Nepal's Experience in Expanding the Delivery of Injectable Contraception

A brief overview

Presentation at

Expanding Access to Injectable Contraception

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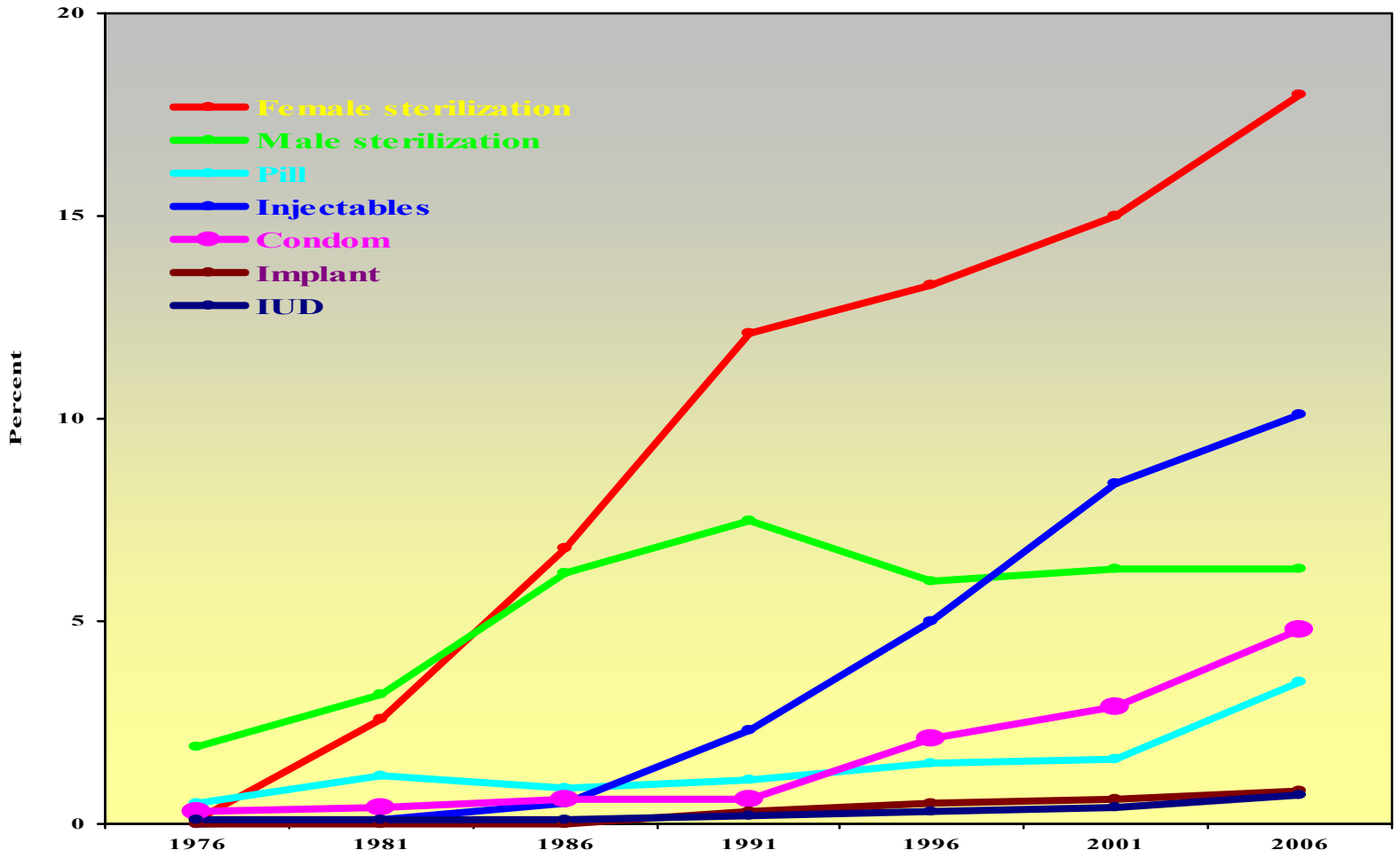
Background

