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Integrating Family Planning into the Expanded Programme on Immunisation (EPI) Services

Operations Research Report

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Strengthening Health Systems-Improving Services

EXECUTIVE SUMMARY

A. Introduction

The Family Health Division of Nepal's Ministry of Health and Population (MoHP) recognises the importance of strengthening the provision of family planning and counselling for healthy timing and spacing of births, particularly for women during the first year after child birth. WHO recommends a two year interval between births as a means to reduce the risk of adverse maternal and child health outcomes (WHO 2005). Yet in Nepal, one fifth of births occur within that two year period and 50% within less than 35 months (DHS 2011). Only 9% of women who had a live birth in the past 5 years recall being counselled on family planning during postpartum check-up (DHS 2011).

This piece of operational research responds directly to the huge unmet need and demand in Nepal for family planning information and services by integrating family planning services into Expanded Programme on Immunization (EPI) clinics in one district. It investigates whether the integrated service can increase uptake of family planning services among women in the district, particularly among new users, without negatively impacting on the delivery of the (highly successful) core EPI service.

The Family Health Division (FHD) led the operational research in coordination with Child Health Division (CHD). The research was designed and implemented with technical support from the Nepal Health Sector Support Programme (NHSSP) with monitoring support from the Health Research and Social Development Forum (HERD).

The research began in July 2012 and was monitored and evaluated using the following methods:

1. On-going monitoring of intervention sites — Focused monitoring was conducted in 20 selected health facilities and routine monitoring data was collected from EPI registers at all the sites. Supplementary data was collected from the HMIS.
2. A rapid process evaluation — This evaluation used a blend of quantitative and qualitative methods including semi-structured questionnaires and discussion guidelines.

B. Key Findings

1. The model successfully increased access to family planning:

- During the 12 months of implementation in the integrated clinics in Kalikot district, the registration data showed that 1539 clients received family planning from these clinics, which is more than the number of family planning users from primary health care outreach clinics in the previous 12 months in the district.
- Thirty-two percent of women attending the integrated clinics reported using a family planning method with 56% of them having received the method from the integrated clinics. The model has successfully increased access to family planning information and counselling for the women who attended EPI services.
- Two-thirds of the women attending the integrated service accessed the group health education provided at the clinics. The research found that some clients feared the side effects of family planning and did not have accurate information on some family planning issues.
- The women who participated in the group education strongly appreciated it.

2. Group information is critical to the success of the integrated model especially as many women who access EPI services are unaware that they are at risk of getting pregnant:

- More than half of the women interviewed did not realise that they were at risk of pregnancy if they gave children supplementary food — nearly 60% gave 'irregular menses' as a reason for not using family planning.
- The women who did not recognise they were at risk of pregnancy are unlikely to be seeking family planning information or counselling or services from any other source. Group education is an opportunity to provide family planning information to women who are vulnerable to unplanned pregnancies.

3. The integrated service did not affect the uptake of EPI:

- EPI performance did not suffer as a result of the integrated family planning/EPI service, with performance remaining in line with or above the previous year's performance for the duration of the research.
- The women clients reported that integration had no negative impact on their experiences of the service. In fact they reported a better experience of immunisation services.

4. The integrated service did not affect family planning performance at Primary Health Care Outreach Services (PHC/ORCs):

- Family planning uptake at primary health care outreach clinics (PHC/ORCs) in Kalikot increased during the period of operational research implementation relative to the previous year performance. This suggests no negative impact on uptake at PHC ORCs as a result of FP integration into EPI services.

5. Women liked accessing family planning at the EPI clinics:

- The women clients reported that they liked the ability to access family planning and EPI at the same place.
- The EPI clinics were seen as convenient places to go for family planning services, although no clients reported that they would attend the clinic for family planning alone.

6. Depo Provera was a particularly popular choice for the women who attended the integrated FP/EPI clinics:

- Ensuring the availability of Depo Provera must be a priority as this is the method chosen by most women and is not available through FCHVs. If shortages of Depo are experienced by women, there are risks to the reputation of the service.
- Over half of women reported that they particularly like Depo Provera because it stops menstruation.

7. Underserved groups are using the service:

- Twenty-six percent of family planning users were Dalit, who represent 24% of Kalikot's population. This suggests that this group is not marginalised from the service —rather that integration increased their access to family planning services.

