challenges in terms of offering a quality service. For example, many NBCs do not have adequate space or equipment (autoclaves, boiling equipment) for private and hygienic IUCD insertion, and the absence of equipment and contraceptives adds to the burden of the visiting providers (who had to carry these with them). Furthermore, the lack of adequate space in some NBCs make the prospect of vaginal examination and IUCD insertion in those conditions unappealing to clients. These issues were confirmed through exit interviews with clients and endline interviews with service providers and VPs. These challenges are less significant in the case of implants given their easier insertion in the arm and lower needs of asepsis and privacy (when compared to IUCD). In summary, excluding IUCDs from modality A may help VPs run a better service, face less complications to maintain asepsis and reduce the load that they have to carry to the NBCs to run a LARC clinic. Clients interested in IUCD could be referred to other health facilities where quality provision can be guaranteed, including birthing centres (see later).
  - The fact that modality B was less cost-effective does not mean that the coaching of SBAs in birthing centres should not be attempted. In fact, the evidence suggests that coaching did result in higher uptake of LARC, and the costing analysis has also shown that while modality B is costlier to set up, once it is set up the costs to sustain it are much lower than for modality A, because modality B uses the existing infrastructure, human resources and commodities. It should also be taken into account that in addition to family planning the SBAs targeted by coaching deliver other important maternal, neonatal, child health and safe delivery services. It is also likely that in the longer term and with better tailored coaching services modality B might produce better results in terms of value for money. However, we did not have enough data and information to model such results.
  - Similarly to the argument made for modality B, the fact that IUCD uptake was far less popular (which remains the primary reason for it to be less cost-effective and cost-beneficial than implants) does not mean that IUCDs should not be delivered in birthing centres. For starters, the national family planning policy of Nepal establishes that IUCDs should be one of the five contraceptives on offer in birthing centres at all times. Secondly, offering IUCDs in birthing centres represents very small set up and implementation costs vis-à-vis the possibility that some women may demand it from time to time.

Finally, while interpreting costing results the short implementation period of the pilot – 8 months – should be kept in mind, as well as the unusual circumstances (earthquake, fuel crisis and commodity shortages) that surrounded pilot implementation. The short implementation period is important in relation to the costing work in at least two ways. One, because the unit costs might have been lower if the pilot was to 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 an increased number of new users. Secondly, the short implementation has not allowed for a proper look at trends in uptake and costs over time, which can provide useful information linked to the evolution of each of the two modalities. For example, it is likely that demand for LARC under modality A would decrease as a greater proportion of unmet need for LARC is met, which would modify the cost-effectiveness and cost-benefit considerations presented in this report. The discussion here would be similar to that found in the literature when regular supply of vaccinations in static facilities is compared with vaccination campaigns. Even if one modality may deliver faster, more cost-effective results, both modalities actually complement each other and are therefore used in combination by many countries.

6. Conclusions and recommendations

The costing analysis has provided additional elements to consider in relation to the opportunity, relevance and feasibility of replicating or scaling up the two implementation modalities. This chapter brings together the main conclusions and recommendations from the evaluation of the visiting provider pilot. We have used numbered paragraphs in order to facilitate discussion about specific conclusions and recommendations. *Recommendations are shown in italics.*

6.1 Modality A

There are several important issues that need further attention by policy makers and programme managers before a decision to scale up this modality can be made. In the opinion of the evaluators the implementation period (8 months) has been sufficient to test the hypothesis that increased supply of LARC through visiting providers in NBCs can increase the uptake of LARC substantially, cost-effectively and rapidly. However, there is some way to go before this intervention can be scaled up or even replicated elsewhere. *Our overall recommendation as evaluators is that the factors and issues mentioned in this section should be tested, adapted or modified through a second generation intervention used to strengthen the intervention, help sustain its results and continue to 'reach the unreached'*.

1. **Modality A is worth scaling up**. The direct provision of LARC by visiting providers in NBCs achieved – and probably exceeded - the expected results by attracting within a short period of time a large number of women who adopted LARC as their contraceptive method of choice. The pilot confirmed high unmet need for LARC and achieved a high degree of client satisfaction with the service.

   While the pilot intervention overall was quite cost-effective, modality A was much more cost effective than modality B, largely because the uptake of LARC in the 31 NBCs by three visiting providers was five times higher than the uptake registered in the 8 birthing centres with their full complement of staff. The high cost effectiveness of modality A was further confirmed by lower average and unit costs per new LARC user, by lower per capita costs and by much more favourable cost per DALY averted. The scale up costs that we estimated suggested that it would cost 38% (fixed costs) or 60% (variable costs) less to scale up modality A when compared to modality B.

   In conclusion, Modality A offers a rapid and cost effective way to meet the high unmet demand for LARC and to attain rapid increases in CYP.

Recommendation:
to scale up this modality through a second generation intervention where the findings and recommendations from this evaluation are used to strengthen the intervention and help sustain its results.

2. **Focus on implants**. LARC uptake was fifteen times higher for implants than for IUCDs. In all cases – for both modalities - the provision of implants proved more cost effective than IUCD provision, largely because implants outnumbered IUCDs as the LARC method of choice. Backward modelling further showed that the average unit cost of reaching an additional LARC user by the intervention overall (both modalities combined) would have been reduced by 63% if only implants are delivered (as opposed to delivering both implants and IUCDs). The cost benefit analysis showed that the highest return for every rupee invested was achieved by implants in modality A, which returned 11.7 rupees for every rupee invested, in contrast with the 1.3 rupees return for IUCDs.

   In conclusion, the case for delivering IUCDs in NBCs is quite weak based on costs and, in addition, delivering IUCDs in NBCs presents with it particular challenges. These include inconvenience to clients due to poor infrastructure and lack of privacy for vaginal examination and insertion: difficulty to maintain asepsis in insufficient, inadequate space; additional workload to visiting providers who need to carry all the equipment with them.

Recommendation:
for all the stated reasons we would recommend that IUCDs should not be regularly provided in NBCs, and that the focus should be on delivery of implants. Clients interested in IUCD can be referred to the nearest health facility with birthing centre or higher level facility.

3. **Regularity and predictability of LARC clinics**. The regularity of the service was the main concern raised by key informants from the NBCs and DHO. For example, there were important differences in the numbers of LARC clinics run in each NBC, with some NBCs running just one LARC clinic while others as many as five. It is not clear what drove the decisions on where to run a LARC clinic but it would make sense from a programme perspective to ensure an even geographical distribution of LARC clinics within the district. Also, in order to provide equitable access to interested clients across the district a spread of NBCs that takes into consideration the characteristics (population, size, accessibility, etc) of the VDCs. Under the current system there is a risk that women from more remote NBCs would not have equitable access to LARC services or that visiting providers concentrate their efforts mainly of the NBCs with easier access. Ultimately, it should be the DHO's responsibility to attempt an equitable distribution of LARC clinics.

Recommendation:
it would be worth to further explore in future replications of modality A the pros and cons of institutionalising and fixing the frequencies of LARC clinics in NBCs every year to ensure that interested clients know where and when to go, and to help health staff and FCHVs plan mobilisation of patients accordingly. The objective would be to move from a 'pilot' modality where decisions on where and when to run LARC clinics are made adhoc to a modality where higher predictability is ensured.

