

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

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SUPPORTED BY:



ORGANIZED BY:



Government of Nepal  
Ministry of Health and Population  
Department of Health Services  
**Family Welfare Division**



**SMART-HIPs**  
Supporting Measurement and Replication Techniques of High Impact Practices

# Understanding the Implementation and Measurement of selected FP HIPs in Nepal

Results Dissemination

Center for Research on Education Health and Social Science (CREHSS)



evihdaf



# Study Overview



## Supporting HIP scale-up

**Scale up:** Deliberate efforts to increase the impact of successfully tested health innovations to benefit more people and to foster policy and programme development on a lasting basis.

- Scale-up of HIPs requires careful planning, coordinated stakeholders, and precise monitoring to:
  - Improve and adapt implementation
  - Ensure progress towards national goals
- Scale-up monitoring differs from program monitoring:
  - Focuses on practice implementation rather than impact
  - Captures institutionalization within the broader health system and replication of the practice across service delivery points or geographic areas

# Global study: 5 HIPs across 5 countries

**Study goal:** To improve decision-making for HIP implementation and scale-up by **harmonizing and streamlining measurement** across implementation contexts.

**Burkina Faso:**

- IPPFP
- MM

**Nigeria:**

- PAFP
- PDS
- MM

**Uganda:**

- IPPFP
- CHWs
- PDS

**Mozambique:**

- PAFP

**Nepal:**

- IPPFP
- CHWs/FCHV

**Service Delivery HIPs:**

1. IPPFP: Immediate Postpartum Family Planning (3)
2. CHWs: Community Health Workers (2)
3. PDS: Pharmacies and Drug Shops (2)
4. PAFP: Post-abortion Family Planning (2)

**Social and Behavior Change HIP:**

1. MM: Mass media (2)

## Nepal's FP Policies supporting PFPF/IPFPF

S.N.	Policies/Documents	PFPF	IPFPF
1	National Medical Standard for Reproduction Health, 2020	✓	✓
2	National Medical Standard for Maternal and Newborn Care, 2020		✓
3	Safe Motherhood Policy, 1998	✓	
4	Nepal's Safe Motherhood and Newborn Health (SMNH) Road Map 2030	✓	
5	The Right to Safe Motherhood and Reproductive Health Act, 2075 (2018)	✓	
6	National Family Planning Costed Implementation Plan 2015-2020	✓	✓
7	Nepal Health Sector Strategy, 2015-2020	✓	
8	National Health Sector Strategy, 2016-2021	NS*	
9	National Female Community Health Volunteer Program Strategy, 2011	NS*	
10	Family Planning Training Manuals (IUCD, PPIUCD, Implant, No-Scalpel Vasectomy, Minilap training manual)	✓	✓
11	Family Planning (FP) Quality Improvement (QI) Tools	NS*	

*NS\* :The documents do not specify PFPF or IPFPF, but mention FP in general*

# Global study objectives and concepts

<b>1. Measure the vertical scale of HIP implementation.</b>	<b>Vertical scale</b> (institutionalization): extent of integration into national systems
<b>2. Measure the horizontal scale and reach of selected HIPs to sub-populations.</b>	<b>Horizontal scale</b> (expansion/replication): geographic coverage in terms of service availability
	<b>Reach</b> : extent to which HIP is used by different population sub-groups
<b>3. Assess implementation quality of selected HIPs, including policy-level intention and readiness to offer the intended standard of care and/or to adhere to SBC industry standards.</b>	<b>Quality of implementation</b> : extent to which HIP is implemented according to key implementation components, with a focus on policy-level intention to provide an explicit standard of care and readiness to offer that standard of care
<b>4. Estimate the costs to implement and sustain implementation. Identify cost drivers and efficiencies for selected HIPs.</b>	

## Objectives and concepts for today's presentation

3. Assess implementation quality of selected HIPs, including policy-level intention and readiness to offer the intended standard of care.

**Quality of implementation:** extent to which HIP is implemented according to key implementation components, with a focus on policy-level intention to provide an explicit standard of care and readiness to offer that standard of care



## ➤ Objective of Study for IPPFP

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1. To assess the availability of contraceptive commodities.
2. To determine the technical competency of service providers.
3. To evaluate the availability of staff at health facilities for ANC counseling.
4. To assess the practice of documentation regarding the counseling and methods provided.

# Readiness Results –IPFP

- **Health Facility Assessment**
- **Service Providers**



## IPPFP readiness assessment sample

**IPPFP:** Subset of 7 districts (*Kailali, Dang, Makawanpur, Mugu, Dhanusha, Dhankuta, Kaski*)



† At organizations implementing/supporting implementation of HIP (past 2 years)

\* Facilities were eligible if they were a **birthing center** and **had at least 1 delivery per month for the previous 3 months**

\*\* 2 providers were interviewed who have provided FP counseling to a postpartum mother within the last 3 months

## Study Districts and Sample size Covered: IPFP

Districts	Number Health Facilities	Number of IPFP providers
Kailali	38	75
Dang	34	65
Makawanpur	23	44
Mugu	18	33
Dhanusha	11	22
Dhankuta	8	15
Kaski	8	16
<b>Total</b>	<b>140</b>	<b>270</b>

- Results are **not** nationally representative
- If there were more than two service providers in one health facility, we purposively selected those involved in providing more of the services of interest
- All health facilities that had at least one delivery case in each Baishak, Jestha and Ashar months

## Core Components:

### Choice (Methods)

Technical Competency  
Staffing



## ➤ IPPFP Readiness standard: Choice

**CHOICE:** Health facilities are appropriately equipped with supplies, equipment, and methods to offer a full choice of methods appropriate during the immediate postpartum period.