8. Important human resource characteristics of integrated FP/EPI services with a high family planning uptake and good service provision were:

- more than one health worker staffing the clinic;
- there being at least one female member staffing the clinic (to encourage women to adopt and use family planning methods); and
- all staff having received training on this approach.

C. Recommendations

1. Scale up the provision of integrated EPI/family planning services in remote mountain and hill districts where the contraceptive prevalence rate (CPR) is low.
2. Develop and test a model to integrate family planning services in EPI clinics in Terai districts.
3. Develop the skills of health personnel to strengthen the group health education component of the integrated EPI/family planning model.
4. Mobilise and enable health workers to provide quality integrated services by carrying out human resource mapping prior to implementing integrated services, orientating staff on this initiatives and awarding multi-year contracts to contracted staff.
5. Create a supportive environment for delivering integrated EPI/family planning services.
6. Review infrastructure requirements for the integrated EPI/family planning service and use community networks to improve accommodation for outreach services.
7. Ensure reliable and adequate levels of contraceptive supplies for EPI/family planning clinics.
8. Strengthen routine reporting and monitoring on the services provided at integrated clinics through practical training and constructive feedback.
9. Establish a strong referral service at the integrated clinics for required family planning services.
10. Undertake overall and targeted marketing of the integrated service to increase access for marginalised groups.
11. Strengthen PHC-ORCs to provide women who have adopted Depo at integrated clinics with a convenient means of getting subsequent supplies of this means of contraception.

CONTENTS

ACRONYMS

AHW	auxiliary health worker
ANC	ante natal care
ANM	auxiliary nurse midwife
BS	Bikram Sambat (Nepali Calendar)
BCG	Bacillus Calmet Guerin
CHD	Child Health Division
CPR	contraceptive prevalence rate
DPT	diphtheria, pertussis, tetanus
DHO	district health office
EPI	Expanded Programme on Immunisation
FCHV	female community health volunteer
FGD	focus group discussion
FHD	Family Health Division
FP	family planning
GoN	Government of Nepal
HERD	Health Research and Social Development Forum
HFOMC	health facility operation and management committee
HMIS	Health Management Information System
HTSP	healthy timing and spacing of pregnancy
HF	health facility
HP	health post
HWs	health workers
IUCD	intra uterine contraceptive device
LAM	lactation amenorrhea method
MCHW	maternal child health worker
MDG	Millennium Development Goal
M&E	monitoring and evaluation
MNCH	maternal, neonatal and child health
MoHP	Ministry of Health and Population
NDHS	Nepal Demographic Health Survey
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
PHC	primary health care
PHCC	primary health care centre
PHC/ORC	primary health care/outreach clinic
PNC	post natal care
SBA	skilled birth attendant
SHP	sub health post
SII	semi structured interview
SWAP	sector wide approach
UNICEF	United Nations Children Fund
VDC	village development committee
VHW	village health worker

1 RATIONALE FOR INTEGRATING EPI AND FAMILY PLANNING SERVICE PROVISION

1.1 INTRODUCTION

Nepal has made significant progress with its family planning programme over the last thirty years. The total fertility rate has decreased from 6.3 per woman of child bearing age in 1976 to 2.6 in 2011 (MoHP et al 2011), and the contraceptive prevalence rate (CPR) has increased from 2.9% to 43% within the same period. Large reductions in the maternal mortality ratio in recent years have been partly attributed to improved family planning. The government has increased investments in family planning and developed a strong policy framework to meet targets of a CPR of 67% by 2015 and a further slight reduction in the total fertility rate to 2.5 by 2017 (CREHPA 2010).

Despite these gains, the unmet need for family planning in Nepal is still high with 27% of married women reporting unmet needs in 2011 (10% for birth spacing and 17% for birth limiting) (MoHP et al. 2007). In addition, large disparities exist in rates of contraceptive use and the levels of unmet need vary substantially by place of residence. Unmet need is highest among younger women (42% among 15-19 year olds and 37% among 20-24 year olds) and hill dwellers (30% compared to 24% among women from the mountains, 28% among rural women and 20 among urban) and also women from the lowest wealth quintile (MoHP 2007). Among different social groups, Muslims have the highest unmet need at 37% followed by Dalits at 31% (Bennett et al 2008).

1.2 THE PROBLEM

Short birth intervals are associated with the higher risk of death among new born, children and mothers (Paudel et al. 2013 and USAID 2009). A fifth of births in rural Nepal occur at less than a 24 month interval and 50% have less than a 35 month interval, with there being a higher proportion of unmet need and short birth intervals in remote areas.