4. **Recruitment and retention of visiting providers.** Retaining visiting providers proved difficult as several of them resigned soon after joining the initiative. In total 8 visiting providers were recruited for three positions over the 9 months of the pilot. The high attrition rate does not seem casual and is probably linked to several factors, some of which were reported by the visiting providers themselves during endline interviews. Examples of issues reported or likely to have affected retention included:

    a. The workload was too heavy. Visiting providers had to travel a lot, including long distances, spend the night in unsuitable accommodation, carry heavy loads with them to the NBCs and deliver the services alone. While these matters can be handled for a while they are not conducive to job satisfaction and could render the whole modality unsustainable. It is crucial to make the job more appealing to potential candidates before the pilot is replicated or scaled up. Either more visiting providers should be recruited or they should be asked to cover smaller geographical areas or to cover their assigned areas in a phased manner. Evaluators do not know the rationale behind opting for exactly three visiting providers, but any rationale should be revised in the light of matters raised by both visiting providers and DHO staff during endline interviews.

    b. Security and job satisfaction. There is also a need for visiting providers to be able to travel accompanied by a second person who can not only provide company but help the visiting provider with the delivery of the service and the maintenance of quality standards. Therefore, rather than just a 'buddy' (a name suggested at times while discussing this pilot) what the visiting provider would need is a second health worker, not necessarily of the same level of competence but able to help with the counselling of patients, the recording on client details, the reporting of uptake, the maintenance of asepsis and cleanliness in the clinic locations, etc.

    c. Job security. Employment issues were not addressed in any depth during interviews with visiting providers but a number of statements that they made suggested that they see this job as a very short term solution until better employment opportunities open up for them. It is important to further explore matters linked to the remuneration package, job stability and (perhaps) career ladder conditions that will help retain visiting providers before scaling up.

Recommendation:
based on the above realities it is strongly recommended that the work and employment conditions of visiting providers be carefully revised to achieve a more reasonable workload and better work and employment conditions. It is also recommended that visiting providers should be accompanied by a second health worker to increase their safety and to share part of the current workload.

5. **Increased targeting of mobilisation efforts.** The mobilisation effort for modality A worked quite well and was a key factor explaining high turnout of clients to the NBCs. FCHVs played a key role in such effort and effectively mobilised clients. Most of the LARC takers lived within one hour from the NBC. In future, as successive LARC clinics are held in a particular NBC it is likely that some areas will have been mobilised more than others, resulting in 'pockets' where unmet need for LARC may be higher. To reduce to the extent possible these pockets of under-served population it may be necessary for DHO and NBC staff to provide guidance to FCHVs so that their mobilisation effort targets under-served, under-visited households that were not covered – or less covered - in the past.

Recommendation:
planning of mobilisation should be undertaken with support from DHO and NBC staff so that FCHVs spread evenly and equitably their mobilisation efforts, particularly after the first two or three LARC clinics have been held in a particular NBC.

6. **Supply of commodities to NBCs**. Because NBCs in Ramechhap do not regularly deliver LARC there were several commodities that are not available in most NBCs, including contraceptives, surgical spirit, autoclave, cotton, gauze, etc. During the pilot, visiting providers were often expected to carry these materials with them (by bus or by walk as no other transport was available) which does not seem adequate or sustainable. On occasion (in the initial months of the pilot) contraceptive shortages were often experienced because the supply of required contraceptives and other commodities had not been properly estimated to match demand. It is important to note that the pilot has associated transport and logistical costs that should be properly estimated and addressed. It does not seem unreasonable that if visiting providers are to travel around many facilities all the time – as they are expected - the DHO should be able to guarantee transport (whether hired vehicles or whatever other means). Likewise, districts adopting this modality should increase their supplies of commodities that are essential to deliver the service.

Recommendation:
as part of the eventual scaling up of this modality the Logistics Management Division should be made aware of these matters and seek proper financing before the pilot is eventually scaled up.

7. **Managing future interventions: who will support the DHO?** Coordination arrangements for this pilot were crucial and demanding and the pilot imposed a fair amount of additional work and costs to the DHO (time, staff, resources) for it to manage pilot implementation and its logistics. On top of that one should consider the additional support provided by NHSSP staff for the planning and coordination of LARC clinics on agreed dates, for the training of staff and for the oversight of the pilot. The time and efforts by NHSSP staff may have been underestimated in the costing analysis which has not included the NHSSP overheads. Yet, it can be safely assumed that without the additional support by NHSSP contracted staff the pilot would not have worked as it did and that without additional support DHOs across Nepal would not be able to replicate this modality or achieve similar results.

Recommendation:
if the pilot were to be replicated or scaled up the role played in the pilot by NHSSP would need to be played by some other entity – a management agent - whose role, budget and accountability for results would need to be explicitly defined and guaranteed.

8. **Individual counselling**. The programme should continue to emphasize the importance of providing individual, one to one counselling to clients on best contraceptive options prior to the LARC insertion. The workload associated with this modality does not make it feasible for the visiting provider to deliver the counselling herself in all cases, unless she is accompanied by a second health worker.

Recommendation:
emphasise individual counselling and systematize/write the way in which the counselling should be delivered in terms of process and key messages to be included.

9. **Recording information from clients**. Partly because the visiting providers often had to manage the LARC clinics on their own the recording of client data was not done as planned in the pilot concept note. As a result we do not know much about the characteristics of the clients (ethnicity, distance to facility, occupation, etc). Lack of client data is the main reason why the evaluation could not satisfactorily answer some important questions: were the women reached by the intervention poor or poorer than average? Were they from distant or nearby households? Were they using a contraceptive before adopting LARC? The only data that evaluators have used originates in a very small, non-representative sample of clients. Most of the times existing registers make provision for recording this type of data but, invariably, these sections are left blank. Such information would be useful for monitoring and evaluation purposes but, importantly, it would help family planning programme managers better adapt the intervention to the characteristics of NBCs.

Recommendation:
we strongly recommend that if this modality is scaled up more attention and investment is devoted to proper recording of user data, at least in a representative sample of NBCs or for a representative sample of clients.

6.2 Modality B

While the uptake figures for modality B show a statistically significant increase of uptake for implants - and less so for IUCD - during the intervention, the results are modest in terms of the potential of this modality to rapidly and cost effectively increase the uptake of LARC, particularly in comparison with modality A. We do not really know why fewer women turned up in BCs for LARC services. Since it appears safe to assume that the unmet need for LARC is similar in catchment areas of BCs and NBCs the only hypothesis that we can offer as evaluators is that mobilisation was less effective in modality B or that the availability of an outsider visiting provider was more attractive to women than the prospect of getting the service from the same BC staff. There is some evidence supporting that mobilisation was less intense for modality B and that the message that 'LARC services are now available at the BC' may not have worked as well as the clear, specific date provided in modality A about when the service would be available at the NBC. The erratic pattern of coaching in some BCs may be another factor, but we do not really know.

Modality B was also less cost-effective per additional LARC user or per DALY averted than modality A, and the cost benefit was also much lower, but the main factor driving these results was the significant differences in uptake between both modalities. The results were better for implants than they were for IUCD, which yet again was heavily influenced by uptake of implants being almost 15 times higher than for IUCD.

LARC users interviewed in BCs were very satisfied with the LARC services that they received: most got the LARC service of choice, did not have to wait for long and were complimentary of the quality of the service and of the behaviour of service providers. Most clients took an hour or less to reach the facility.

Given all the above, is modality B worth scaling up? The fact that modality B delivered less LARC uptake and was also less cost-effective does not mean that the training and coaching of SBAs in birthing centres should not be scaled up. In fact, the evidence suggests that training and coaching did result in higher uptake of LARC, and the costing analysis has also shown that the costs to sustain modality B – once set up costs are excluded - are actually lower than for modality A. In addition, the SBAs who were targeted by training and coaching deliver – in addition to family planning – other important maternal, neonatal, child health and safe delivery services and will continue to be present in BCs, so it makes sense to ensure that they can deliver LARC properly, and training and coaching have proven to increase their competence and to increase LARC delivery in BCs.

On the implant versus IUCD argument, the fact that IUCDs were far less popular than implants does not mean that IUCDs should not be delivered in birthing centres. To begin with, the national family planning policy of Nepal establishes that IUCDs should be one of the five contraceptives on offer in birthing centres at all times. Secondly, offering IUCDs in birthing centres represents very small set up and implementation costs vis-à-vis the possibility that some women may demand IUCDs from time to time. Besides, the importance of BCs being able to deliver IUCDs is increased by the fact that BCs have the right conditions to offer this service (space, autoclaves, equipment, other staff who can support SBAs, etc.), which many NBCs do not have. Lastly, if our recommendation is accepted in relation to excluding IUCD provision from NBCs, then the case for making IUCDs available in BCs is even stronger.