- A facility has **all methods** appropriate to the immediate postpartum period that it is authorized to distribute (observed or reported available, at least one non-expired of each) on the day of the assessment.
  - Short-acting methods (all facilities): Intramuscular injectable (DMPA-IM), male condom
  - LARCs (as authorized): IUD and implant
    - **Basic Health Center and below** = *Health Posts, Urban Health Center/Unit, Community Health Centers, Basic Health Service Centers*
    - **PHC/Primary Hospital**=*Primary Healthcare Centers, Primary Hospitals*
    - **Other Hospitals**= *District and all other hospitals*
- All necessary **supplies and equipment for postpartum LARC insertion** are present on the day of the assessment, if they are authorized to be inserted at the facility (observed or reported available).
  - *9 supplies: Antiseptic, cotton, sterile gloves, syringe, filter needle, anesthetic, gauze, band-aid, gloves.*
  - *11 pieces of equipment: Table, light, sterile drape, tray, dish, ringer forceps, uterine sound, tenaculum, scissors, speculum, Kelly forceps.*

## Method Choice: Availability of commodities and equipment

	Total Sample, by Category	All methods available N (%)	All LARC sup. and equipment available N (%)	Health facilities meeting the standard <i>(supplies, equip and commodities for all IUD, Implant, Condom, Depo)</i>	Health facilities meeting standard <i>(supplies, equip and commodities for LARCs)</i>
<b>Overall</b>	<b>140</b>	<b>72 (51.4%)</b>	<b>59 (42.1%)</b>	<b>44 (31.4%)</b>	<b>45 (32.1%)</b>
<b>Facility type</b>					
Basic Health Center and below	106	47 (44.3%)	35 (33.0%)	<b>22 (20.8%)</b>	<b>22 (20.8%)</b>
PHC/Primary hospital	11	7 (63.6%)	7 (63.6%)	<b>6 (54.4%)</b>	<b>7 (63.6%)</b>
Other hospital	23	18 (78.3%)	17 (73.9%)	<b>16 (69.6%)</b>	<b>16 (69.6%)</b>

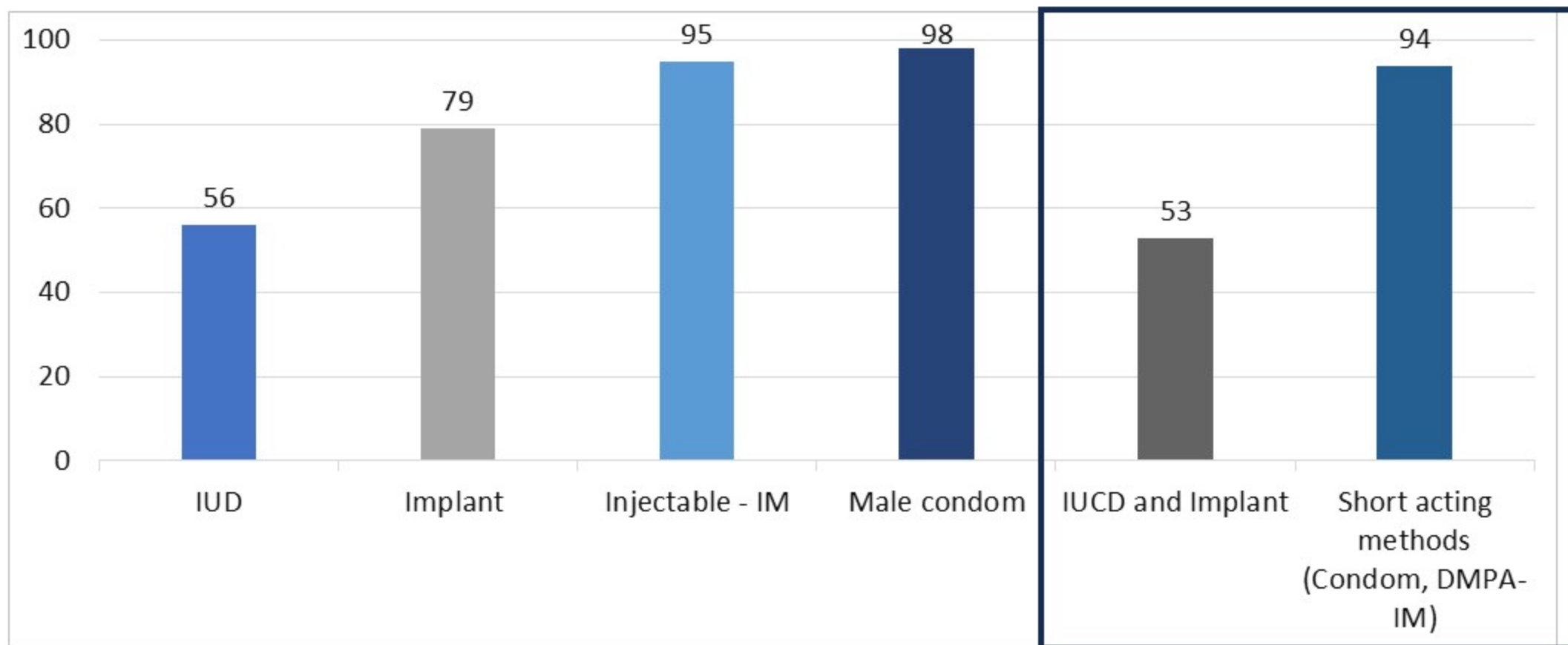
Short-acting methods: Intramuscular injectable (DMPA-IM), male condom

LARCs: IUD and implant

9 supplies: Antiseptic, cotton, sterile gloves, syringe, filter needle, anesthetic, gauze, band-aid, gloves.