The Government of Nepal, under the Family Health Division of the Ministry of Health and Population (MoHP), has emphasised the need to strengthen family planning counselling and services to postpartum women. The 2011 Nepal Demographic Health Survey (NDHS) found only 9% of women who had had a live birth in the five years preceding the survey had been given information or counselled on family planning during their postpartum period. Various studies have demonstrated a substantial unmet need and demand for family planning information and services at all stages of pregnancy, delivery and in the postpartum period.

1.3 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 (Levine et al. 2006). More recently however, there has been an increasing emphasis on integrating family planning programmes into other health services (Mulligan et al. 2010 and WHO 2010). 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 are an attractive candidate for integration with family planning programmes, as they offer an opportunity to strengthen family planning services for

postpartum women with high levels of unmet need for family planning and a poor understanding of the return to fertility following delivery (Bordal et al. 2010).

Other benefits include:

- The Expanded Program on Immunisation (EPI) is one of the most widely implemented and well-established health programmes in the world. In Nepal, almost all women visit EPI services between 1 and 5 times during the first year of life of each of their children. Linking 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 (LAM) ends, and fertility returns (FHI, 2010).

There is little evidence that integrating EPI with other services affects EPI delivery or immunisation coverage. 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 (Wallace et al. 2009). 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 (WHO 2005).

A systematic review of literature on the integration of immunisation services identified overburdened staff, unequal resource allocations and logistical difficulties as the risks of integration (Wallace et al. 2009). However, these are not unique to integrated health service delivery. The review concludes that when additional interventions are carefully selected for compatibility and receive adequate support, coverage of these interventions may improve – provided that immunisation coverage is already high (Wallace et al. 2009).

Some success has been achieved in EPI/family planning integration trials. For example, the introduction of family planning messages into EPI services in Togo in 1994 was 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 (Huntington and Aplogan 1994). However, trials in Zambia and Ghana have been less successful (FHI 2011). Insufficient evidence of impact exists to date, and there is a growing body of evidence that contextual factors and the method of implementation can substantially impact on the success of service integration and on utilisation rates (FHI, 2010).

1.4 THE CASE FOR INTEGRATION IN NEPAL

The need to integrate FP services in EPI clinics was proposed by district stakeholders during a district context specific planning workshop held in May 2011 which identified a substantial unmet need for family planning using modern methods in Kalikot district. Kalikot is one of the districts of the Karnali zone and is one of the most economically, socially and culturally challenged districts in Nepal. It covers an area of 1741 km^2 and has a population of 136,948, which is growing at a rate of 2.94% per year (2011 census) (CBS 2012).

In addition to these general arguments, 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 and cost of travelling long distances over difficult terrain on multiple occasions to access separate services. Nepal's family planning services have been integrated with maternal and child health (MCH) services since the Third Five Year Plan (1965-70) and at the community level, family planning services are delivered by female community health volunteers (FCHVs) as part of their wider MCH responsibilities. The draft report (2010) to UNFPA on the status of Family Planning and Reproductive Health in Nepal has '[the] increased integration of family planning services into other areas' as a key recommendation (CREHPA 2010), and the Implementation Plan of the Nepal Health Sector Programme-2 (NHSP-2) states that 'all available routes will be used to integrate family planning services with other Ministry Services' (MoHP 2010). Nepal's Family Planning Services Policy, which was drafted in 2011, specifies that "Family planning services will be offered through the immunisation clinic, ayurvedic dispensaries (aushadhalaya), nutrition clinic or Voluntary Counselling and Testing centres" (MoHP 2012).

Furthermore, immunisation coverage in Nepal is high with 87% of children between 12-23 months fully immunised (MoHP et al. 2011), making EPI a good candidate for this approach.

2 THE OPERATIONS RESEARCH PROJECT

2.1 AIM

The overarching aim of this operations research was to increase the uptake of family planning among women during the extended post-partum period (up to one year after child birth) through developing and implementing an integrated model of EPI/family planning service provision in Kalikot district, western Nepal.

