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VISITING SERVICE PROVIDERS:

Expanding access to Long Acting Reversible Contraception in Nepal

Long Acting Reversible Contraceptives (LARCs) are under-utilised in Nepal, despite being an effective birth control method. Low awareness of LARCs among women and lack of effective outreach services to mobilise and refer eligible women has, to an extent, contributed to their low uptake. More importantly though, serious shortages of skilled health workers needed for such services has meant that only 3.3% of married women using contraception, choose implants and 1.4% choose intra-uterine contraceptive devices (IUCDs).

LARCs can only be given to women by providers who have the clinical skills for inserting or removing IUCDs and/or implants. But, less than 50% of facilities in Nepal are able to offer these services; and though health posts are often the nearest accessible facilities for women, only 15% of the health posts in mountain areas and 22% in hill and Terai regions provide these services[1].

LARCs are birth control methods that include IUCDs and implants. They:

- ✓ are easy to use
- ✓ can be very effectively used for years
- ✓ remove risk of conception due to any user errors
- ✓ are highly acceptable to women as they do not have serious side-effects
- ✓ can be used by all women of reproductive age including adolescents

In 2015, Nepal's Ministry of Health and Population (MoHP) with support from external development partners piloted an innovative and interim approach to expand quality LARC services to hard- to-reach communities and populations, through a cadre of Visiting Service Providers (VSP). This was rolled-out in subsequent years to other parts of Nepal. This technical note is a summary of the VSP innovation model; and offers practical guidance for implementing the model, drawing from the experiences and lessons learnt in Nepal. This technical note may be useful for a global audience interested in designing and implementing LARC services, particularly in low-resource settings.

1 NHFS 2015: Nepal Health Facility Survey 2015 Final Report, Ministry of Health Ramshah Path, Kathmandu, New ERA, Kathmandu, Nepal NHSSP, Kathmandu, Nepal, ICF Rockville, Maryland USA, January 2017

THE VISITING SERVICE PROVIDER MODEL

In low-resource settings such as Nepal, where very few family planning (FP) service providers have received competency-based training on LARC; and when those trained are mostly based at hospitals and in urban areas, the VSP model has immense potential to improve LARCs uptake. VSPs, as the name suggests, are trained providers who visit primary level health facilities as per planned schedules to deliver LARC services.

Profile of a Visiting Service Provider

Who they are

- ✓ Dedicated LARC service providers
- ✓ Auxiliary Nurse Midwives (ANMs) or Staff Nurses (who may have had Skilled Birth Attendant training)
- ✓ Trained on IUCD and implant insertions and removals
- ✓ Deputed especially in hard-to-reach areas and willing to travel to these areas (with or without an accompanying partner)

Who they are not

- × Providers of short-acting or permanent methods of contraception (They may however refer women/men for other methods)

Visiting Service Providers help expand the contraceptive choices for women living in remote and hard-to-reach areas, by taking LARC services to the health facilities closest to them. Being women themselves, VSPs are able to gain the trust of women who need contraception; and as professionals they are able to build and maintain relationships with government staff, facility management members and health volunteers at community level. The VSP model also includes an on-site coaching and mentoring-based learning approach to help strengthen the competence and confidence of health providers at the lower level health facilities, during their visits. This helps the local health providers to continue to provide usual services, whilst also learning on-the-job. Some VSPs also take on the responsibilities of monitoring the quality of LARC provision at the lower-level facilities where they have coached or mentored.

Role of a Visiting Service Provider

Periodically visits health posts & birthing centres where there are no LARC services, to directly provide IUCDs or implants; and FP counselling to eligible women who visit the facilities.

Coaches and mentors other trained health providers (who are not confident providers of IUCD and implants) on-site at the remote health posts/birthing centres during visits

