Providers' perspectives on delivering postpartum FP services in Nepal

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Health service providers in Nepal appeared to be highly motivated to deliver quality postpartum family planning (PPFP) and transfer their knowledge to colleagues, but lack of adequate human resources, work overload, irregular and insufficient supply of family planning (FP) commodities and IEC materials, lack of support from hospital leadership were the key barriers to the provision of high quality FP services and transfer of knowledge and skills.

BACKGROUND

Most Nepali women interact with the health system only during pregnancy, for delivery, or for immunizing their children. Providing family planning (FP) services during immunization visits is often difficult since immunizations are primarily done by dedicated health workers who are not trained in FP service delivery. In contrast, antenatal checks and deliveries are largely conducted by obstetricians, nurses, or auxiliary nurse midwives (ANMs). Given their background and conditional on receiving FP-related training, these healthcare providers are better suited to deliver FP services to women without adding the burden of recruiting new staff on the Nepali health system. The provision of FP services in the immediate postpartum period allows women to conveniently meet their fertility goals as they do not have to make costly trips to health facilities at a later date.

Nepali government has focused its efforts on increasing the availability of long-acting FP methods and FP counseling services. Despite this, IUD use in Nepal remains very low: only 1.4% of currently married women in Nepal were using an IUD in 2016.

There are many reasons for the low uptake of IUDs in Nepal. First, unlike temporary FP methods which are available at most health posts, primary health care outreach clinics, or pharmacies, long acting reversible contraceptives (LARCs), such as IUDs, are only available at healthcare facilities that have obstetricians and gynecologists, or nurses, or ANMs who are trained in providing such FP methods.

The effect of limited availability of LARCs on IUD uptake is compounded by the various geographical and financial barriers Nepali women face in accessing the health system. Additionally, medico-legal restrictions, fear of side-effects, poor perception of pregnancy risk, and socio-cultural factors such as lacking decision-making power due to lower status of women, pressure to give birth to at least one son, pressure to give birth soon after marriage, and stigma attached to pre-marital sex all affect the uptake of family planning in general and LARCs in particular.

In Nepal, providers' views on PPFP and immediate postpartum IUDs (PPIUDs) in particular are seldom documented because of which the role of providers in uptake of these contraceptive methods is unclear. The degree to which women are involved in choosing a particular method may differ by type of provider as well as by the nature of the provider-client interaction.

OBJECTIVES

This study seeks to explore the perceptions and experiences of service providers in Nepal with regard to PPIUDs.

The study also seeks to understand trained providers' attitudes in sharing and diffusing their knowledge and skills about PPIUDs to other service providers who have not received specific training on PPFP or PPIUD counselling and insertion.

METHODOLOGY

Intervention details

This study is part of a broader trial studying the impact of an International Federation of Gynaecology and Obstetrics (FIGO) led intervention to institutionalize PPIUD training and provision as part of antenatal and delivery services in six public tertiary hospitals in Nepal.

Hospitals were selected based on geographical location and high volume of obstetric cases (between 6,000 and 11,000 a year). They were pair-randomized into two groups of three based on geographical location and annual obstetric caseload. Group 1 hospitals implemented the intervention after three complete months of baseline data collection while Group 2 hospitals implemented it after nine complete months of baseline data collection. The intervention was implemented by the Nepal Society of Obstetricians and Gynaecologists (NESOG).

In-depth interviews

We purposively selected 14 service providers (7 obstetricians/gynaecologists, 5 nurses and 2 auxiliary nurse midwives) from across the six hospitals and conducted in-depth interviews with them after they received training on PPFP and PPIUD as part of the intervention.

In-depth interviews were conducted between December 2015 and October 2017, taking into account the stepped-wedge nature of the intervention roll out. Written informed consent was obtained from all participants before taking the interview. The interviews were audio-recorded, transcribed and translated into English. We adopted a themetic approach to analyse the data.

Ethical approval for this study was received from the Nepal Health Research Council.

KEY RESULTS

Service providers recognised the importance of providing postpartum contraception

Postpartum contraception services, especially PPIUD have been perceived as important by the service providers. Major reasons for this, as providers share, is long-term method of contraception and having fewer side effects such as not interfering with breastfeeding. They also felt it addresses the missed opportunity of providing FP service to women and this in turn, reduced unmet need for FP.

> *Overall I am very* positive *towards PPIUD. There is still high unmet need for family planning. Many women are likely to be missed because of family planning service are generally not provided in maternity ward.*
>
> - ID02, nurse, less than 5 years of work experience

Providers also acknowledged the importance of involving clients in the process of making recommendations about using PPIUDs. As a "client driven" approach to family planning, many providers, including doctors, nurses, and ANMs, suggested that they only make FP recommendations after talking with clients about their fertility goals and preferences.

Providers felt the content of the training intervention was comprehensive and well presented

Providers were satisfied with the training content and found the sessions to be comprehensive and well presented. Additionally, the focus of the training towards knowledge transfer was also duly acknowledged.

> *In previous training, we were only taught to give services but now in the training we were taught how to give service and also on how to train others and to bring into practice in other places as well. The main difference in this training is that we are able to transfer whatever knowledge and skills we have learned to other colleagues as well.*
>
> - ID 03, Nurse, 5-10 years of experience

Sessions on immediate PPIUD counselling, insertion, and management of complications were found to be especially useful by the participants. They also found dummy demonstration models (MAMA-U) particularly helpful for practicing PPIUD insertions.