2.2 FORMATIVE RESEARCH PROCESS

A formative investigation undertaken in early 2012 established that demand exists for an integrated service. It found that most women attended the health facility closest to their home, with only a few travelling more than two hours to meet their own health needs, such as family planning, rather than the needs of their children. Over 80% of women interviewed as part of the operational research design process stated that they would use a combined family planning/EPI outreach service if it was closer than a static clinic, and nearly three-quarters of the women identified an outreach clinic location as closer to their home than any health post or sub-health post. However, the study acknowledged that on the supply side, human resource issues could present the main challenge to providing quality EPI and primary health care (PHC) outreach services, particularly as not all cadres of health worker are entitled to field allowances for outreach work, which in itself is considered a low status activity. The report recommended engaging HFOMCs and district officials as 'drivers' to promote the integrated service and intensive training, supervision and monitoring so that health workers felt supported in delivery of the new service.

The development of the operations research model was led by the Family Health Division (FHD), which coordinated closely with colleagues from Child Health Division (CHD) and Kalikot district officials. The operational research was designed and implemented with technical support from NHSSP with monitoring support from the Health Research and Social Development Forum (HERD).

The operational research design workshop was held from 1-3 May 2012 in Manma, the Kalikot district headquarters. The aim of the workshop was to:

- engage district health office (DHO) officials and periphery level health service providers in the planning process and ensure ownership of the operational research intervention;
- understand service providers' perspectives on the proposed EPI–family planning integration model;
- field test the behaviour change communication (BCC) and information education communication (IEC) materials developed to support the programme; and
- undertake a detailed human resources mapping exercise, identifying any issues that might be encountered during implementation.

Participants included 20 periphery-level health service providers and district level supervisors including the District EPI Supervisor. The workshop was attended and facilitated by officials from FHD, CHD, the Regional Health Directorate (RHD), NHSSP and HERD.

2.3 THE INTEGRATED FAMILY PLANNING/EPI SERVICE DELIVERY MODEL

The integration of family planning/EPI was described as the following series of steps to guide health workers to deliver the combined service (also shown diagrammatically in Figure 1).

Step 1: Before the immunisation session begins, all EPI clinics will provide a **group health education session** on healthy timing and spacing of pregnancy (HTSP) using a four page flex chart specifically designed for this operational research. The objectives of this session were:

- to make women aware of HTSP, its advantages and disadvantages; and
- to provide information about the family planning methods available at the integrated service so they could make an informed choice about the family planning method most suited to their needs.

Step 2: After the group health education session, each participant (**mother) is asked informally during vaccination of her child whether she needs FP based on her child's age, and engaged in conversation about family planning and birth spacing.** She is also reminded once again to talk with health workers individually if they want to know more about family planning or to use some of the methods available.