11 pieces of equipment: Table, light, sterile drape, tray, dish, ringer forceps, uterine sound, tenaculum, scissors, speculum, Kelly forceps.

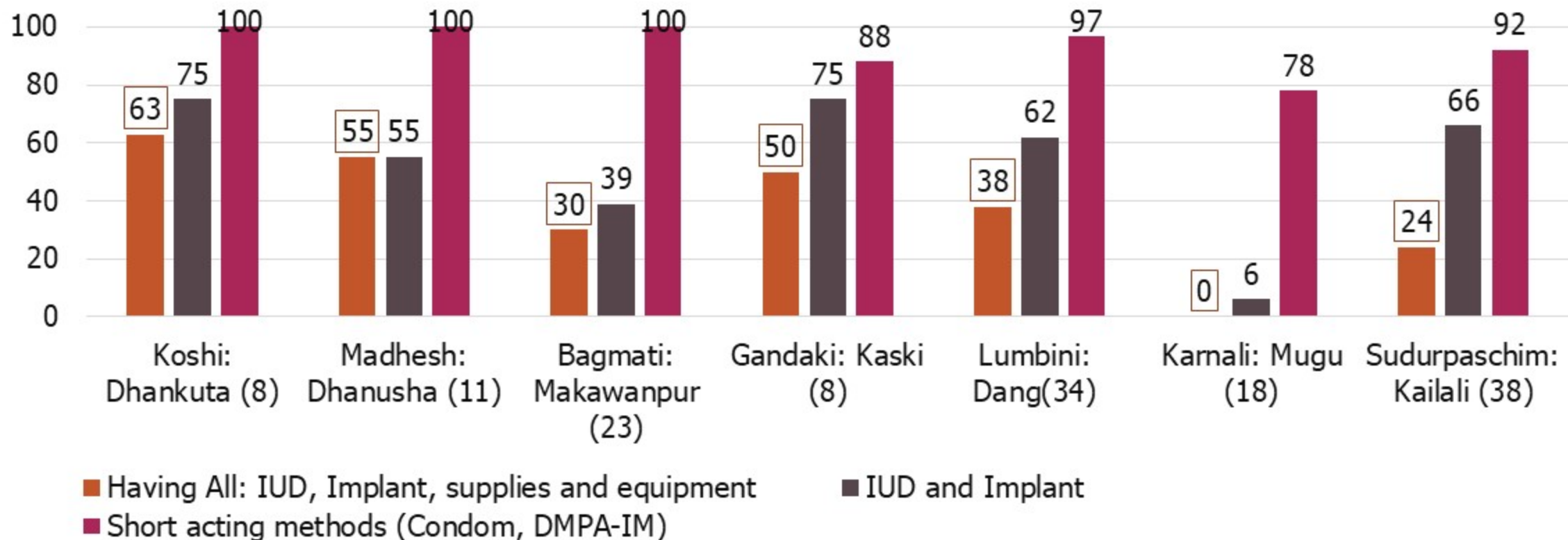
## Method Choice: Availability of commodities



% facilities with each method, observed or reported available, non-expired (n=140)