In conclusion, our recommendation as evaluators is that training and coaching of SBAs (and maybe other staff) in birthing centres should continue to be delivered (alongside modality A) and should be scaled up. However, coaching should be delivered more effectively, as discussed in the following conclusions and recommendations.

6.2.1 On issues that are specific to this modality

10. **Coaching should be delivered professionally.** The frequency, regularity and periodicity of coaching sessions should be improved as these patterns were very uneven during the pilot (see 4.4.1 – quality of coaching and barriers). Some BCs received too few visits by visiting providers, often widely spaced or very late during the life of the pilot. Coaching and mentoring should be provided early and regularly over a period of time and include regular supervision in order to tailor coaching to the specific competence or other issues faced by the SBAs. Coaching should also have greater focus on developing the counselling skills of SBAs and perhaps of other staff in the BCs, a point that was raised in the interviews with visiting providers.

Recommendation:
the coaching of SBAs should be delivered as a professional service, regularly and predictably, incorporating stronger personal supervision and strengthening counselling skills of SBAs. Coaching should also be better linked to mobilisation, in order to ensure that clients will turn up on coaching days, as coaching is not effective without clients.

11. **Some visiting providers to be specifically allocated to coaching in BCs.** There is no reason why the same visiting providers delivering services in NBCs should be the ones delivering coaching in BCs. In fact, it would probably work better if both activities (coaching in BCs and delivering LARC in NBCs) were provided by different persons, so that the logistics of both modalities do not impact on one another as was the case during the pilot.

Recommendation:
to test this revised approach in a second generation pilot and to compare results with a view to future policy.

12. **Mobilisation in catchment areas of BCs**. While we are unable to prove it there are several reasons to believe that the mobilisation approach used in modality B should be revised. For example, since coaching requires LARC clients, the mobilisation in catchment areas of BCs should guarantee that at least some LARC clients are present on coaching days. Likewise, there may be advantages in having *LARC clinic focus days* in BCs (see next conclusion point), as making the LARC service in BCs more predictable would also help mobilisation of clients interested in LARC. Clearly, the 'business as usual' approach of telling women to come to the health facility whenever they want did not work as well as giving these women a specific time during which the service will be available.

Recommendation:
the approach to LARC client mobilisation in the catchment areas of BCs should be revised and strengthened given the high investment that has been made to enable LARC delivery in BCs and the need to tailor coaching to the physical presence of LARC clients on coaching days.

13. **Regularity and predictability of LARC clinics in BCs**. While LARC services should be theoretically available at any BC at any time it may be advisable to ring fence certain days as 'LARC clinic days' where the focus on family planning delivery in BCs would be on LARC. The advantage of this approach would be to help FCHVs and other health workers better mobilise LARC clients on the days when the service will be available and to help BC staff deliver a better coordinated service on those days. One lesson from the pilot is that telling women that the service will be available 'any time, any day' may be less effective than telling them that they should go for the service at a particular time.

Recommendation:
family planning policy makers should consider the pros and cons of ring-fencing certain days or weeks in BCs during which LARC services will be prioritised, in a way similar to how both static and campaign approaches to vaccination of children are used in combination in many countries.

6.2.2 On issues that are common to both implementation modalities

14. **Retention of visiting providers.** The temporary nature of employment under the pilot as well as the need for a more reasonable workload, greater job security and more work satisfaction of visiting providers deserve close analysis and attention should the pilot be replicated

15. **Supply of commodities to NBCs**. There were less issues reported in birthing centres on the availability of equipment and commodities because – unlike in NBCs - BCs are expected to provide LARC on a regular basis. Nevertheless the DHO would need to pay close attention to additional requirements linked to a predictable increase in demand for LARC during the intervention in BCs.

16. **Distance to the health facilities**. The majority of LARC service users lived in the vicinity of the BCs at one hour travel distance or less. This means that in order to maintain demand for LARC across the catchment areas over time mobilisation should increasingly cover more distant areas where potential clients may live who are targeted less often by FCHVs.

17. **Recording information from clients**. The same issues about poor recording of patient data observed in NBCs were also experienced in BCs, this resulting in loss of valuable information for programme and policy purposes. Without client data service delivery will fail to tailor services equitably across catchment areas, because important information like the place of origin or clients will be missing.

18. **Support to the DHO.** In scaling up this modality, one should consider the additional support provided by NHSSP staff for the planning and coordination of this modality. While the need for support is likely to be less intense for modality B than it is for modality A the case for identifying and perhaps contracting additional support to help the DHO manage the initiative should be considered by policy makers. Without such support the ‘business as usual’ is likely to cause insufficient attention to those BCs where LARC uptake is lowest and therefore where coaching of SBAs is more necessary.

7. References

Ministry of Health and Population (MOHP) (2012). Family Planning Strategy.

Ministry of Health and Population (MOHP), New ERA, and ICF International Inc. (2012). Nepal Demographic and Health Survey 2011. Kathmandu, Nepal: Ministry of Health and Population, New ERA, and ICF

Nepal Family Health Program (Undated). NFHP Technical Brief #7, Expanding IUCD/Norplant Services accessed at http://nfhp.jsi.com/Res/Docs/techbrief7-iucd.pdf

NHSSP (2014). Concept note: mobilizing visiting provider to expand Long Acting Reversible Contraceptives - expanding contraceptive choice for women in rural areas of Nepal through skilled visiting providers. Draft, November 2014

Paudel, Y. R. et al (2015). Women's Satisfaction of Maternity Care in Nepal and Its Correlation with Intended Future Utilization. International Journal of Reproductive Medicine. http://dx.doi.org/10.1155/2015/783050

Annex 1 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 (3 March, 2015) and the mid-term progress report (November 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.

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 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. This required the evaluation team to perform a close monitoring of the intervention in a sample of sites, as described later.

This evaluation will attempt to test a number of assumptions and to answer the following broad evaluation questions:

1) Does the provision of visiting providers to Non Birthing Centres (direct provision modality) increase the uptake of LARC among WRA?

2) Does the coaching/mentoring provided by VPs to existing trained service providers in Birthing Centres (coaching modality) enhance their LARC provision skills to the extent of enabling them to deliver LARC on their own when the VP is not present? Did LARC uptake increase in the BCs?

3) What is the perspective of beneficiaries/clients about the quality of services provided by VPs and services providers coached by the VPs?

4) How effective are the advocacy activities by FCHVs and HFOMC to raise awareness about the new LARC and FP services on offer and to generate demand among WRA?

5) What are the main factors affecting or determining the feasibility, replicability and sustainability of the VP pilot model as implemented?

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 proposed
1. Does the provision of visiting providers to Non Birthing Centres (direct provision modality) increase the uptake of LARC among WRA?	Quantitative assessment. A before and after approach will be used to compare uptake of LARC during the intervention period and during an equivalent period on the year before. However, since NBCs do not usually deliver LARC (as they lack qualified staff trained in LARC) the uptake of LARC during the previous year will be considered to be zero. The HMIS register from each of the 31 NBCs included in the pilot will be used as the main source of data, with data being collected from registers by research assistants on a monthly basis. Qualitative data will be collected from visiting providers and available service providers to explore implementation issues and perceptions on quality of services in a sample of 4 NBCs using endline interviews and observations from RAs when they visit the health facilities, possibly on days when the VP plans to deliver services in that facility.
2. Does the training on implants and the coaching/mentoring on IUCD insertion and removal provided by VPs to existing trained service providers in Birthing Centres (coaching modality) enhance their LARC provision skills to the extent of enabling them to deliver LARC on their own when the VP is not present? Did LARC uptake increase in the BCs?	Quantitative assessment. A before and after approach will be used to compare uptake of LARC during the intervention period (using HMIS or facility registers) and during an equivalent period on the year before (using HMIS data available at the facility or reported. Data from the year before will be collected by research assistants at baseline (before the intervention begins) and then monthly from each of the 8 BCs. Uptake tables by month and graphs will be used to show the relationship (in real time) between coaching sessions delivered by the VPs and the uptake of services. Qualitative data will be collected from visiting providers and available service providers to explore implementation issues and perceptions on quality of services in a sample of the 8 BCs using endline interviews and observations from RAs when they visit the health facilities, possibly on days when the VP plans to deliver coaching to that BC.
3. What is the perspective of beneficiaries/clients about quality of services provided by VPs and services	In NBCs, qualitative data will be collected from service users through exit interviews on service days when research assistants visit NBCs in order to explore perceptions on contraceptive choice and quality of services. In BCs, qualitative data will be collected from service users through exit interviews on service days in the 8 BCs in order to explore perceptions on contraceptive choice and quality of services.