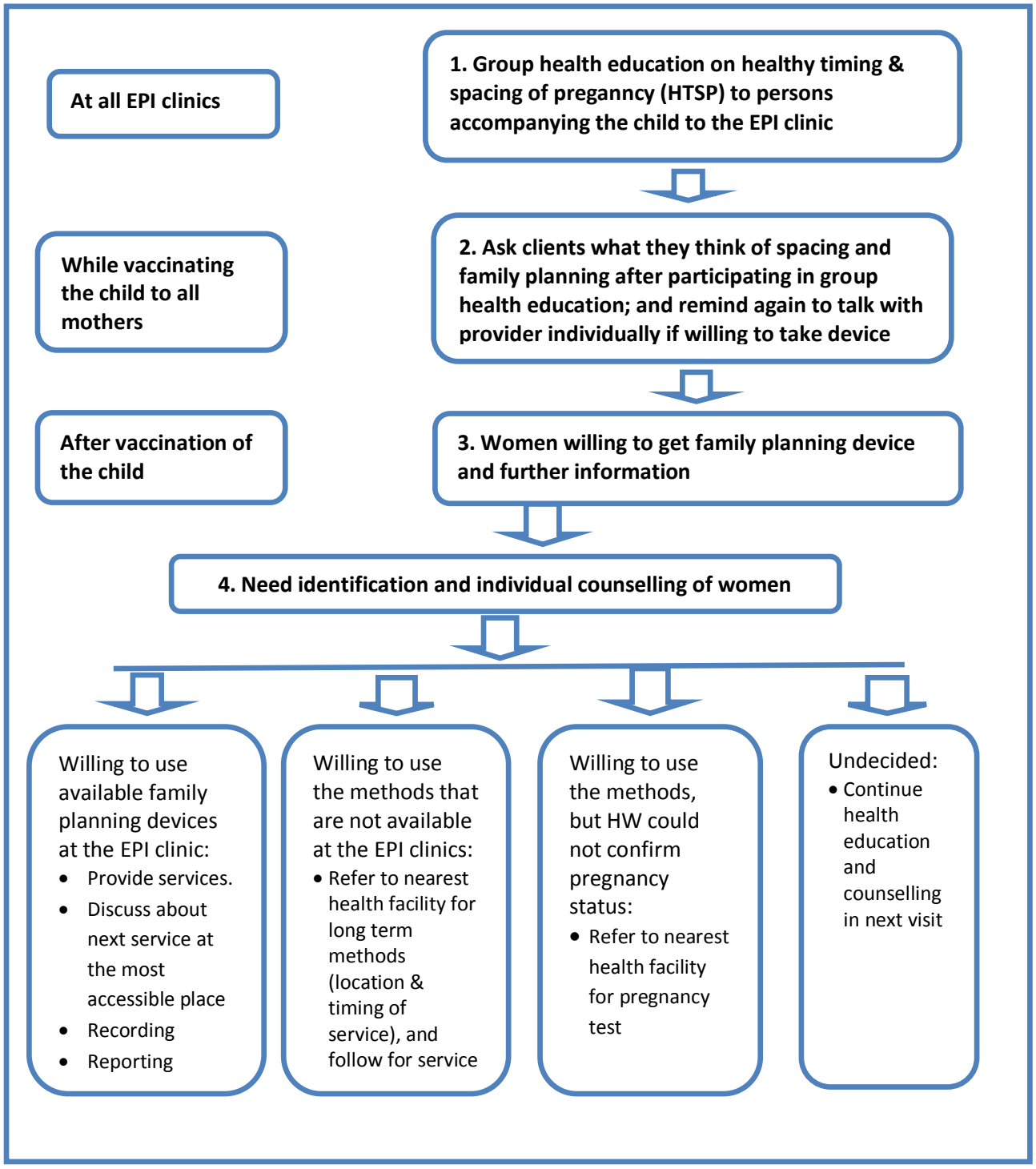
Step 3: If women are interested in using family planning, **further information and individual counselling** is to be provided using the 'need identification flowchart' and 'family planning flip chart' developed to support the integrated service.

Step 4: Based on the informed choice of mothers, **family planning methods including Depo Provera, pills and condoms will be provided to clients**.

Step 5: If women's pregnancy status is not confirmed, women will be referred to the nearest health facility for pregnancy testing and provided with a supply of condoms for fifteen days. At the same time, **women wanting long acting methods (Norplant, Copper-T, permanent sterilisation) will be referred to a nearby static clinic.**

Step 6: All the **family planning services provided will be recorded in a primary health care outreach clinic (PHC/ORC) register, provided to each health institution, revised for this OR**. Uptake of family planning methods will be recorded in the family planning service register and reported monthly in the HMIS.

Figure 1: EPI family planning Integrated Service Delivery model



2.4 IMPLEMENTATION OF THE OPERATIONAL RESEARCH

In June 2012, a two-day training event was organised for health service providers including EPI and FP service providers, health facility in-charges and district supervisors, and a one-day orientation for female community health volunteers (FCHVs) and a HFOMC representative from each health facility.

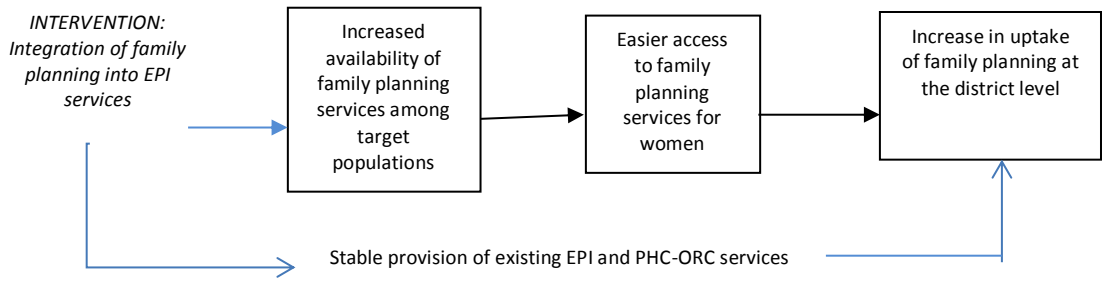
The one year intervention began in Shrawan 2069 BS (mid-July 2012) across 30 sites in Kalikot district. 20 sites were randomly selected and intensively monitored during the implementation period.

