INTEGRATION OF FAMILY PLANNING IN THE EXPANDED PROGRAMME OF IMMUNISATION

BACKGROUND

Nepal has made significant progress with its family planning programme over the last thirty years. The Total fertility rate (TFR) has decreased from 6.3 in 1976 to 2.6 in 2011,[i] and the contraceptive prevalence rate (CPR) has increased from 2.9% to 43% within the same timeframe. Large reductions in the maternal mortality ratio in recent years have been partly attributed to improved family planning. The government has increased investment in family planning and developed a strong policy framework to meet the targets of a CPR of 67% by 2015 and a further slight reduction in the TFR to 2.5 by 2017.[ii]

However, despite these gains, the unmet need for family planning in Nepal is still high, with 25% of married women reporting unmet need in 2006 (9% = unmet need for birth spacing; 15% = unmet need for limiting births).[iii] In addition, large disparities exist in rates of contraceptive use, and levels of unmet need vary substantially by place of residence. Unmet need is highest among younger women (38% among 15-19 year olds and 33% among 20-24 year olds), mountain dwellers (30%), women from the hills (28%), rural women (25.5%) and women from the two lowest wealth quintiles.[iv] The unmet need for urban women is 19.8%. Among different social groups, Muslims have the highest unmet need at 37% followed by Hill Dalits at 34%.[v] In contrast, the total level of demand for contraception, which encompasses both current use and unmet need, varies little by women's background characteristics.[vi]

SERVICE INTEGRATION – THE FUTURE OF FAMILY PLANNING DELIVERY?

Many large-scale family planning programmes in developing countries were originally organised around vertical structures with central management and logistics.[vii] More recently however, there has been an increasing emphasis on integrating family planning programmes into other health services.[viiiix] The potential benefits of integration include generating cost efficiencies, higher coverage rates and an improved continuum of care allowing for a more patient-centred approach within the health system.

In particular, immunisation programmes have been presented as an attractive candidate for integration with family planning programmes, as they offer an opportunity to strengthen family planning services for postpartum women, who have high levels of unmet need for family planning and a poor understanding of the return to fertility following delivery.[x] In addition, the integration of family planning and immunisation programmes has been identified as potentially beneficial for a number of practical reasons:

- The Expanded Program on Immunisation (EPI) is recognised as one of the most widely implemented and well-established health programmes in the world. Linking the successful EPI delivery systems to family planning could potentially increase family planning coverage without substantially increasing cost.

- There are obvious similarities in the target populations of the two interventions.
- The delivery timetable for immunisation programmes would allow family planning messages and/or services to be delivered on multiple occasions at precisely the time when lactational amenorrhea ends, and fertility returns.[xi]

Although there has been some concern that integrating EPI programmes with other services could adversely affect EPI delivery and immunisation coverage, there is little available evidence of this, and it is an issue that would be monitored as part of the operational research. A recent systematic review of EPI integration found that in those trials where coverage rates have been monitored, no negative impact on immunisation coverage was detected.[xii] Indeed, the 2006-2010 WHO Global Immunisation Vision and Strategy actively encourages the integration of immunisation services with other health interventions as a key strategic area.[xiii]

A recent systematic review of literature on the integration of immunisation services by Wallace et al identified overburdened staff, unequal resource allocation and logistical difficulties as the risks of integration.[xiv] However, Wallace et al specify that the challenges to integration are not unique to integrated health service delivery, but are rather the challenges any health intervention faces (logistics, data management, balancing staff workloads, etc.). The review concludes that when additional interventions are carefully selected for compatibility and when they receive adequate support, coverage of these interventions may improve – provided that immunisation coverage is already high.[xv]

Some success has been achieved to date in EPI/family planning integration trials. For example, the introduction of family planning messages into EPI services in Togo was tested in 1994, and found to be associated with an 18% increase in awareness of available family planning services, and a 54% increase in the average number of new family planning acceptors per month.[xvi] Positive results are not assured, however, and trials in Zambia and Ghana have been less successful due to failure to implement as designed.[xvii] Insufficient evidence of impact exists to date, and a growing body of evidence suggests that various contextual factors and the method of implementation can substantially impact on the success of service integration and on utilisation rates.[xviii]

THE CASE FOR INTEGRATION IN NEPAL

In addition to more general arguments in favour of the integration of family planning services, Nepal's unique geographical profile adds to the case for integration. By combining EPI and family planning services, women in remote rural settings could be spared the inconvenience of travelling long distances over difficult terrains on multiple occasions to access separate services. Furthermore, EPI clinics along with Antenatal Care (ANC) represent the few occasions where women are in contact with the health services. In light of this, Nepal's family planning services have been integrated with maternal and child health services since the third Five-Year Plan (1965-70). At the community level, some family planning services, notably contraceptive pills and condoms, are delivered by Female Community Health Volunteers (FCHVs) as part of their wider set of Maternal and Child Health (MCH) responsibilities. Greater integration of family planning is increasingly recognised as a key strategy for improving reproductive health in Nepal. The draft report to UNFPA on the status of Family Planning

and Reproductive Health in Nepal identifies "increased integration of family planning services into other areas" as a key recommendation,[xix] and NHSP-2 itself states that "all available routes will be used to integrate family planning services with other Ministry Services".[xx] In response to this call for integration, the draft Family Planning Services Policy in Nepal (2011) specifies that "Family planning services will be offered through the immunisation clinic, Ayurvedic Aushadhalaya, nutrition clinic or Voluntary Counselling Testing centres".

Furthermore, immunisation coverage in Nepal is high, with 87% of children between 12-23 months fully immunised,[xxi] exceeding a national coverage target of 85% and making EPI a good candidate for integration. Integration of family planning service in EPI clinics was also stated as a need by district stakeholders including service users.

NHSSP RESPONSE: PILOTING EPI/FAMILY PLANNING INTEGRATION

FHD/CHD, with the support of NHSSP, is working to implement a trial of the integration of family planning messages and services with immunisation services (EPI outreach clinics) in a remote area of Western Nepal (Kalikot), where geographical accessibility is a frequent issue for service users.

This Operational Research study will assess the success of the initiative in terms of increased utilisation of family planning, lack of adverse effects on immunisation levels, and increased ease of access to family planning services. It will also monitor and assess the workload of health workers, resource allocation at local level and the availability of commodities. The work will both account for supply-side factors such as resourcing, planning and implementation, and also investigate demand-side issues of access and social exclusion. In addition, it will provide evidence regarding measures to address gender and caste/ethnicity based constraints.

This intervention will be designed together with EPI and FP service providers, health facility in-charges, district managers and central level staff to overcome the challenges. Baseline data will be collected at the beginning of the study and continuous monitoring on the utilisation of services and the challenges faced by health workers will inform the DHO on improvements in service delivery. The evaluation findings will be used to inform recommendations for any further scaling-up of integration in Nepal.

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