Monitors quality of LARC provision

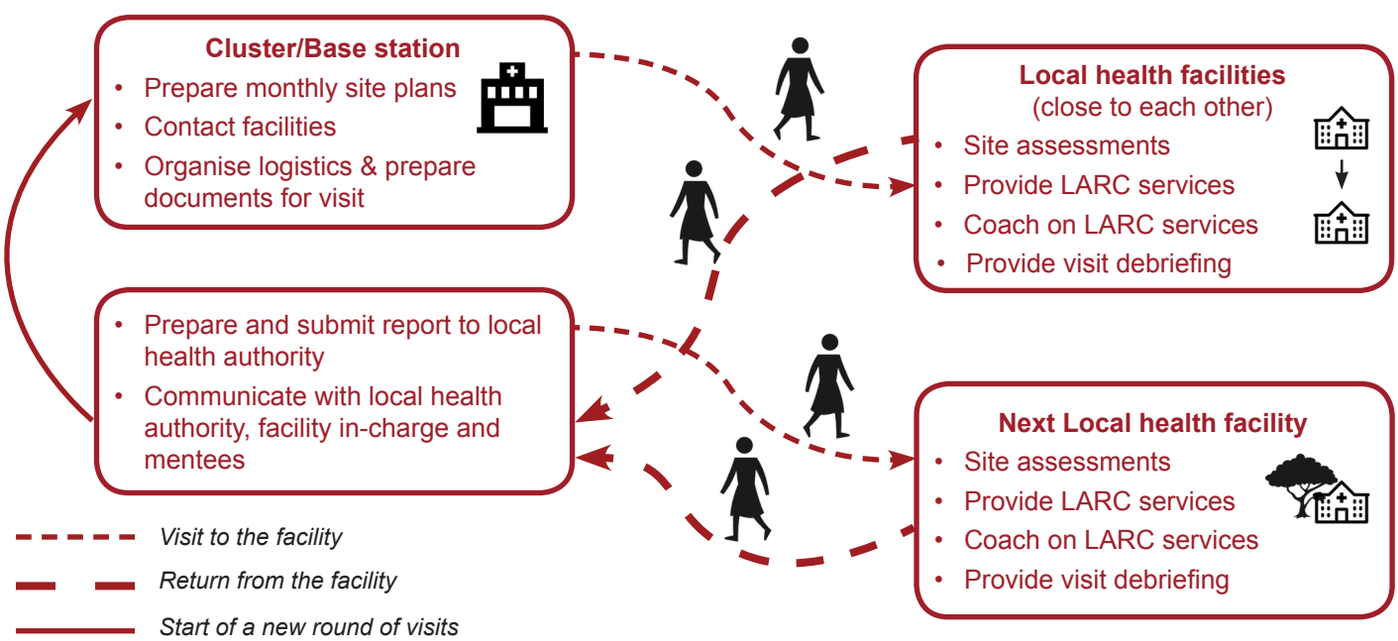
DESIGNING AND IMPLEMENTING THE VSP PROGRAMME

The principles on which the VSP programme can be designed, and the steps followed for implementation are laid out below:

Identifying priority areas	• Assess geographic/administrative regions to identify those that have high-need for LARCs (based on human resource availability, service data, distance to facilities, etc.) • Choose priority regions where the VSP programme can be implemented
Having Consultations	• Undertake a detailed planning meeting/workshop with health facility in-charges and decision-makers in the local administration (e.g. district, municipality) • Discuss the VSP model and its process (interventions, recording, reporting, monitoring, and required resources) • Undertake a situation analysis of the local area on LARC services availability in health facilities; status of equipment and supplies needed for LARC services, map providers trained/yet to be trained; map number of sites and trained health providers who need coaching/mentoring • Draw up agreements and commitments to roll-out the intervention in respective local administrative areas and health facilities
Defining the roles of VSPs	• List out the specific roles and responsibilities of the VSPs after having identified the need in each local administrative area (i.e. municipality; district). For example, some areas may need just one component – either direct provision or coaching/mentoring, while others may need both.
Recruiting VSPs	• There can be two modalities of VSP recruitment. a. VSPs can be recruited externally from the open job market for fixed contract period. b. VSPs can be mobilised internally from existing local public sector health providers. The latter option is usually applied by VSP programme led by the government when hiring of VSPs freshly from the job-market is not feasible; or when mobilisation of existing staff is encouraged
VSPs capacity enhancement	• Provide the recruited VSPs an orientation on the programme, and coaching/mentoring skills training • Provide LARC skills training or refresher depending on competency levels. Three different levels of skills are possible: a. New VSPs with no skills on LARCs; b. VSPs who may need to learn one or more LARCs clinical skills; c. VSPs who may have the clinical skills but need a refresher. • Orientation/training should also include various aspects on preparedness, management and referral of complications and adverse events after LARC service delivery; and use of FP quality improvement tools.