Main Study Questions	Evaluation designs proposed
providers coached by the VPs?	In total 80 exit interviews will be conducted.
4. How effective are the advocacy activities by FCHVs and HFOMC to raise awareness about the new LARC and FP services on offer and to generate demand among WRA?	It will not be possible to quantify or assess accurately the effectiveness of mobilization and awareness raising by FCHVs and HFMOC as this would require collection of population based data in a large number of facilities given that the number of potential WRA seeking LARC 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.
What are the main factors affecting or determining the feasibility, replicability and sustainability of the VP pilot model as implemented?	Information will be collected through in-depth interviews at end line with VPs, service providers (including the coached SBAs in the BCs), district health managers and NHSSP staff overseeing the implementation of the pilot. Information thus obtained will be triangulated with that obtained for previous questions, particularly 2, 3 and 4.

Outputs expected from the pilot and their evaluability

The concept note for this intervention defined a series of 'outcomes of interest' to be monitored during the intervention. The 'outcomes were primarily service outputs, and while evaluators did consider such outputs during the evaluation design it was not always feasible or cost-effective to measure all of them. This is briefly summarised in the table below.

'Outcomes of interest' defined in the concept note for the Visiting Provider pilot	Considerations on evaluability
Increased LARC utilisation in targeted areas	The 'increase' can only be measured accurately through experimental or quasi-experimental designs using control groups. This was discarded at design. Instead, a proxy measure of the increase will be used by comparing LARC uptake during the intervention with an equivalent period the year before. Targeted areas will refer to the 8 BCs and 31 NBCs targeted by the pilot intervention.
Increased range of LARC methods available in targeted areas	If LARC are delivered in BCs and NBCs we will assume that availability of contraceptives has increased.
Increased regularity and continuity of LARC services in targeted areas	This cannot be measured accurately at a reasonable cost, so proxy measured will be attempted depending on data accuracy in facility registers. Regularity and continuity will be defined differently for each of the two implementation modalities.
Increased number of rural health facility staff providing LARCs services as per national guidelines	This will be measured only in BCs. The focus will not be on 'staff' but on 'facilities' able to deliver LARC. How many of these delivered LARC before the intervention will be assessed indirectly from the service registers of the previous year.
Intervention coverage i.e. number of WRAs reached	Since the facility records only provide data on users taking a service (and not, for example, receiving counselling) the coverage of WRAs will be assessed by counting the total

'Outcomes of interest' defined in the concept note for the Visiting Provider pilot	Considerations on evaluability
	number of WRA who are inserted LARC under each of the two modalities.
Number of households reached by FCHVs	It is not possible to estimate this parameter for technical and cost/benefit reasons as it would require either a survey of FCHVs (which would provide only rough estimates by FCHVs) or a population survey (ruled out due to low cost benefit). All that the evaluation will do is ask LARC users the source of the information about the availability of LARC in the health facilities.
The costs of providing the VP service	See section on costing in the main report.

Monitoring and evaluation sites

Spreading resources thinly to cover many sites for M&E would not enable a deepening investigation with a variety of M&E techniques. Hence, we propose to visit a sample of 12 health facilities (8 BCs and 4 NBCs) to generate rich information to better answer the evaluation questions.

While all the 8 BCs will be covered for M&E purposes only 4 NBCs will be targeted for the purposes of monitoring implementation and collecting information from service providers (at endline) and service users (exit interviews).

Frequency of monitoring. Monitoring pilot implementation will take place during the whole evaluation period (March to October 2015) by two research assistants in 12 selected sites: 8 BCs and 4 NBCs. Our primary monitoring focus in the 8 BCs where VPs will coach/mentor service providers on LARC will be to generate rich data that links the coaching process with the uptake of LARC. RAs will attempt to visit as many BCs as they possibly can during days when the coaching takes place. In NBCs, on the other hand, RAs will attempt to visit each of the 4 NBCs twice, on days when the VP plans to deliver services in that health facility.

On aggregate, each RA will attempt to monitor a minimum of 3 sites per month. While RAs have been asked to select the facilities to be visited at random this may not be possible unless the programme of visits by VPs can be known by the RAs in advance and the plan of visits is adhered to strictly. Evaluators do recognise that this may not be always feasible due to a number of unpredictable, operational reasons.

Focus on monitoring. A monitoring checklist was prepared and RAs were trained on its use. This checklist will help the evaluation team monitor if the required standard operating procedures to be adopted in the pilot have been maintained and if continuous supply of commodities has been ensured. Monitoring activities by RAs will include observation notes from the days in which they visit facilities, informal interviews with service providers and VPs during service days and endline interviews with VPs, service providers, NHSSP and DHO staff. If possible a small sample of FCHVs will be interviewed informally at endline to

understand how the mobilisation and communications were implemented at community level.

In addition to these tasks RAs will collect LARC uptake information from the service registers and will undertake exit interviews among users.

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 12 months to implement the evaluation. RAs will be responsible for monitoring the process of service delivery (against the standard protocol) in selected health facilities mentored by visiting providers 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. Likewise, a communication officer will have the responsibility of desk-based communication with 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 asnd 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 12 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 qualitative 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 (included in Annex 1), in an attempt to fill in these gaps during the endline interviews and visits to the facilities outside the evaluation period (which ends on the 30th November).
- 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 VPs and 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 RO 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)

Evaluation questions	Specific questions	Source and means of verification
1. Has the intervention led to a measurable increase in range of contraceptives methods available to WRA?	▪ Overall how much has the use of LARC changed (increased or decreased) in the district/pilot sites compared to previous year? ▪ What was the utilisation of family planning services with regard to method types, and how does it compare from last year's?	▪ 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)
	▪ Was there availability of the method that you wished to use? If not, what method was that and what was the reason given to you for the service not being available?	▪ Exit client interview
2. Did the staff in rural facilities provide LARC (IUCD and Implant) in the months after receiving coaching and mentoring by VPs?	▪ How many staff of which type received coaching and mentoring from the VPs?	▪ Information from records kept by NHSSP on the pilot intervention (NHSSP to provide)
	▪ How many LARC were inserted by the coached staff in the 3-6 months (depending on implementation arrangements) after receiving the coaching? Did you feel VPs effectively provided coaching/mentoring?	▪ Facility register from the facilities where coaching/mentoring was received in the sample of facilities used for evaluation ▪ Interviews with coached service providers in sample of health facilities. Cross check results from interviews with actual data from those facilities (to verify that if they say that they inserted more LARC this can be certified by facility kept data).
3. Has the intervention led to enhanced IUCD and implant skills of service providers?	▪ What was the opinion of coached/mentored service providers about the VP coaching received? – Did the coaching mentoring give you sufficient confidence in inserting LARC? What worked better and worse in relation to the coaching/mentoring? – Did you actually insert LARC in the months following the coaching?	▪ Interview with service providers before and after receiving coaching/mentoring from VPs ▪ Observation checklist