On the other hand, they also suggested areas of improvement such as increasing the duration of the training and providing enough time to practice PPIUD insertions.

Providers were confident in providing PPFP services

Almost all providers (13 out of 14) were confident in providing PPFP services including PPIUD insertion, complication management, and removal. They were also well prepared to respond to queries and concerns of service seekers regarding PPIUD.

However, despite receiving training, some nurses and ANMs shared that they require additional support from their senior colleagues on managing PPIUD-related complications. Likewise, they also realised the need for refresher trainings to be updated alongside having more human resources to provide PPIUD services.

> *If there is any complication while inserting IUD, I need to inform our doctors. Only after informing the doctors, we try to manage complications. We are not fully confident in managing complications…*
>
> - ID 03, Nurse, 5-10 years of work experience

In terms of supply side, providers also highlighted some challenges of providing postpartum FP services such as insufficient IUD sets, lack of human resources and, high workload and lack of sufficient time for PPFP services such as counselling.

> *As we have other works, we are not being able to provide adequate time in counselling. If we don't have time and cannot provide counselling, then the patient will not be able to know about the availability of PPIUD service.*
>
> - ID 11, Nurse, 5-10 years of work experience

Providers provided many suggestions in increasing access to quality PPFP service delivery

In terms of having better access to quality PPFP services, providers suggested of having a dedicated counsellor and a private counselling space. Likewise, they also suggested for regular supply of IUDs and other equipment, and a greater involvement of concerned government departments to monitor the quality of services being offered at the health facilities.

> *The Family Health Division should do supervision and monitoring on a regular basis, the hospital should make this [PPIUD] service as a general regular service, all the necessary materials should be supplied on time to make the service better and sustainable.*
>
> - ID 05, Obstetrician/gynaecologist, over 10 years of work experience

Providers were willing to transfer their knowledge and skills to other providers

All providers were willing to transfer their knowledge and skills regarding PPFP and PPIUD to their colleagues in other facilities. Willingness was also shown in terms of extension of these services to the private sector. However, providers also identified important barriers to ensuring the proper transfer of PPFP knowledge and skills. They argued that there was of little support from heads of hospitals, and seniors staff members to ensure knowledge and skills transfer. Furthermore, supply-side barriers in other facilities also complicated the process for transferring knowledge to providers within and outside of their facilities.

> *….Yes, transferring knowledge and skills is definitely possible. There is no new thing to be added…….it can be done in the private facility. The service provider here also goes to private facility to provide service so there is not any difficulty in transferring skills to other providers.*
>
> - ID 04, Obstetrician/gynaecologist, 5-10 years of work experience

> *The transfer of knowledge and skills about PPIUD will depend on management of health facilities….If health facility considers PPIUD as important method like any other FP methods, then service delivery is possible. But, sometime private and government health centres may lack necessary manpower, materials, private hospitals may charge fee for service delivery, there may be less trained staffs, clients may show unwillingness to pay and get the service. If the health facility manages these issues, then I have no problem in providing service.*
>
> - ID 09 Obstetrician/gynaecologist, 5-10 years of work experience

DISCUSSION AND IMPLICATIONS

Overall, the study findings reveal that the providers view PPFP positively, find training useful in many ways, and are willing to transfer their skills and knowledge to colleagues across different types of facilities.

Despite the usefulness of the PPFP training, several factors were outlined by the providers such as

improving the quality of training content and PPFP service provision, and the process of transferring knowledge and skills.

Key barriers to providing high quality FP services included:

- Lack of dedicated FP counsellor and private counselling space in a facility
- Irregular and insufficient supply of IUDs and IEC materials
- Insufficient number of staff, high workload, and lack of support from hospital leadership

Integrating FP services into existing Nepali health system requires increasing existing human resources before scaling-up integrated postpartum contraceptive services.

Overall, providers considered providing postpartum contraceptive services a significant step for improving reproductive health services in Nepal. However, there are some systemic challenges such as the need for a dedicated counsellor for postpartum contraception. There is insufficient time during antenatal care (ANC) visits to cover postpartum contraception despite providers' willingness to do so.

Thus, integrating PPFP training, counselling, and insertion services into the Nepali healthcare system will require not just addressing supply-side challenges but also ensuring better ownership and coordination from health care management. This motivates health care providers not just for providing better services but also capacitates them through regular capacity building initiatives.

CONCLUSIONS

This study concludes that providers were highly motivated to provide quality family planning services and transfer their knowledge and skills; however, they also identified several facility and training related factors which prevent them from doing so.

Interventions aimed at addressing structural factors (such as increasing human resources for health and private space for counselling) and other supply-side factors (such as timely and regular supply of the required equipment, refresher training, and regular monitoring and support visits from concerned government departments) are needed to improve postpartum family planning services in Nepal.

Integrating postpartum family planning services into the healthcare system will also require ensuring better ownership from facility management and potentially training doctors, nurses, and auxiliary nurse midwives.

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SOURCES

Most of the results in the policy brief are from:
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