- **Three-monthly injectable contraception -- Depo-Provera® -- was piloted in urban areas of Nepal during 1971-73.**

- **Subsequently, it was incorporated into the MoH family planning program. However, the availability and accessibility remained limited through the early 1990s. Scenario changed dramatically in the mid-90s.**

- **Use of Depo in all segments of population rose, as shown in the next two slides. Its overall prevalence in 2006 was over 10%, which constituted one-fourth of the total prevalence of contraceptive methods.**

Trends in Current Use of Modern Contraceptive Methods, Currently Married Women (15-49), Nepal, 1976-2006



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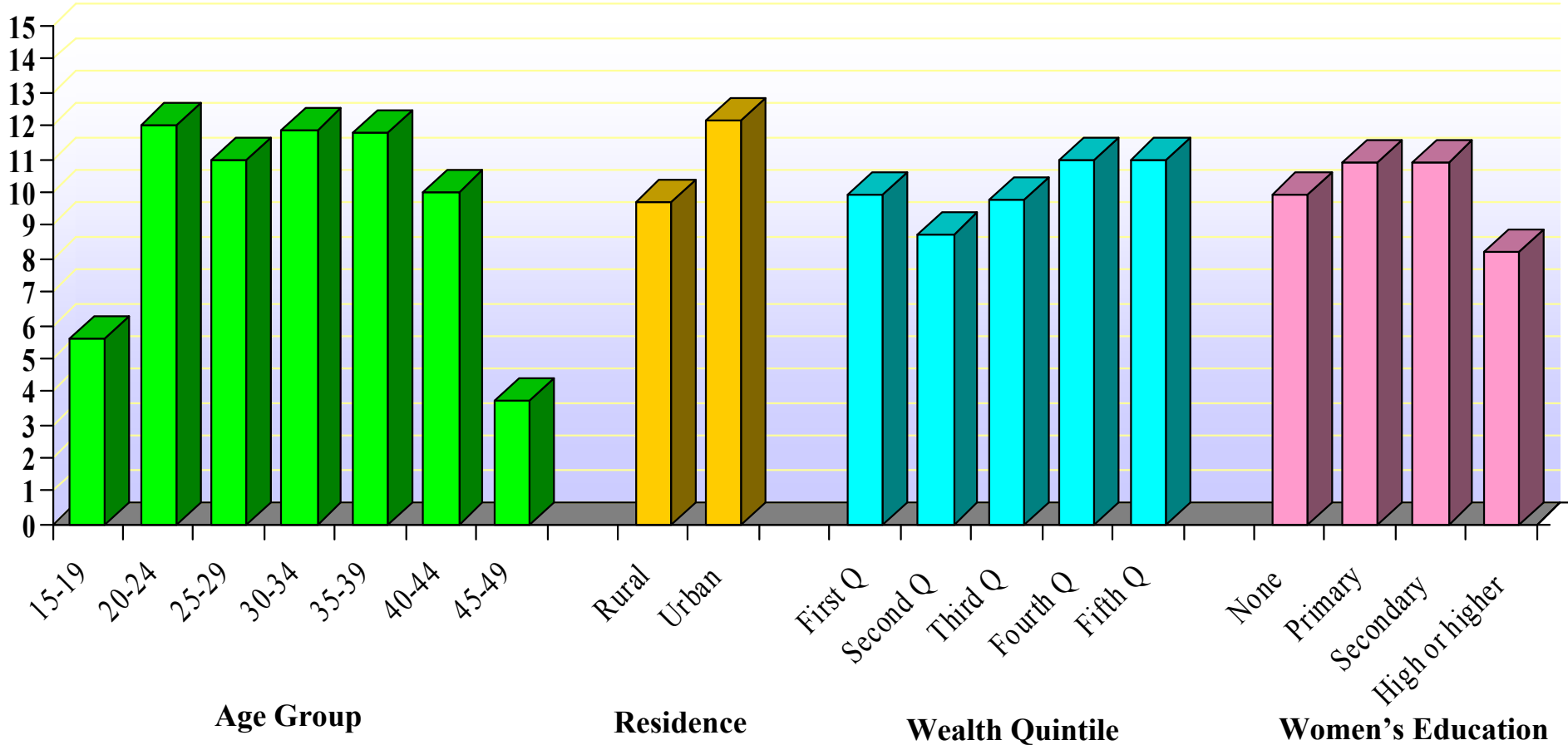
Prevalence of Depo among Currently Married Women (15-49), by Selected Characteristics, NDHS 2006