Evaluation questions	Specific questions	Source and means of verification
	▪ If yes, how many? How does this compare to the number of LARC you inserted last year? ▪ If no, why? What factors precluded you from inserting more LARC? – What aspects did you like or dislike about the coaching? ■ Were there any cases of failure/unsuccessful insertion? (If yes, ask the respondent about what s/he did in relation to that) ■ Were there any cases of complications to clients? (If yes, ask the respondent about what s/he did in relation to that) ■ Do you need additional coaching BEFORE you feel confident enough to insert LARC? ■ What other factors are currently missing for you to insert more LARC in your health facility?	
4. Has the intervention led to increase in number of new users?	■ Among the users of family planning services (LARC), what proportions were new users and existing users? ■ How many switched family planning methods? ■ Which method did they switch to? Reasons for this shift?	■ HMIS and service delivery registers ■ HMIS (face sheet) ■ Client exit interview
5. How is the quality of the services perceived by the clients?	■ How long did it take you to reach the health facility from your house? (30 minutes or less; about an hour; two hours or more? ■ What was the reason for coming to the health facility today? (for a curative service; for a family planning service; specifically for a LARC commodity; other - specify) ■ If you came specifically for a LARC: who told you that LARCs would be available today? ■ How long did you have to wait from arrival until a service provider attended to you? ■ How do you rate the quality of the service you received? (close answers from v good to v bad) ■ Where you treated with respect by the nurse/SBA? ■ Did the nurse/SBA explain to you various options of family planning commodities available at this facility? Did the nurse/SBA use any drawings or pictures to explain the various options? Could you understand easily the options that were being offered to you? ■ Did you get the family planning commodity that you wanted? Which was that commodity? If not, what reasons were you given?	■ Exit Client interview ■ Case story ■ Observation checklist

Evaluation questions	Specific questions	Source and means of verification
	▪ (to those who adopted a LARC) Was the nurse/SBA skilled in delivering the LARC to you? Did she know what she was doing? Did she deliver the LARC in a reasonable time?	
6. How is the quality of the services perceived by the service provider in terms of technical quality? *(measured at more than one occasion when the VP service is being offered and the evaluator is at the facility)*	▪ To what extent are the full range of family planning methods available on the day of family planning clinic (for each family planning method provide as possible answers: always, most of the times, seldom, never) ▪ To what extend was the full range of family planning methods available on normal days when the VP was not present? (Offer same answers as above. If significant difference is found between days when VP is present and not present ask the service provider to explain why in her opinion there is such difference? ▪ What were the barriers to maintain the continuous supply of LARC commodities and equipment? ▪ Did you receive full support from DHO, and NHSSP staffs to deliver the services? If no, what support was missing?	▪ Interview with service providers/VPs ▪ Observation checklist
7. What complications/side effects of LARC did client experience (retrospective question, not necessarily related to the VP service received) and where did she go for management?	▪ Have you ever experienced any side effects or complications after being inserted with a LARC (to which of the two is she referring to?) ▪ What complication/side effects did you face after the insertion of implant or IUCD?(Record the side effects mentioned) ▪ Where did you go to solve your problem? Did you remove the method? ▪ Have you been inserted with a LARC today? If yes; did the HF staffs counselled you about the possible side effects/complication of the method you are using and the measures you should take in such situation?	▪ Exit Client interview ▪ Case story
8. What complications/side effects of LARC have been reported to the service provider and how were these managed?	▪ Have any women reported LARC side effects or complications to you? ▪ If yes, how many cases can you recall of such complications in the last three months? ▪ What were the main complications reported? (provide a list for service provider to chose) ▪ Why do you think such complications occurred? (Bad luck; bad practice by provider; lack of hygiene? Etc.) ▪ What do you do when these complications or side effects are reported? Do you deal with the problem yourself or do you refer the case elsewhere?	▪ Interview service provider on a VP clinic day

Evaluation questions	Specific questions	Source and means of verification
9. Has the pilot been implemented as per the set protocol/criteria?	▪ Did the VPs or service providers follow the standard protocol while providing coaching/mentoring and delivering family planning services? ▪ Did the DHO and NHSSP staffs support the pilot as required? ▪ Have there been any specific changes to the pilot design after its implementation that are likely to have affected the results? What changes had been made, if any?	▪ Observation checklist ▪ Key informant interview with NHSSP and service providers
10. How are the feasibility, sustainability and scalability of the pilot perceived?	▪ Where there any unintended affects during the pilot? What unintended effects occurred? ▪ In your opinion, did the unintended effect affect the sustainability and/or replicability of the pilot? ▪ What benefits or positive outcome were achieved that could lead to sustainability and scalability of the pilot?	▪ Key informant interviews at end line
	▪ What suggestions do you have to improve the pilot's effectiveness, efficiency, and sustainability?	▪ Interviews with VP and service providers at end line
11. What were the roles of DHO to ensure effective implementation of the pilot?	▪ 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 family planning supervisor in planning and implementation of the pilot? ▪ Did they perform their roles as expected? ▪ Were they supportive in functioning of the pilot?	▪ Key informant interviews ▪ NHSSP staffs ▪ Observation

Annex 2 LARC uptake in non birthing centres

Table A2.1: Number of visits by VPs to the 31 NBCs, by calendar month.

SN	Non Birthing Centres	No. of visits	March	April	May	June	July	August	September
			Chaitra	Baishak	Jestha	Ashar	Shrawan	Bhadra	Ashoj
1	Bethan HP	3		1		1			1
2	Baluwajor SHP	2		1				1	
3	Bhatauli SHP	3			2	1			
4	Chanakhu SHP	3		1		1		1	
5	Chisapani SHP	4	1	1		1		1	
6	Chuchure SHP	4		1		2		1	
7	Daduwa HP	5		1	1	1		1	1
8	Dimipokhari SHP	3	2						1
9	Duragau SHP	2			1			1	
10	Gagal (Bhadaure HP)	2		1					1
11	Gauswara SHP	1						1	
12	Gumdel SHP	2	1			1			
13	Gupteshwor HP	2					1	1	
14	Himganga SHP	2				1			1

SN	Non Birthing Centres	No. of visits	March	April	May	June	July	August	September
			Chaitra	Baishak	Jestha	Ashar	Shrawan	Bhadra	Ashoj
15	Khadadevi SHP	2	1				1		
16	Lakhanpur SHP	1					1		
17	Majhuwa SHP	1						1	
18	Makadum HP	3		1		1		1	
19	Pakarbas HP	3				1	1		1
20	Phulasi SHP	1			1				
21	Pinkhuri SHP	1		1					
22	Pritee HP	2					1	1	
23	Rajbhir SHP	2					1	1	
24	Rakathum SHP	2			1			1	
25	Rampur SHP	4		1		1		1	1
26	Rasanalu SHP	4		1	1			1	1
27	Saipu SHP	2			1			1	
28	Sukajor SHP	2		1				1	
29	Sunarpani HP	3		1	1		1		
30	Tilpung SHP	4			2	1			1
31	Tokarpur HP	2						1	1
	Total	**77**	**5**	**13**	**11**	**13**	**7**	**18**	**10**

Source: Spreadsheet of dates of VP visits and LARC uptake provided by NHSSP

Table A2.2: Implant (new users) in 31 non-birthing centres in 2015

	Jan[a]	Feb[a]	Mar	Apr	May	Jun	Jul	Aug	Sept	Totals	Number of Visits
Facilities	**Magh**	**Falgun**	**Chaitra**	**Baishak**	**Jestha**	**Ashar**	**Shrawan**	**Bhadra**	**Ashoj**		
Bethan HP				13		5			34	**52**	**3**
Baluwajor SHP				2				5		**7**	**2**
Bhatauli SHP					24	5				**29**	**3**
Chanakhu SHP				16		20			5	**41**	**3**
Chisapani SHP			8		7	9		12		**36**	**4**
Chuchure SHP				2		14		10		**26**	**4**
Daduwa HP				4		16	16	13	13	**62**	**5**
Dimipokhari SHP			28					8		**36**	**3**
Duragau SHP					16			12		**28**	**2**
Gagal (Bhadaure HP)				2					13	**15**	**2**
Gauswara SHP								30		**30**	**1**
Gumdel SHP			11			3				**14**	**2**
Gupteshwor HP							14	8		**22**	**2**
Himganga SHP						11			1	**12**	**2**
Khadadevi SHP		(10)[a]	9				14			**23**	**2**
Lakhanpur SHP							17			**17**	**1**
Majhuwa SHP								16		**16**	**1**
Makadum HP				13		8		8		**29**	**3**
Pakarbas HP						8	22		16	**46**	**3**
Phulasi SHP					9					**9**	**1**