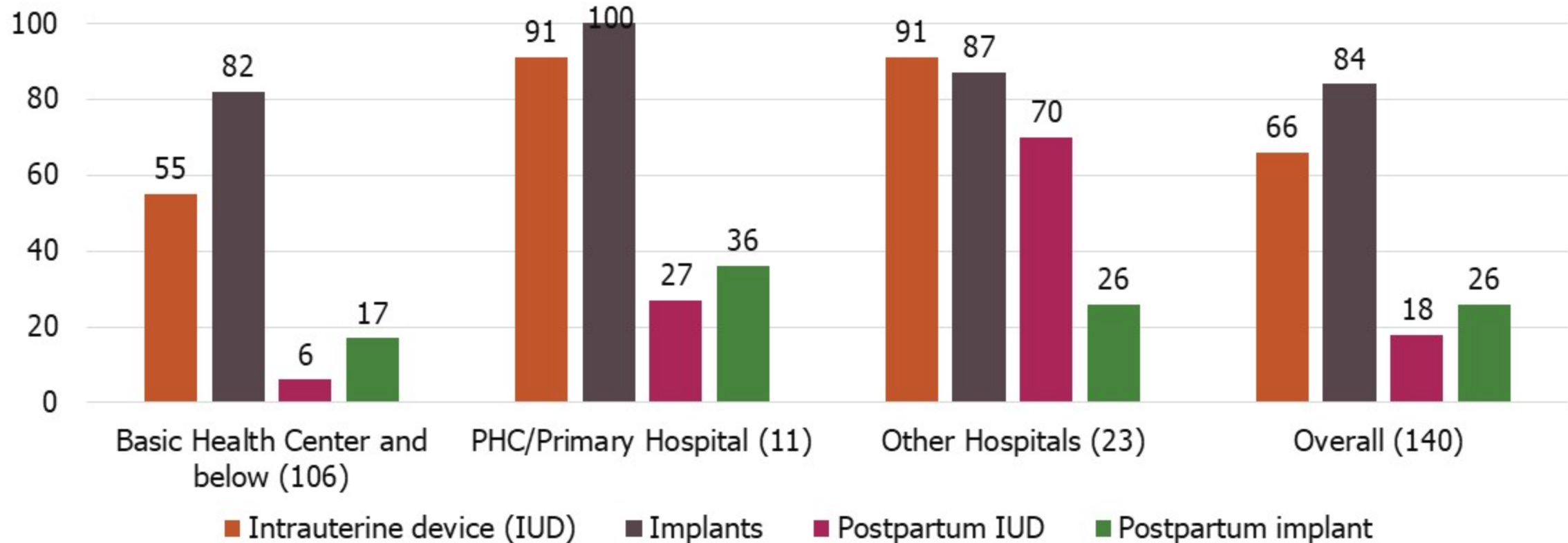


## Method Choice: Availability of commodities and equipment by province



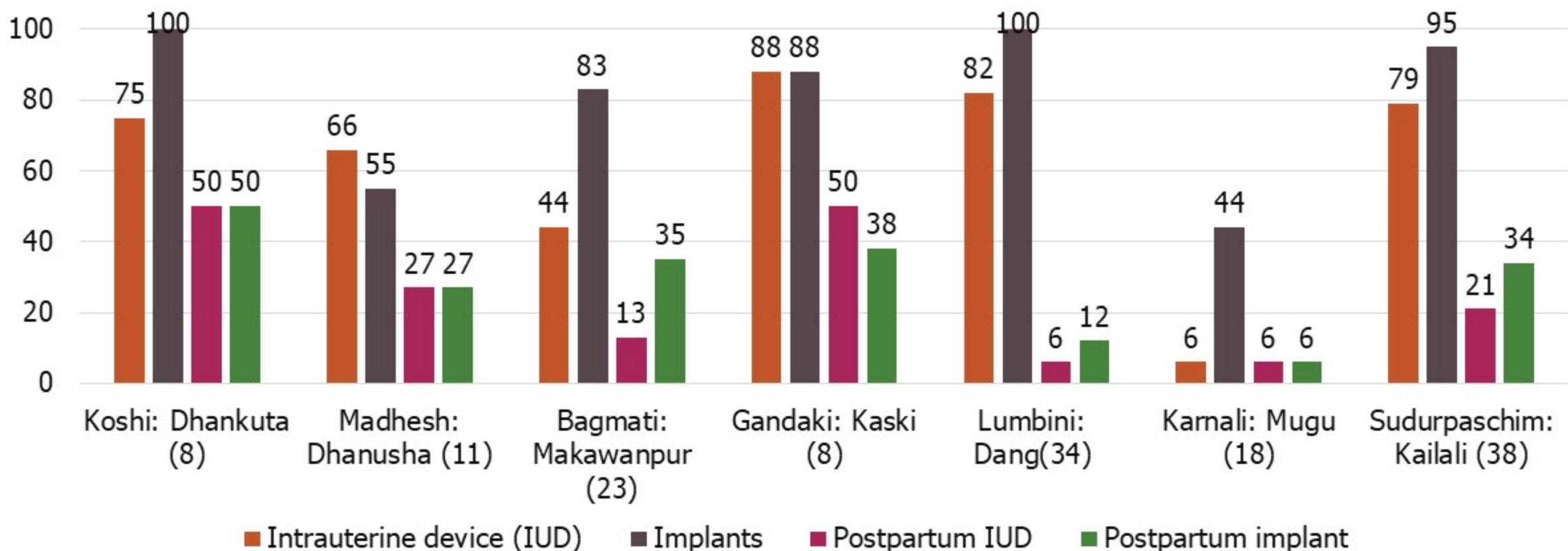
% of HFs meeting choice component by province and commodities availability

## Method Choice: Availability of LARC Services



% of HFs with Availability of LARC services by type of HF

## Method Choice: Availability of LARC services by province



% of HFs with Availability of LARC services by province

# Core Components:

Choice

**Technical Competency (Training)**

Staffing



## IPFP Readiness standard: Technical Competency

**TECHNICAL COMPETENCY:** Providers have received training and achieved competency in the delivery of IPFP counseling and service provision.

At least one of the family planning providers interviewed from the facility:

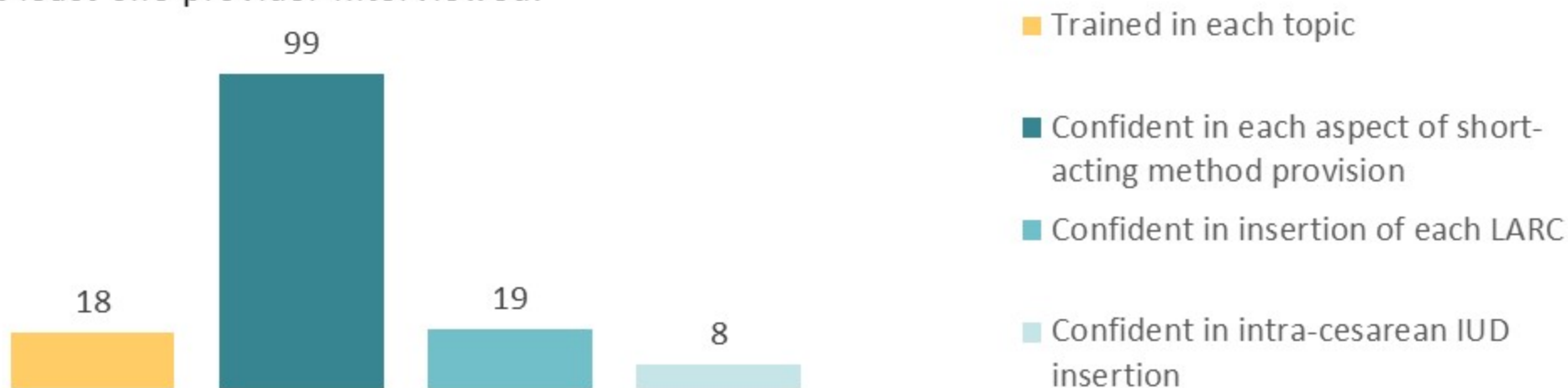
- Reported having been **trained** in each IPFP topic.
  - Client-centered counseling, appropriate contraceptive options for postpartum clients, implant insertion, postpartum IUD insertion.
- Reported being **very confident** in her/his ability to carry out aspects of IPFP service provision authorized based on facility level.
  - All facilities: Client-centered counseling, prescribing appropriate short-acting methods for postpartum clients (all facilities).
  - As authorized: Implant insertion, postpartum IUD insertion (within 10 minutes, within 48 hours).
  - As authorized: Intra-cesarean IUD insertion.