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One-year Discontinuation Rate, Currently Married Women (15-49), Nepal, NDHS 2006

Method	Rate (%)
Pill	64.0
Injectables	41.9
Condom	73.4

Key questions we may ask

- **What factors led to the rapid increase in Depo use over the years in Nepal?**
- **What has been the experience in Nepal?**
- **What have been the lessons learnt?**

Roles of demand and supply

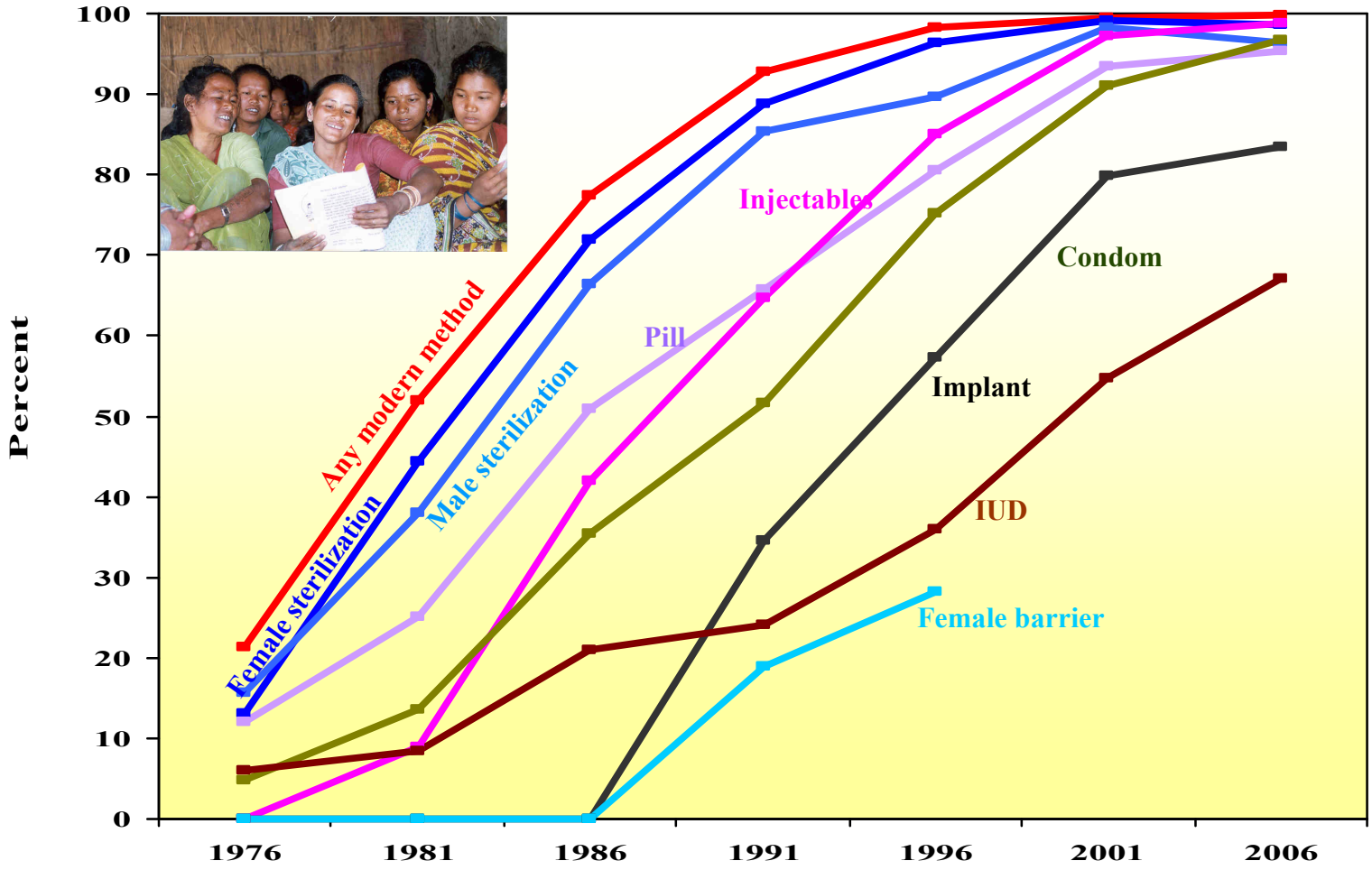
Demand – Gradual, sustained improvement in awareness; increasing preference for injectable contraception