Equipping VSPs	• Provide VSPs with all equipment - prepacked LARCs insertion/removal kits/sets, and LARCs commodity and supplies (unless already in available in the health facilities) • Provide VSPs with basic personal protection gear containing items like a backpack, rain coat/umbrella, torch light/head light, and a whistle. Also, orient VSPs on sexual harassment and where to report if needed. • Create and facilitate the 'buddy system' where VSPs can work in pairs, or have a companion when visiting hard-to-reach areas, to ensure their safety and security
Laying out VSP movement	• Depending on the size and accessibility issues of the local administrative area, local health authorities create geographical clusters of contiguous health facilities. • Each cluster agrees on one centre/station where VSPs stay and make their field movement from. • VSPs travel to health facilities as per the visit plan. These plans could be based on topography, access to motorable roads, and location of the facility from each cluster station
Providing the services	• VSPs need to conduct an initial site assessment for LARC services in all health facilities using FP quality improvement (QI) tools for LARC services. The same tool is continued subsequently at follow-up visits for monitoring purposes. • VSPs coach on LARCs and provide services directly as needed. Coaching can be initiated after facilities are equipped with necessary FP commodities and equipment • VSPs make more frequent visits in the initial months to ensure local providers are coached consistently, until a facility is capable of delivery of LARCs services itself.
Management of VSPs	• VSPs are required to prepare reports based on the visits and FP QI assessments and report the findings to local health authorities. • Supervisory visits are made by local health authorities at least on a quarterly basis. Joint supervision and monitoring visits from any supporting partners and other levels of government health authorities is also encouraged • VSPs can also be mobilised to provide LARC services when satellite clinics, reproductive health-RH camps, voluntary sterilization-VSC camps, and cervical screening/visual inspection with acetic acid-VIA camps are conducted.

Model of VSPs field movement within each cluster



Who does the VSP coach?

1. Skilled Birth Attendants (SBA) at the lower facilities who are usually ANMs and Staff Nurses who have specifically received the SBA training, and are officially the IUCD providers. However, they usually lack the confidence to undertake the procedures due to lack of practice or hands-on training.
2. ANMs and Staff Nurses, who have not received the SBA training but have received group-based IUCD training, but lack practice and confidence
3. Para-medics, who are non-physician non-nursing health care providers, but have been trained to provide implants

KEY MESSAGES FROM IMPLEMENTATION EXPERIENCE

Empowering the local administration helps to improve services: In a federal system, where significant decision-making and implementation responsibilities lies with local governments, it is important that they have access to timely support, resources, training, guidelines and other resources from the federal levels. Increased capacities also need to be matched with a sense of ownership of the initiative and hence meaningful engagement from the design stages is essential.

Proper planning and budgeting are foundational for programme delivery: A structured and well-grounded basis for design, budgeting and implementation planning is essential. Geographical areas where the programme is needed and best suited for have to employ robust equity criteria, and budgets have to be allocated accordingly.

Systematic, structured and regular communication is key for buy-in and effective implementation: Health facilities and their administrators across the various service levels – federal to local – should have access to guidelines, regular updates, supportive supervision and other modes of interactions. Communication lapses can weaken trust and buy-in towards the programme.

Establishing a clinical back-up after VSP visits helps responsiveness to complications/emergencies: Follow-up for complications or removals, if any, can be particularly challenging in remote areas that have no local fully-skilled service providers. Programmes should consider back-up plans appropriate for their contexts, such as training VSPs to address this through subsequent/return visits, providing mobile numbers that clients can call if needed, keeping an updated list of referral sites with their contact details or coaching trained providers on VSP days on removals.

Greater use could be made of mobile outreach service events: Experience shows that dedicated service days create excitement among women in the village. There is also a perception that external providers provide better quality services. Women travel together in groups, providing mutual support and encouragement but also increasing their safety. The camaraderie created encourages attendance by those who might otherwise be hesitant to attend.

KEY ACHIEVEMENTS OF THE VSP PROGRAMME IN NEPAL

- Women adopting LARCs in the implementing year, showed a near a two-fold increase from the previous year.
- Overall uptake of LARCs increased each year, particularly that of implant users
- Acceptance of IUCDs was lower than implants, and new acceptors of implants increased; and a three-time increase in additional implant users was seen.
- Women were better able to accept LARC services as these were delivered by a skilled female service provider, which is culturally more acceptable.
- The coaching/mentoring model helped to transfer skills to the lower cadre health workers thereby creating a larger pool of providers.
- The VSP approach helped trigger other efficiencies in the system. For example, it led to increased capacities, self-reliance and confidence at the lower facilities to procure basic/simple supplies needed for IUCD and implant services such as antiseptics, band-aids and bandages.

RECOMMENDATIONS

1. Ensure VSP service delivery standards and guidelines, as well as monitoring and evaluation framework draw on good practice.
2. Strengthen LARC training sites to deliver high quality services as well as FP training.
3. Orient elected representatives and other duty bearers to familiarise them about LARCs and effective methods to deliver the services, covering both short-term as well as long-term ways of potentially delivering these services
4. Prioritise internal mobilisation of VSPs, and in areas of particularly high need, such as remote settings, VSPs should be provided with longer-term contracts to incentivise applicants.
5. Ensure service delivery points provide high quality FP services including LARCs through the use of standardised quality improvement tools.
6. Encourage demand through behaviour change communication interventions.

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