	Jan[a]	Feb[a]	Mar	Apr	May	Jun	Jul	Aug	Sept	Totals	Number of Visits
Facilities	**Magh**	**Falgun**	**Chaitra**	**Baishak**	**Jestha**	**Ashar**	**Shrawan**	**Bhadra**	**Ashoj**		
Pinkhuri SHP				3						**3**	**1**
Pritee HP							12	28		**40**	**2**
Rajbhir SHP							9	7		**16**	**2**
Rakathum SHP					21			30		**51**	**2**
Rampur SHP				19		18		1	5	**43**	**4**
Rasanalu SHP				9	3			3	11	**26**	**4**
Saipu SHP					40			11		**51**	**2**
Sukajor SHP				4				5		**9**	**2**
Sunarpani HP				2	6		26			**34**	**3**
Tilpung SHP					40	5			4	**49**	**4**
Tokarpur HP								3	37	**40**	**2**
Total		**(10)[a]**	**56**	**89**	**166**	**122**	**130**	**210**	**139**	**912**	**77**

[a] January and February will not be counted for evaluation purposes as they preceded the evaluation period.

Source: NHSSP data on uptake and visits based on information provided by VPs and compiled regularly (at least monthly).

Table A2.3: IUCD (new users) in 31 non-birthing centres in 2015

	Jan[a]	Feb[a]	Mar	Apr	May	Jun	Jul	Aug	Sept	Totals	Number of Visits
Facilities	**Magh**	**Falgun**	**Chaitra**	**Baishak**	**Jestha**	**Ashar**	**Shrawan**	**Bhadra**	**Ashoj**		
Bethan HP							3		1	4	**3**
Baluwajor SHP										0	**2**
Bhatauli SHP						4				4	**3**
Chanakhu SHP				5						5	**3**
Chisapani SHP			3						2	5	**4**
Chuchure SHP										0	**4**
Daduwa HP						1		3		4	**5**
Dimipokhari SHP									4	4	**3**
Duragau SHP										0	**2**
Gagal (Bhadaure HP)				6						6	**2**
Gauswara SHP								1		1	**1**
Gumdel SHP				9		2				11	**2**
Gupteshwor HP										0	**2**
Himganga SHP										0	**2**
Khadadevi SHP		(2)[a]								0	**2**
Lakhanpur SHP								3		3	**1**
Majhuwa SHP										0	**1**
Makadum HP										0	**3**
Pakarbas HP										0	**3**
Phulasi SHP						1				1	**1**

	Jan[a]	Feb[a]	Mar	Apr	May	Jun	Jul	Aug	Sept	Totals	Number of Visits
Facilities	**Magh**	**Falgun**	**Chaitra**	**Baishak**	**Jestha**	**Ashar**	**Shrawan**	**Bhadra**	**Ashoj**		
Pinkhuri SHP										0	**1**
Pritee HP									1	1	**2**
Rajbhir SHP										0	**2**
Rakathum SHP										0	**2**
Rampur SHP					5	4		1		10	**4**
Rasanalu SHP									1	1	**4**
Saipu SHP										0	**2**
Sukajor SHP										0	**2**
Sunarpani HP										0	**3**
Tilpung SHP						1				1	**4**
Tokarpur HP										0	**2**
Total		**(2)[a]**	**3**	**20**	**5**	**13**	**3**	**8**	**9**	**61**	**77**

[a] *January and February will not be counted for evaluation purposes as they preceded the evaluation period.*

Source: NHSSP data on uptake and visits based on information provided by VPs and compiled regularly (at least monthly).

Annex 3 LARC uptake in birthing centres

Table A3.1: New Implant users in 8 birthing centres 2014-2015

	2014										2015										Total for pilot
	Jan	Feb	Mar	April	May	Jun	Jul	Aug	Sep	Oct	Jan	Feb	Mar	April	May	Jun	Jul	Aug	Sep	Oct	
Birthing centres	Magh	Falgun	Chaitra	Baishak	Jestha	Ashar	Shrawan	Bhadra	Ashoj	Kartik	Magh	Falgun	Chaitra	Baishak	Jestha	Ashar	Shrawan	Bhadra	Ashoj	Kartik	
Pharpu													CS						CS		
<20 Years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	3	**5**
Bamti													CS	CS						CS	
<20 Years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	0	0	0	0	0	1	9	4	4	1	1	2	1	4	**26**
Kubukasthali														CS				CS	CS		
<20 Years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	2	3	0	5	2	0	0	3	2	2	1	0	3	1	0	0	1	4	4	1	**14**
Namadi													CS					CS			
<20 Years	0	0	0	0	0	0	*	*	*	*	0	0	0	0	0	1	0	0	0	0	**1**
>20 Years	0	0	0	0	0	0	*	*	*	*	0	4	0	5	0	1	5	2	4	0	**17**
Bhujhee																				CS	

	2014										2015										Total for pilot
	Jan	Feb	Mar	April	May	Jun	Jul	Aug	Sep	Oct	Jan	Feb	Mar	April	May	Jun	Jul	Aug	Sep	Oct	
Birthing centres	Magh	Falgun	Chaitra	Baishak	Jestha	Ashar	Shrawan	Bhadra	Ashoj	Kartik	Magh	Falgun	Chaitra	Baishak	Jestha	Ashar	Shrawan	Bhadra	Ashoj	Kartik	
<20 Years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	0	0	0	0	0	1	2	1	0	0	1	2	1	1	**8**
Khaniyapani													CS		CS	CS					
<20 Years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	**3**
>20 Years	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4	3	8	15	14	2	**49**
Hiledevi																	CS				
<20 Years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	0	0	0	0	4	0	1	5	0	4	0	0	3	1	**14**
Okhreni																CS		CS			
<20 Years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	1	3	0	0	0	0	0	0	0	2	3	2	0	1	1	3	3	5	1	**16**
Totals per month	**2**	**4**	**3**	**5**	**2**	**0**	**0**	**3**	**2**	**2**	**7**	**10**	**18**	**20**	**9**	**11**	**20**	**29**	**33**	**13**	**153**
Number of coaching sessions													4	2	1	2	1	3	1	2	
**Uptake data for Namadi (from July to October 2014) was not available.*																					
CS indicates that a coaching session was held at the birthing centre by the visiting provider																					
Please note that only March to October 2015 data will be counted as uptake from the pilot																					

Source: HMIS reporting forms for uptake and VPs for dates of coaching sessions

Table A3.2: New IUCD users in 8 birthing centres 2014-2015

Birthing centres	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Total shaded cells	January	February	March	April	May	June	July	August	September	October	Total pilot
Pharpu																						
<20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	1	0	0	0	0	0	0	0	**1**	0	0	2	1	0	0	0	0	0	0	**3**
Bamti																						
<20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	1	0	0	**1**
Kubukasthali																						
<20 Years	0	0	17	0	0	0	0	0	0	0	**17**	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	5	3	0	**8**
Namadi																						
<20 Years	0	0	0	0	0	0	*	*	*	*	**0**	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	*	*	*	*	**0**	0	0	0	0	0	0	6	0	2	0	**8**
Bhujhee																						
<20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	3	0	0	**3**
Khaniyapani																						
<20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	1	0	0	1	0	0	0	0	**2**
Hiledevi																						
<20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	**0**

Birthing centres	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Total shaded cells	January	February	March	April	May	June	July	August	September	October	Total pilot
>20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	1	0	0	0	1	**2**
Okhreni																						
<20 Years	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	**0**
>20 Years	0	0	0	0	0	0	0	0	0	0	**0**	1	0	2	1	1	1	0	0	0	0	**5**
Totals per month	0	0	18	0	0	0	0	0	0	0	**18**	1	0	5	2	1	3	6	9	5	1	**32**
Number of coaching sessions														3	2	1	2	1	3	1	2	
**Uptake data for Namadi (from July to October 2014) was not available.*																						
Please note that only March to October 2015 data will be counted as uptake from the pilot																						