## ► Technical Competency: Main Results

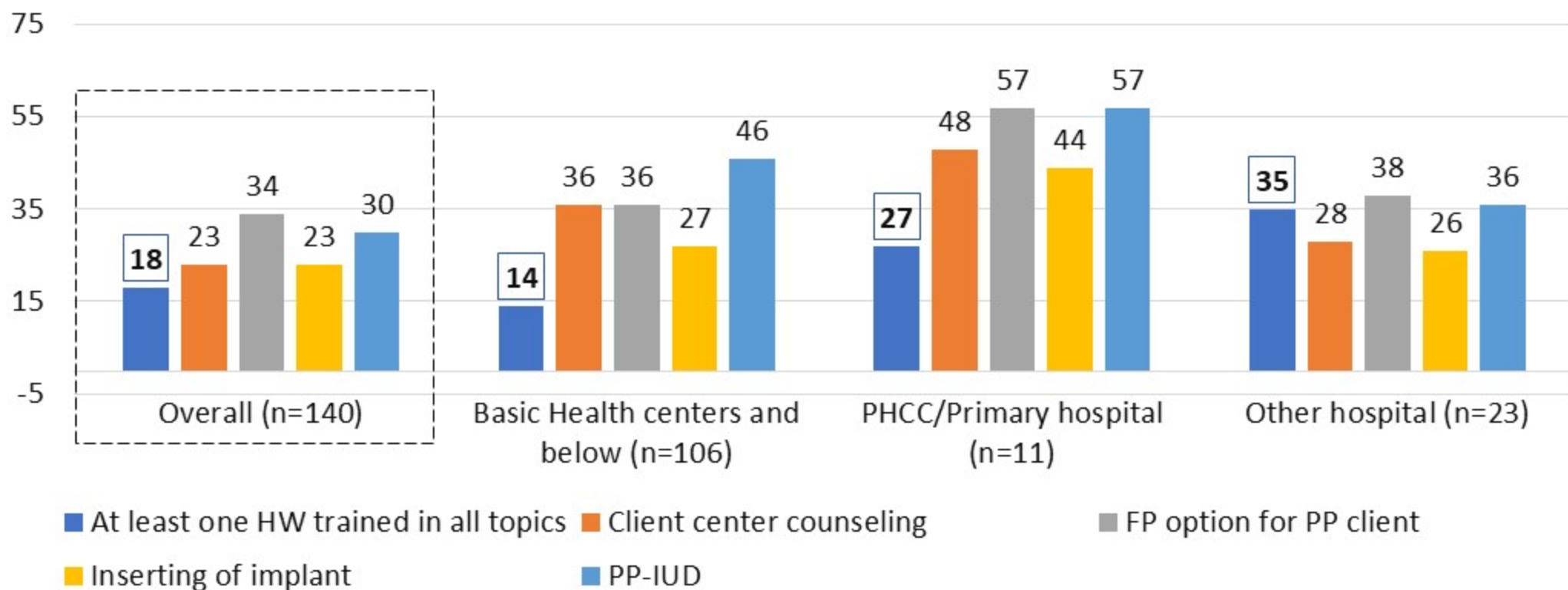
% facilities meeting standard

Trained AND confident for:	Nepal (n=140)
Short-acting	18%
Short-acting + LARC	11%
Short-acting + LARC + intra-cesarean	5% out of 140 HFs 9% out of PHC level 22% out of other hospital

% facilities with at least one provider interviewed:

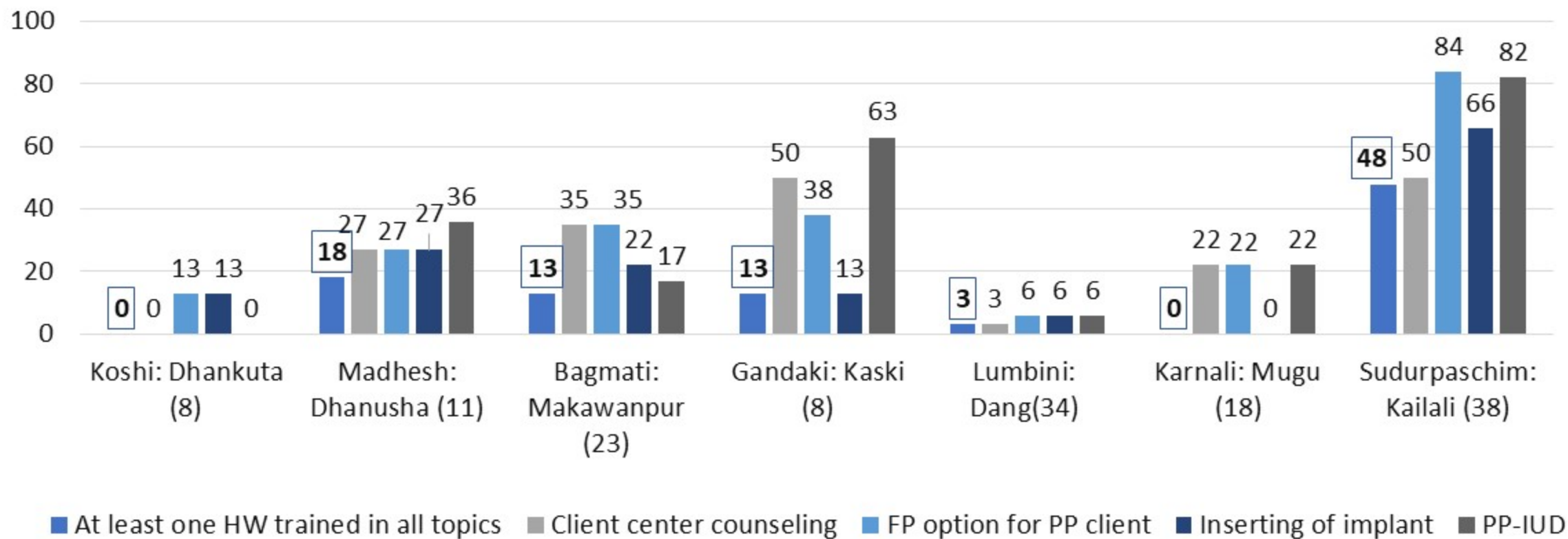


# Technical Competency: Training on IPPFP topics



% facilities with health service provider trained in IPPFP topics

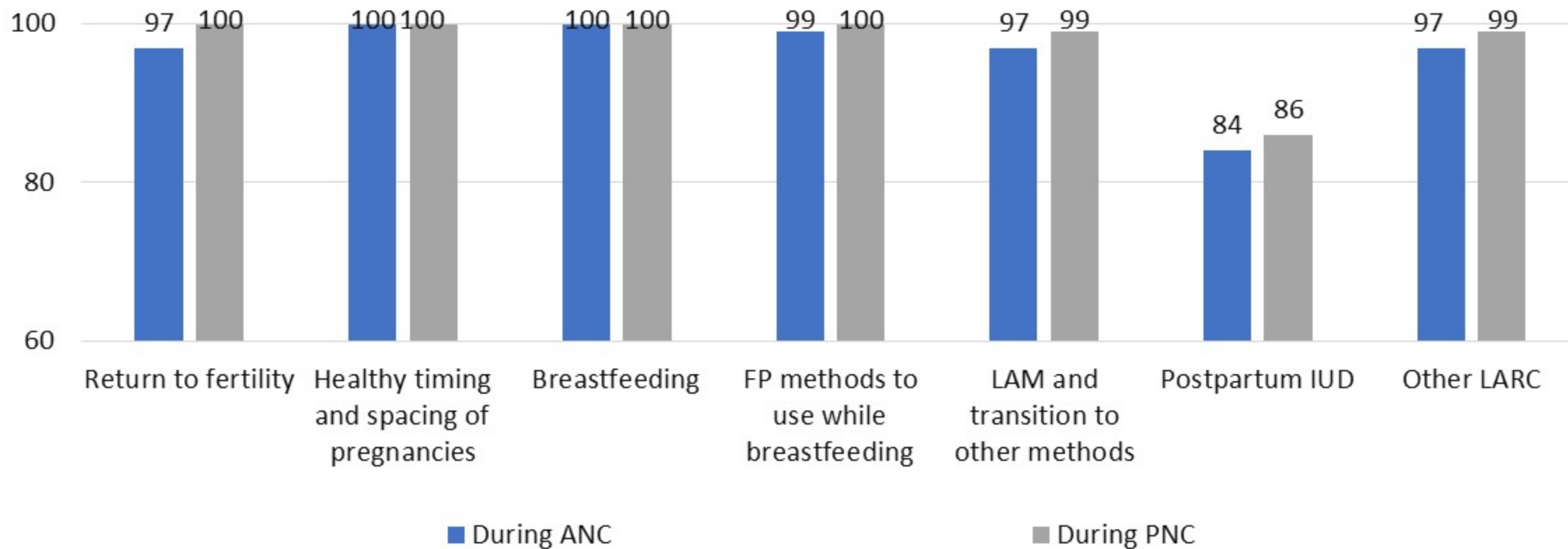
# Technical Competency: Training on IPPFP topics by province