Supply – Strengthening of the supply side of service delivery

Not either / or – both sides have been critical.

This presentation, however, focuses on the supply- side issues.

Women's (15-49) Awareness of Modern Contraceptive Methods, Nepal, 1976-2006



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Community-level Tier of the MoH Service Delivery System in Nepal

Sub-health Post

- N = 3,200
- Personnel (three persons each)
  - Auxiliary Health Worker (AHW) – 10th grade education, 15-month AHW training -- 1 week of COFP training
  - Village Health Worker (VHW) – 8th grade education, 6-month VHW training -- 1 week of COFP training, 1 week of Depo training
  - Maternal and Child Health Worker (MCHW) – 8th grade education, 3-month MCHW training -- 1 week of COFP training, 1 week of Depo training

Health Post

- N = 700
- Personnel (5 - 7 persons each)
  - Health Assistant (HA) – 10th grade education, 3 years of HA training
  - Assistant Nurse Midwife (ANM) – 10th grade education, 18-month ANM training -- 1 week of COFP training
  - AHW (2)
  - VHW
  - Admin staff

Addressing supply-side challenges

Up until early 1990s, the two major factors limiting availability of, and accessibility to, the method were:

1. **Clinical examination was a prerequisite for administration and use of Depo.** This severely restricted who could provide and where it could be provided. Thus, a vast majority of especially rural communities without any clinical facility was excluded.

2. **Public sector was the sole mechanism through which services could be provided.** Market segmentation was absent; one-size-fits-all approach was followed.

Addressing supply-side challenges *(cont'd)*

- **Pilot programs** were initiated in the mid-90s to see if Village Health Workers (VHWs) -- who had at least eighth-grade education and 3-month basic training in public health care, and who spent a large part of their time in respective communities -- could be trained to provide counseling and related services for use of Depo

- **Studies** were conducted to evaluate outcomes and to determine the likely "worst-case scenario" if a checklist were to be used instead of the clinical examination.

- **WHO's *medical eligibility criteria*** was just-in-time for this declinicalization effort.

Addressing supply-side challenges *(cont'd)*

- **Pilot programs and studies demonstrated that:**

  (a) VHWs could safely provide DMPA at the community level, using a simple checklist of questions; and

  (b) clinical examination, required previously by the national program, need *not* be a prerequisite for administration and use of DMPA in rural areas of Nepal.

- **Based on evidence from various pilot programs, MoH subsequently revised policy.**

- **In-service training was developed to train CHWs and MCHWs on Depo**

- **Today about 8,000 CHWs and MCHWs are the key providers of Depo to people living in respective catchment areas of Sub-health Posts, the bottom level of MoH healthcare service delivery system.**

- **What has been the impact of these particular innovations in expanding access to services?**

Sources of Contraceptive Methods Reported by Currently Married Women (15-49), NDHS 2006

Source	%	%
Public sector	81.4	
Hospital		8.8
Primary health center		4.5
Health Post		15.0
Sub-health Post		41.4
Outreach		10.3
Other		0.8
Mobile clinic		0
FCHV		0.6
NGOs	4.4	
Private medical	12.8	
Hospital / clinic		5.8
Pharmacy		7.8
Other / missing	1.3	
All	100	