3 EVALUATION METHODOLOGY

3.1 THEORY OF CHANGE

The theory of change underlying this operational research is that the integration of family planning into EPI services will increase the availability of family planning services allowing women greater choice in where and when to access family planning. This greater choice will increase uptake among the population of women with under one child who attend EPI clinics for immunisation services and would face time and opportunity cost barriers to accessing family planning at PHC/ORCs or static health facilities. The operational research therefore assumes the increase in uptake will be among new family planning users rather than a shift in family planning users from PHC/ORCs or static clinics to the EPI. It also assumes the changes in provision will occur without any destabilising effect on the EPI clinic core immunisation function. Eventually the rise in family planning uptake should result in a reduction in unmet needs (although measurement of unmet need is beyond the scope of this operational research).

Figure 2: Theory of change: EPI–family planning integration



The following assumptions underlie the theory of change:

- There is demand for family planning in Kalikot district that is not being met through existing service delivery channels;
- Family planning provision at EPI services will increase and not substitute uptake from other health facility-based or outreach services (e.g. PHC/ORC, although this will be monitored as part of the operational research);
- Other barriers to accessing services will continue to affect whether women are able to make independent choices about accessing family planning. Increasing the number of family planning delivery points addresses only barriers related to geographic access and time-cost of a specific journey to access family planning;
- No other factors exist that hinder the availability of family planning services (stock-outs, health worker shortages, etc.);

3.2 MEASURING SUCCESS OF THE INTERVENTION

Indicators against which the effectiveness of the intervention were assessed are outlined in Table 1.

Table 1: Indicators to assess effectiveness of the integration of family planning services into EPI clinics

Effectiveness of the intervention	Indicators	Data Source
1. Increased availability of family planning services	• Increase in number of family planning service delivery points – EPI clinics	Observation family planning service register
2. Easier access to family planning services for women	• Clients reporting of choice and access for family planning services	EPI exit interviews Women exit interview EPI clients (women) survey Interviews with communities Interviews with HFOMCs Interviews with FCHVs
3. Increased uptake/utilisation of family planning services	• # women accessing FP at EPI services • # users by ethnicity/caste • # users by new user/existing user Variables affecting uptake: • Number of health workers providing EPI service • Sex of provider • Availability of accommodation for service	HMIS Family planning service register DDC for disaggregated population information Observation
4. Stable provision of EPI/family planning	• No. children immunised (BCG, DPT3, measles) • Health worker challenges with integrated EPI/family planning provision (qualitative)	EPI register FGDs with service providers
5.Stable provision of PHC-ORC	• No. clients using PHC/ORC • No. clients accessing family planning at PHC/ORC	EPI register PHC/ORC register HMIS

3.3 METHODS

The evaluation for this operational research is based upon:

- On-going monitoring of selected EPI/family planning integration sites; and
- a rapid process evaluation (at nine months of implementation/evaluation).

The findings of these two approaches are combined in this one report.

On-going monitoring of selected EPI/family planning integration sites — While the operational research was implemented in all functioning EPI clinics in Kalikot district, resources allowed for focused monitoring at only 20 of the 30 sites (and this report primarily presents findings from the 20 monitored sites). Three field monitoring officers received an intensive training on the operational research intervention model and recording and reporting tools. The primary role of the monitors was to observe the EPI clinics on scheduled clinic days and document their observations. They also conducted key informant interviews and collected routine service delivery statistics (related to EPI, family planning and PHC-ORCs) from the health facilities. Focused monitoring enabled service provision information to be collected from 20 of the 30 sites, while utilisation data was available from registers at 28 of the sites. This was supplemented with data from HMIS.

Rapid process evaluation — A process evaluation was carried out from Baisakh 17 - 31, 2070 BS (30 April to 14 May 2013) to review the process of implementing family planning–EPI integration and potential for scalability. Specifically, it helped develop an understanding of:

1. lessons from implementation of the integrated family planning–EPI model;
2. aspects of integration which worked well and did not work well; and
3. contextual factors (issues faced, strategies developed) which affected implementation at district, health facility and community level.

The process evaluation used the qualitative and quantitative methods detailed in Annex 1.

Within the qualitative research design, key informant interviews (KIIs), observations, and focus group discussions (FGDs) were conducted with district stakeholders, health facility in-charges, service providers and clients.

