

IMPLEMENTATION AND SCALING UP **THE HIGH IMPACT PRACTICES** OF FAMILY PLANNING IN NEPAL

23-24 SEPTEMBER, 2024

SUPPORTED BY:



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Comprehensive VSC (Minilap and NSV) Training – Blended learning for Post graduate Doctors A SHIFT FROM TRADITIONAL TO DIGITAL/**BLENDED** APPROACH



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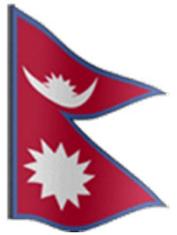
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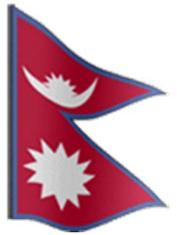


BACKGROUND



- Voluntary surgical contraception- mostly accepted methods (1st minilap & 3rd NSV) by contraceptive users among available methods of contraception in Nepal
- Introduced in 1990/91 but still standard mode of service delivery – Mobile outreach
- Limited access (seasonal service availability only)
- **LSCS service** available up to district level in most of the districts
- VSC service available in very few numbers of clinics in urban setting too.
- **MDGP/Obgynae/surgeon doctors available in many Districts but usually not trained or providing VSC service regularly**





Existing Regular Training Course For VSC Service

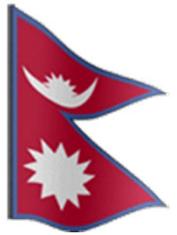
NSV Training

12 days +5 days
group based site based
Participants – 2 (MO)

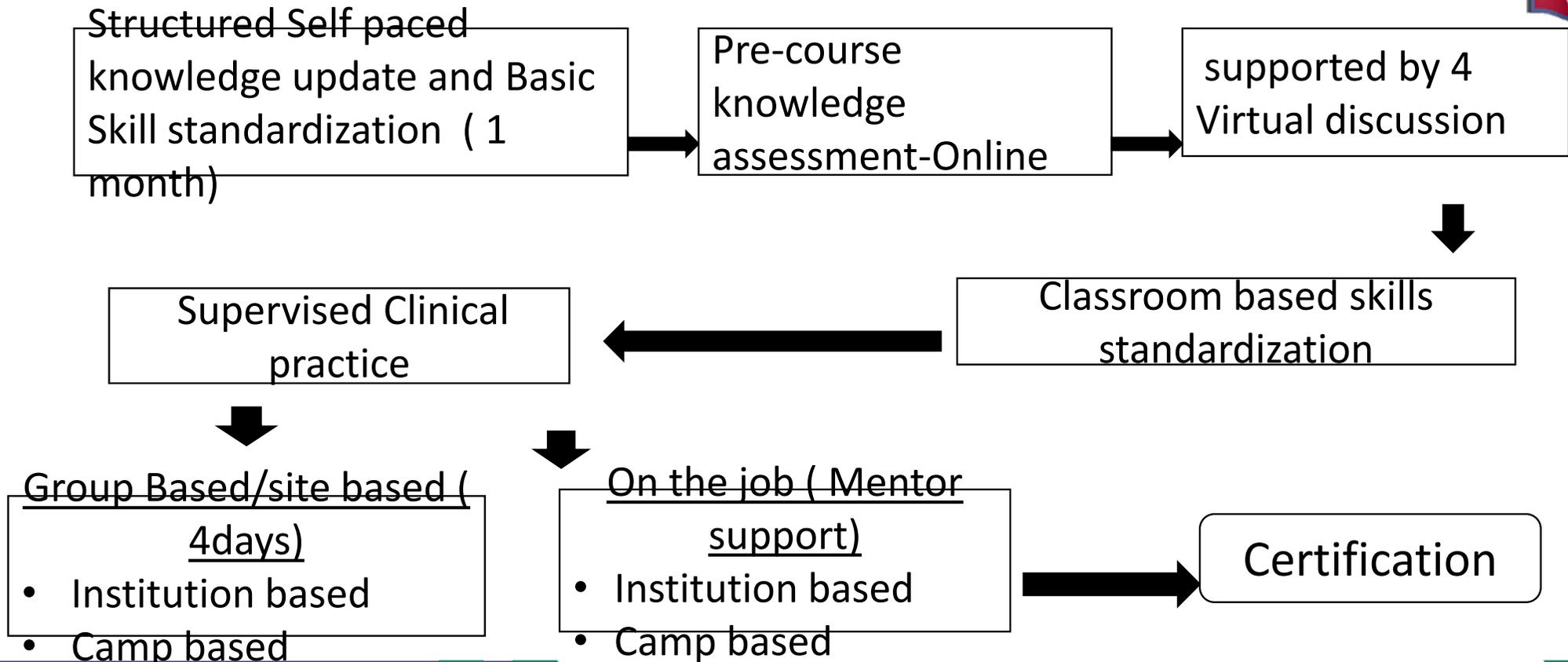
Minilap training

12 days +5 days
group based site based
Participants – 2+2 (MO+Nurse)

- High turn over of service providers
- Long absenteeism
- Less number at a time
- Seasonal dependency for competency
- High cost



TRAINING APPROACH USED





Performance Need Assessment (n=27+22) =49/49(2078-80)



- Knowledge – Basic general surgical knowledge but need to supplement VSC specific knowledge
- Skills – Gaps in counselling skills, IPC and VSC procedure related skills
- Attitude – Motivated to provide the service





Results



- Total batches- 5 batches
- Total no of days used for training – 20 days
- Total no of providers trained -49
- Number of health facility- 32 (4 non-government- medical collage /NGO/cooperative)
- Total district covered-26

Average Pre course knowledge **score– 57.33%**

Average Final knowledge **score – 92.96%**

Skills –

- Counseling and ML/LA Procedure- Satisfactory in simulation and working with real client
- NSV procedure - Satisfactory in simulation, Real client not available





Post Training Status



- Provisional letter of qualification provided
- Most of them had started the service (including NSV)
- Post training virtual mentoring (social media group)
- Onsite mentoring and support
- Certification process
- Few drop out
- Institutional service delivery
- Utilization in district level program (VSC camp)
- Used the skill learnt in other services (bladder repair)





Challenges



- Participants selection
- Time for virtual session – participants
- Manual work
- Management clinical cases for practice
- Post training support
- Institutionalization of service (coordination with HO/Palika)





Lessons learnt



- Feasible to conduct training using blended learning in our context
- Time saving and cost effective
- Effective and proactive learning by learners
- Wider coverage
- Potential 'continuous' VSC service availability due to less turnover of provider (compared to MBBS doctor training)





Recommendations



- Post training active monitoring of service providers
- Online /offline virtual platform for self paced
- Software based assessment (knowledge)
- Videos for counselling and procedures
- Institutionalization –**NHTC owned and reflected in current AWP**
- Integration in post graduate pre-service courses(MDGP/OBGYNE/SURGERY)





Summary



Key Areas	Traditional (conventional approach)	Blended approach
Number of participant per batch	2 doctors in NSV 2 doctors 2 nurses in ML Low coverage	8 Doctors for both method at once Wider coverage
Days of training	12	4
Cost	12days *participant number + trainers number High cost	8 days *participant number +trainers number Cost –effective
Utilization	Less (frequent turn over) Used for mobile outreach camps	Maximum Institutionalization and outreach camps
Mentoring	Not mandatory (occasional post training follow up)	Mandatory





Glimpses – counselling practice session



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Glimpses -Skills practice in classroom



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Thank You

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