% facilities with health service provider trained in IPPFP topics



## Topics discussed with women during ANC and PNC



% facilities with health service provider trained in IPPFP topics

# Core Components:

Choice  
Technical Competency  
**Staffing**



## IPFP readiness standard: Staffing

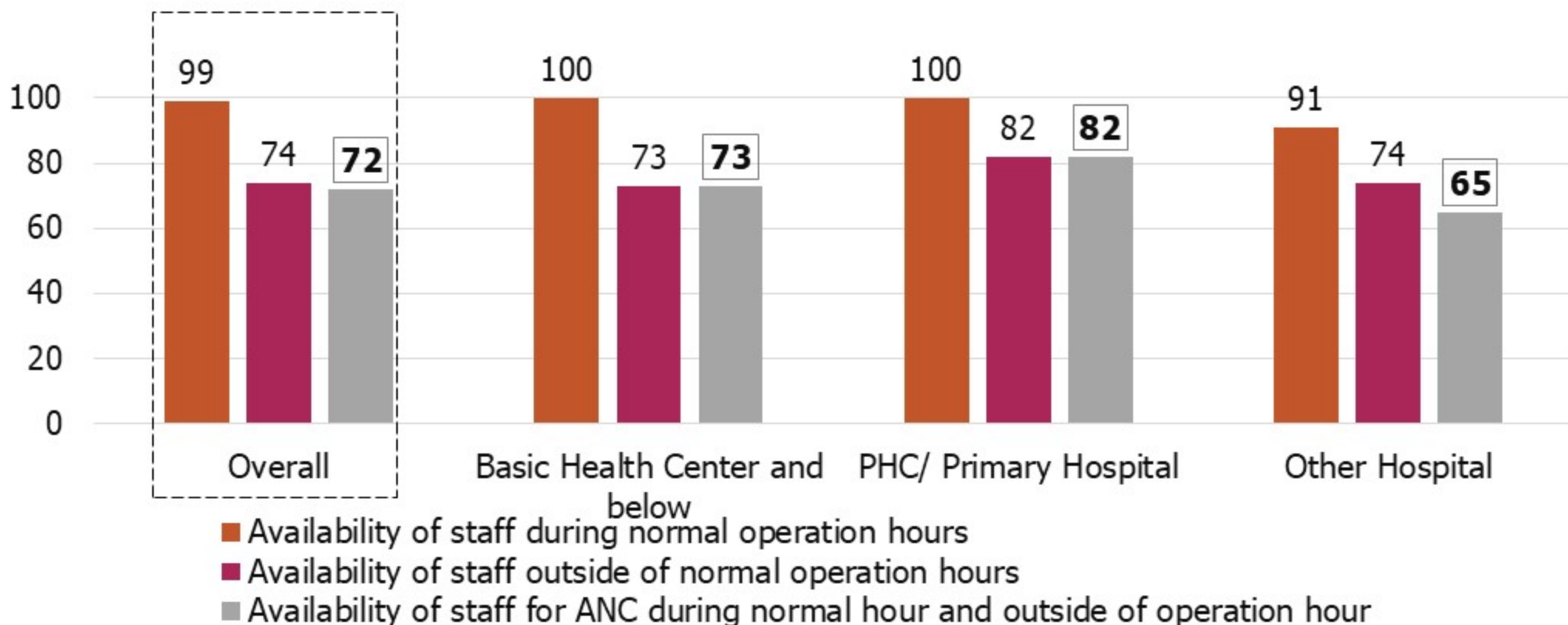
**STAFFING:** Health facilities have providers available to offer family planning counseling to mothers during antenatal care and both counseling and service provision in the immediate post-partum period.

**Data source:** Health facility assessment

- Health facilities have someone available to provide family planning **counseling** to ANC clients **during ANC hours**.
- Health facilities have someone available **in the maternity ward** to provide family planning services.
  - **During** normal operating hours.
  - **Outside** of normal operating hours (mostly relevant for PPIUD insertion within 10 minutes and intra-cesarean IUD insertion).

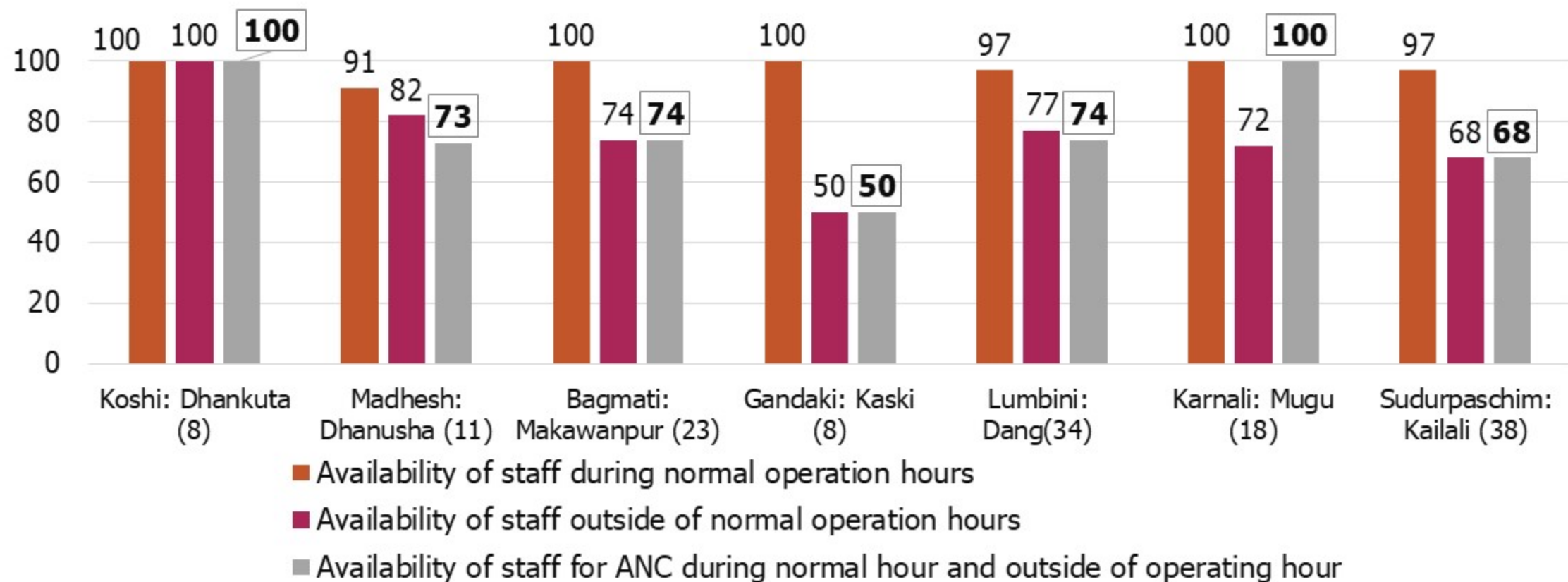
**Contextualization:** This measure is harmonized across countries.