One hundred women were interviewed using a semi-structured survey questionnaire. The women were selected from a range of monitored VDCs, using a systematic random sampling method.

Another 20 women who had visited the integrated EPI/family planning clinics during the first three months of implementation for immunisation of their children were purposively selected from sampled VDCs. These women were interviewed during their visits to immunisation clinics by exit interviews and were interviewed again during the evaluation at their homes. Furthermore, they were stratified into two groups: 10 women who had one child and 10 women who had two or more children. The sampling method is described in more detail at Annex 1.

A total of seven focus group discussions were conducted at various levels, two FGDs each (one with health facility in-charges and one with service providers) in three Ilaka[1] level health facilities and one in the district health office. Four facilities were selected from within the 20 monitored VDCs, and were chosen based on their performance in EPI/family planning integration, i.e. two that had a high uptake of family planning and two with a low uptake. The remaining two were randomly selected from unmonitored facilities. See Annex 2 for the researcher's focus group discussion and interview guides.

The process evaluation was limited as it covered only three of the eleven Ilakas where the integrated service was implemented; so the sample size was too small to generalise findings to the entire district.

3.4 DATA MANAGEMENT

Quantitative data were managed in the Census and Survey Processing System (CSPro) and analysed using SPSS v12. All data were manually edited, coded and cleaned to ensure consistency before the data entry.

The transcriptions of the FGDs were arranged, and themes identified and analysed accordingly.

Informed consent was taken from all study respondents.

[1] An ilaka is a group of adjoining VDCs that serve as an administrative unit

4 EFFECTIVENESS OF THE INTEGRATION OF FAMILY PLANNING SERVICES INTO EPI CLINICS

4.1 INCREASED AVAILABILITY OF FAMILY PLANNING SERVICES

4.1.1 Availability of family planning commodities

Tables 2 and 3 summarise the availability and delivery of family planning services at integrated FP/EPI clinics during the first three quarters of operational research implementation.

Table 2: Availability of family planning commodities in the clinics, by period of project implementation *(source: focused monitoring by HERD)*

Availability of family planning methods	1st Quarter		2nd Quarter		3rd Quarter	
	N=50		N=67		N=60	
	N	%	N	%	n	%
Condom	41	82	50	75	45	75.0
Pills	46	92	66	99	60	100.0
Depo Provera	44	88	66	99	60	100.0

**Percentage total may exceed 100 due to multiple responses*

Table3: Family planning service delivered through EPI clinic , by period of project implementation *(source: focused monitoring by HERD)*

	1st Quarter		2nd Quarter		3rd Quarter	
	N=50 clinics		N=67 clinics		N=60 clinics	
	N	%	n	%	n	%
Delivered any family planning services	46	92.0	49	73.0	54	90.0
Group health education related to proper spacing	42	84.0	44	66.0	52	86.7
Family planning counselling services	20	40.0	31	46.0	22	36.7
Family planning methods	31	62.0	30	45.0	21	35.0
Referral services	2	4.0	0	0.0	5	8.3

**Percentage total may exceed 100 due to multiple responses*

Table 2 shows that pills and Depo Provera were available at nearly all the integrated EPI/FP clinics that took place during quarter 2 and quarter 3. However condom availability reduced from 82% in quarter 1 to 75% in the final two quarters. The reasons for lack of condom supplies at 25% of EPI clinics and how these could be overcome requires more investigation, particularly as more of the EPI clinics that took place in quarter 3 were providing group health education (see below).

Table 3 indicates that availability of methods translated into delivery of family planning methods to clients at 62% of EPI clinics during quarter 1, reducing to 45% in quarter 2 and decreasing further to

only 35% of EPI clinics in quarter 3. This suggests that the momentum behind the project may have been waning by the end of the study period, although again this requires investigation.

While Depo injection was available most of the time during observation, there were supply issues related to this family planning method particularly in Kumalgaun Ilaka:

> *"We demanded 50 Depo Provera from the DHO but received only 25 Depo Provera and we have borrowed Depo Provera twice from the Kumalgaun PHCC and we also need to purchase Depo Provera from the medical shop." — SHP in-charge, Malkot*

This is an example of health service providers, with community support, taking the initiative to improve the availability of family planning methods for their clients. The in-charge at Kumalgaun Primary Health Care Centre (PHCC) was able to purchase Depo because the local health facility operation and management committee agreed that they could charge NPR 5 as an OPD registration fee for all clients except family planning clients, and this money was used to buy Depo from medical stores.