And, the use of Depo will likely keep increasing in future …

Intention to Use a Method in the Future

(Currently married women, 15-49, who are not using but intend to use a method in the future, NDHS 2006)

Method	%
F sterilization	28.2
M sterilization	8.6
Pill	8.1
IUD	1.1
Injectables	30.8
Implants	2.9
Other	3.0
Unsure of a method	15.9
All	100

Addressing supply-side challenges *(cont'd)*

Depo and other contraceptive services through private and commercial sectors

1995 — Private providers network to improve quality and access (Family Health Services Network [PSSN])

- **Physicians pay to join and be part of PSSN**
  - **training**
  - **access to contraceptive supplies (CRS)**
  - **equipment loans**
  - **supervision / monitoring; continuing education**
  - **marketing, logo, prestige**
  - **membership growth *(35 to 138 within a few years)***
- **Expansion**
  - **members to include nurses and paramedics**
  - **additional services — e.g., child health, STIs, antenatal care, infertility services**

Addressing supply-side challenges *(cont'd)*

- Pharmacy Network for SANGINI® [Depo-Provera®] through social marketing programs
- **1994 – Pharmacy Network to improve access to Depo-Provera®**
- **Pharmacies join**
  - **Nurses / paramedics trained in screening, counseling providing Depo**
  - **Linkage to PSSN for other methods or management of side effects**
  - **Marketing, logo, status**
  - **Network growth – outlets – up from 42 to 776; increase in clients served**
- **Approx. 3,000 pharmacies -- in 50 of 75 districts -- currently in SANGINI® network**
- **By 2006 (NDHS), nationally, about 10% of Depo users obtained it from pharmacy; the market share in urban areas was many folds higher.**

Addressing supply-side challenges *(cont'd)*

The result of the two innovations introduced in the mid-90s was:

- **Expansion of accessibility of Depo for people living in rural communities -- thus meeting the increasing demand for services**
- **Expanded access to services through social marketing program by engaging private and commercial sectors that included doctors, nurses, paramedics, and drug shops / pharmacies**

Critical Inputs to the Expansion of Access

- **Defining the Standards for Service Delivery**
  – *Nepal Medical Standard (Family Planning)*

- **Developing Comprehensive Family Planning Counseling**

  Both were developed by a consortium of stakeholders under coordination of MoH

- **Clearly defined roles and responsibilities for MoH and other entities in expanding access to Depo. Role of the District Health Office defined for monitoring of stockouts and quality of services, safety, disposal of syringes**

Critical Inputs to the Expansion of Access *(cont'd)*

- **MoH policy change –** where Depo was available and who could provide service
- **Establishment of well-functioning *Quality Assurance Team* within MoH under public-private partnership**
- **Strengthening of Logistics Management System to ensure regular supply of commodities at all levels of service delivery and to the social marketing program**
- **Regular monitoring and periodic evaluation of activities with assistance from private sector**
- **Training to paramedics in drugshops, clinics; certification, accreditation**
- **Availability of financial resources and technical inputs**

Lessons Learnt

- **Reaching the *threshold* level of demand for services, through awareness and education, is a long process. Once it is reached, momentum is rapidly gained and sustained.**
- **MoH needs to be proactive / visionary in program development and policy changes. It is critical for MoH to be both strategic and catalytic. Much of what happens, and / or does not, depends on its leadership role in coordination, mobilization, and translating knowledge into action in a timely, effective and appropriate manner.**
- **Expanding new modalities of access to services needs to be systematic and comprehensive and supported by commitment of financial resources and technical inputs.**

In Conclusion

- **Expanding access to Depo services beyond the clinic walls has been critical in meeting the increasing demand for it in Nepal.**

- **With proper training provided and standards of services defined, paramedical workers have been the key agents for providing Depo services in safe, acceptable and effective ways in both urban and rural communities in Nepal.**

  Indeed, by 2006, both in the public sector and the private sector, 50% of current users of Depo were obtaining it from places where paramedical workers were providing service.

- **MoH has a critical leadership role in being strategic and catalytic in service delivery innovations, setting of standards, and ensuring that standards are implemented and sustained.**

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