## Staffing: Adequacy of staff



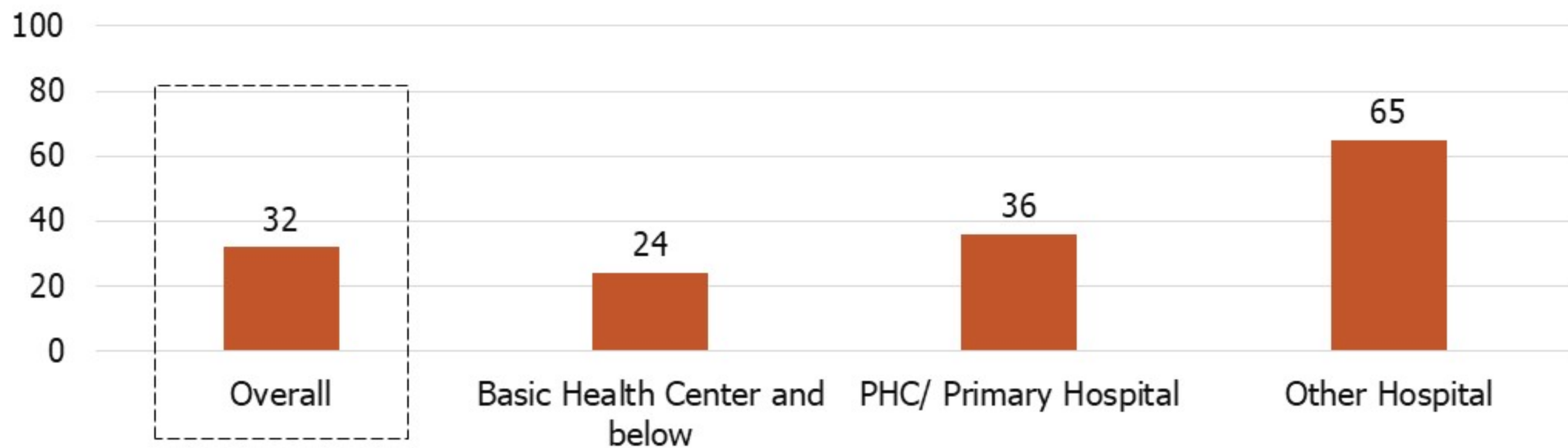
% facilities with staff available to provide FP counseling and methods during normal operation hours and outside of operation hours (n=140)

## Staffing: Adequacy of staff



% facilities with staff available to provide FP counseling and methods during normal operation hours and outside of operation hours (n=140)

## Postpartum woman offered an FP method



% facilities who offer postpartum mother with Family Planning method (n=140)

## IPFP Readiness Standards: Result Summary

Key implementation component	Definition	Percentage of facilities meeting the standard (N=140)
Choice	1. <b>Commodities</b> - Having all family planning methods appropriate to IPP period that a facility is authorized to distribute available on the day of assessment.	51.4% (72)
	2. <b>Supplies and equipment</b> - Having all necessary supplies and equipment for PP LARC insertion present, if authorized to be inserted at the facility.	42.1% (59)
	➤ <b>Facilities meeting both standards</b>	<b>31.4% (44)</b>
Technical competency	1. <b>Capacity</b> - Having at least one health care worker (HCW) trained in all IPPFP topics.	4.3% (6)
	2. <b>Competency</b> - At least one of the family planning providers reported being confident in her/his ability to carry out corresponding tasks.	7.1% (10)
	➤ <b>Facilities meeting both standards</b>	<b>2.1% (3)</b>



## IFFPP Readiness Standards: Result Summary

Key implementation component	Definition	Percentage of facilities meeting the standard (N=140)
Staffing	<b>Adequate staff</b> - Having someone available in the maternity ward to provide FP services during and outside normal operating hours.	72.9% (102)
Documentation and Reporting	<b>Adequate documenting, reporting, and tracking</b> - Documenting numbers of mothers counseled on and receiving FP methods after delivery and before discharge separately from total FP clients.	13.6% (19)





## De-Limitation/Limitation of the study

### De-Limitation

- The study covered one district (including district from all three geographical boundaries) from each province. A total of 140 HFs and 270 service providers were covered.

### Limitation

- The study followed cross-sectional study design. Do not reflect the change over time.
- The study may not be nationally representative
- The study do not include the BTL 'Bilateral Tubal Ligation' (Tubectomy)

## ➤ Key takeaways (IPFP)

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- Most of the health facilities have short acting methods, but fewer have LARC commodities (especially low for IUDs) and equipment.
- Makawanpur, Mugu and Kailai are below the average found within this study (32%) for availability of IUCD, Implant and its supplies and equipment.
- Most facilities report offering LARCs to general FP population, while fewer report offering these to postpartum women.
- The overall proportion of service providers trained in all topics, per the standard, is quite low (<50%) across facility types and regions/districts.
- The availability of maternity staff to provide FP services during normal hours is very high. Availability during off-hours is more variable across sites, though still at or above 50%.

## ➤ Q&A / Discussion

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- Clarifying questions?
- Does this data suggest the need for further exploration of any aspect of HIP implementation? If so, what?
- Reactions to this methodology? Could/should it be replicated in the future? When, how, by whom?
- Any concrete recommendations for next steps?



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# Thank You