Source: HMIS reporting forms for uptake and VPs for dates of coaching sessions

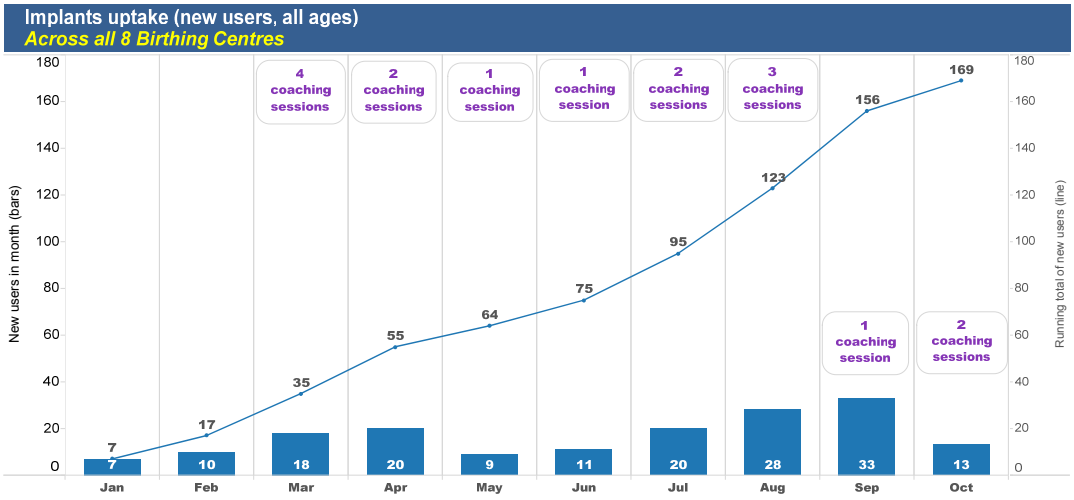
Graphs for birthing centres (not shown in the main report)

Symbols used in the graphs:

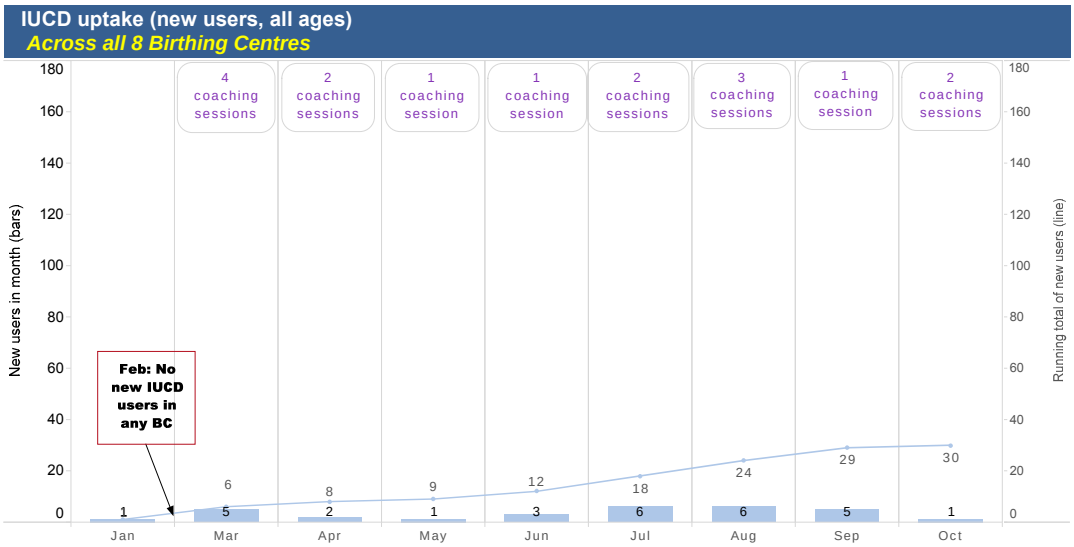
- Bars represent service uptake figures. Darker bars are for implants and lighter bars are for IUCD
- Coloured dots represent cumulative uptake. Darker dots are for implants and lighter coloured dots are for IUCD

All charts show new users, all ages.

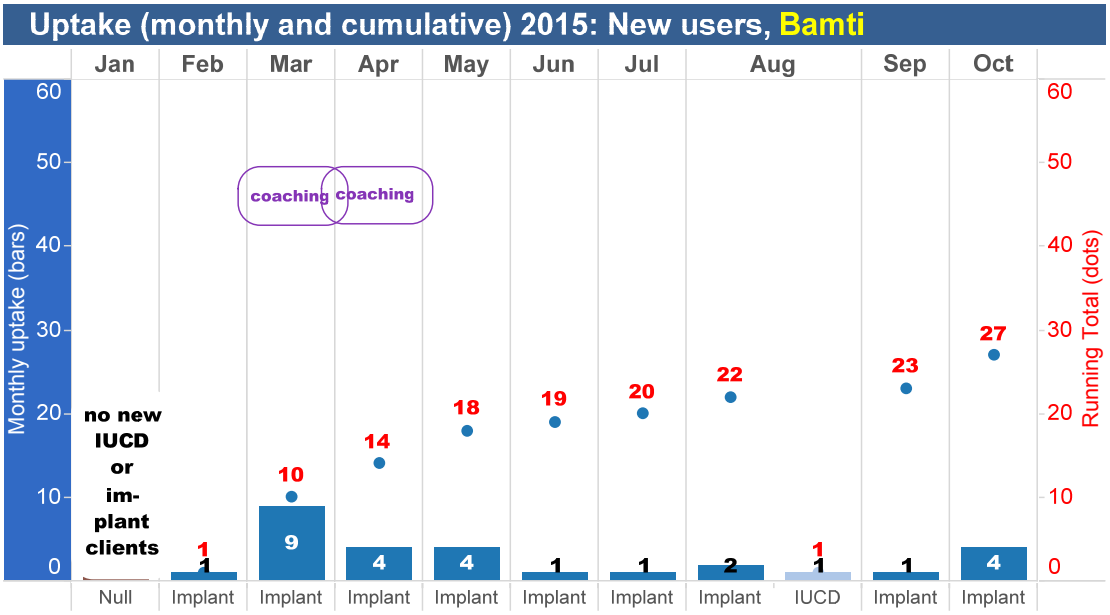
Overall implants uptake across all 8 BCs

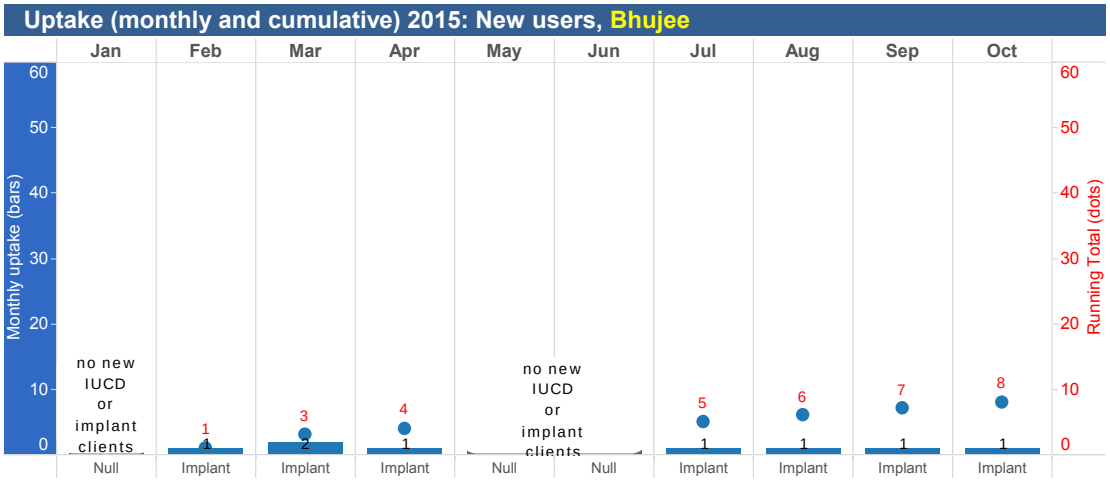


Overall IUCD uptake across all 8 BCs

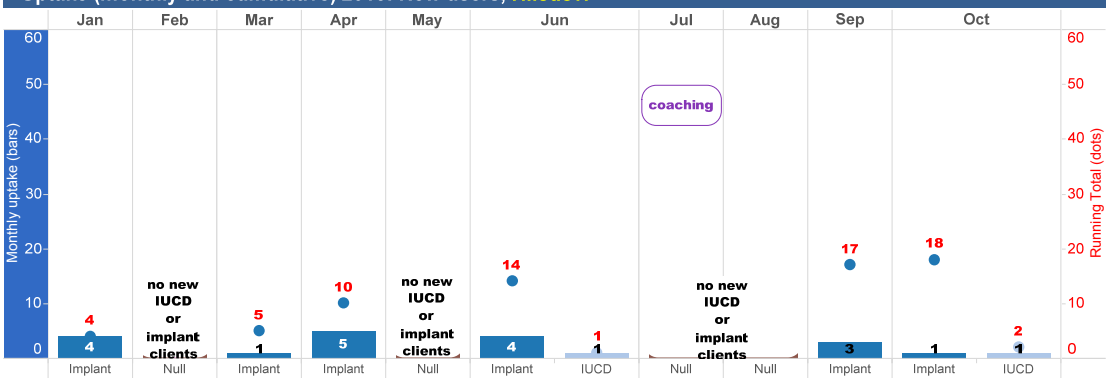


LARC uptake per birthing centre

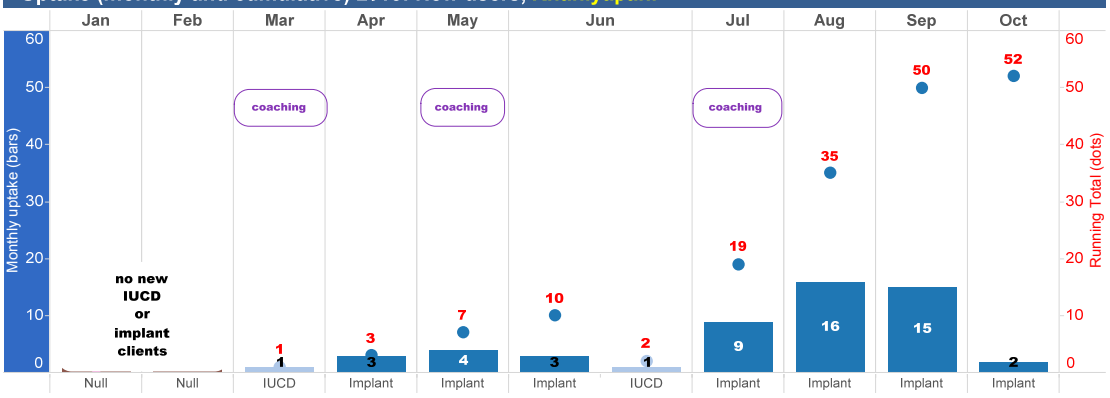




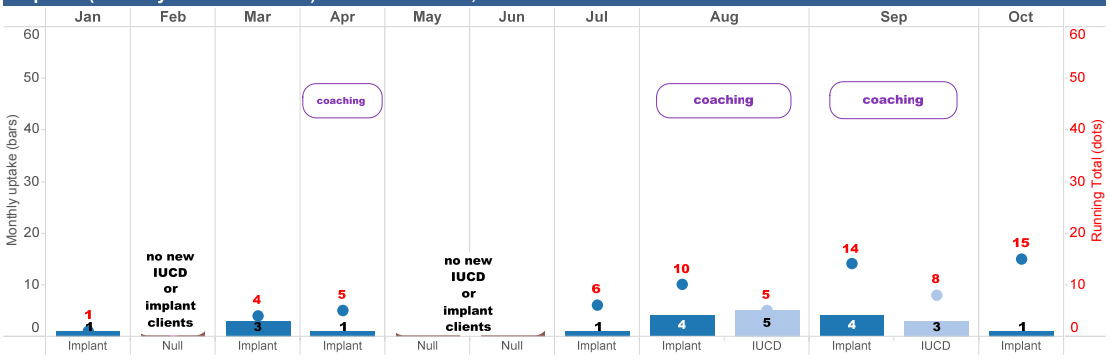
Uptake (monthly and cumulative) 2015: New users, Hiledevi



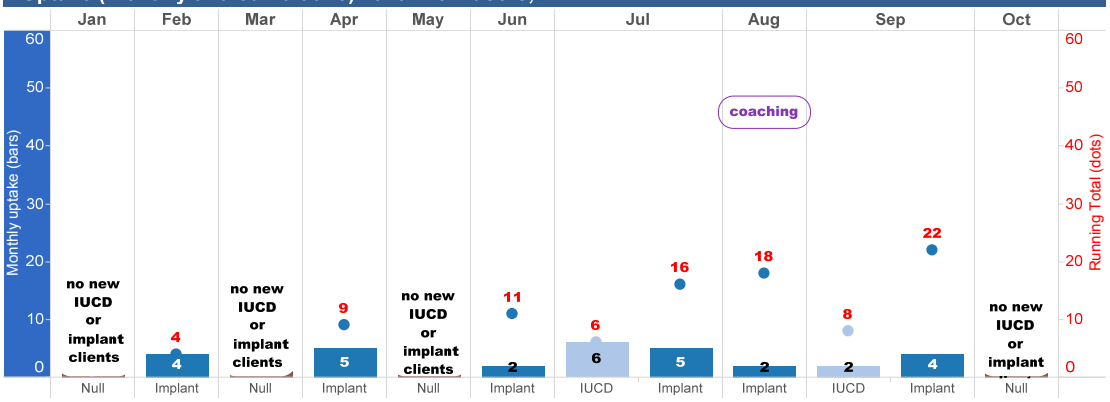
Uptake (monthly and cumulative) 2015: New users, Khaniyapani



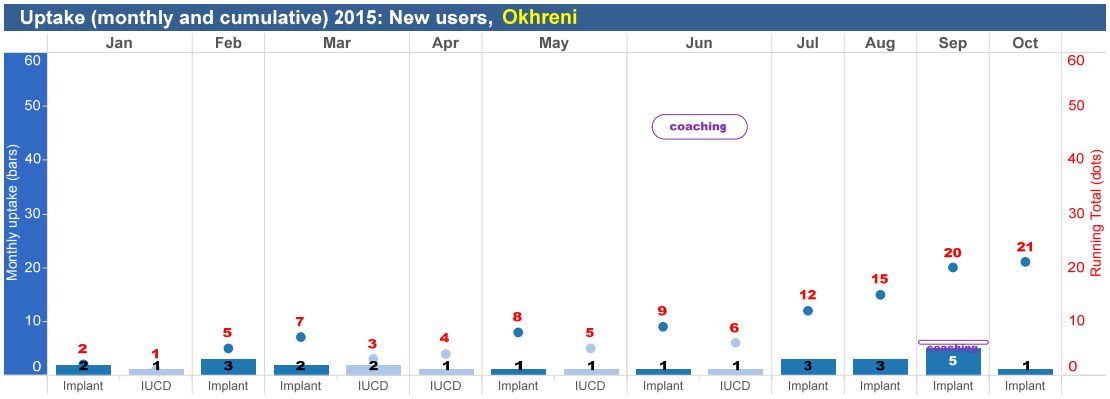
Uptake (monthly and cumulative) 2015: New users, Kubukasthali



Uptake (monthly and cumulative) 2015: New users, Namadi



Uptake (monthly and cumulative) 2015: New users, Okhreni



Uptake (monthly and cumulative) 2015: New users, Pharpu