4.1.2 Availability of counselling and information

By the end of the third quarter of implementation, group health education sessions were taking place at the majority of EPI clinics (87%), despite a dip during quarter 2 when group education was undertaken at only two thirds of clinics.

Group education was undertaken prior to immunisation in over 80% of all clinics, providing a captive audience for family planning information before immunisations began. Interestingly, during quarter 3 the proportion of group health education sessions undertaken by FCHVs reduced (for clinics where data is available).

Overall, health facility in-charges suggested that this component of the integrated service was working well:

> *"Group health education is more effective because we provide all the details of birth spacing and family planning methods and women who are interested come to ask further."— Kumalgaun SHP.*

> *"Group health education is going well because the women discuss among each other and use family planning services learning from women using them." — Health facility in-charge, Rupsa.*

This suggests that group health education serves as a platform for women to discuss issues among themselves — a conversation they are likely to continue with their peers when they return to their villages.

However, observations by field monitors during their visits painted a more mixed picture. As suggested in Tables 2 and 3, group health education sessions were less regular in the clinics, while in some clinics group education had been provided but quality was poor and no IEC materials were used. Human resource shortages also restricted service provision as, despite plans that two workers would be available by the end of quarter 1, during quarter 2, 33% of EPI outreach services were still run by a single worker[2].

[2] Source – field worker observations

Some women may have missed the group health education if they had left the EPI clinic early or had arrived late. Many women had travelled to reach the clinic, so making women wait in order to gather enough women to undertake group education was not feasible:

> *"There is a problem of managing women in a group as they rush off to their work after immunisation" — Health facility in-charge, Kumalgaun.*

This was a prominent issue during the mid-term review workshop; however, in contrast, women indicated they were comfortable to attend group health education sessions and were pleased it was integrated into EPI clinics:

> *"I liked integrated EPI clinics because health workers explained in detail about possible side effects after their children's immunisation." — Woman client, Chhapre VDC*

> *"I liked this clinic because health workers are giving classes nowadays — before we used to just vaccinate our children" — Woman, Phukot VDC*

Inadequate infrastructure also hindered provision of both group health education and the individual counselling of women at integrated EPI clinics; and even when a building was available there were time constraints which prevented them from using it for long:

> *"There is no room for counselling and we usually conduct EPI clinics in school and we have to send the students out of the class and complete the immunisation within an hour" — Health facility in-charge, Kumalgaun*

Table 4 shows the proportion of women who had taken group education and individual counselling (based on a survey of 100 women who attended an EPI clinic).

Table 4: Proportion of women receiving FP services at integrated EPI, by type of service and type of counselling received *(source: EPI client survey)*

	n	%
All women interviewed	100	
Type of service available and Use		
Received group health education	64	64%
Attended referral services	22	22%
Currently use a family planning method	32	32%
Of those using family planning methods (n=32)		
Family planning method received from EPI clinic	18	56%
Family planning method received from health facility	11	34%
Family planning method purchased from a shop	3	9%
Counselling received (among those using family planning methods, n = 32)		
Advantages/disadvantages of methods	20	62.5%
Side effects	19	59.4%
Management of side effects	18	56.3%
All above counselling	18	56.3%
All above counselling – women who received FP from EPI clinics (n=18)	14	78%
All above counselling – women who received FP from other service sites (n=14)	4	29%

Table 4 shows that one-third of the women were still not attending the group education, which may reflect the time constraints they face, as suggested by the KII with health workers or non-availability of health education service at the EPI clinic they attended.

However, the interviews revealed that 78% of *family planning users* from EPI clinics (n=18) and 29% of family planning users from other service sites (n=4) received completed counselling.

Health workers reported time constraints and a lack of human resources as the challenges restricting time for individual counselling during EPI clinics:

> *"To be honest, it is not possible to talk individually in details about family planning in EPI clinics. No counselling is performed till date in Sipkhana. Health workers just enquire whether women understand the contents delivered during group health education or not. If women want any family planning methods, they provide the family planning methods." — Health in-charge, Sipkhana;*

> *"There are obvious differences in providing counselling services to clients in a health facility and in an EPI clinic. Health facilities have separate rooms for antenatal care (ANC) check-ups where nursing staff can provide counselling about family planning. In EPI clinics, health workers need to register the children, vaccinate them and conduct group health education sessions all at once. There will be a crowd, so there can be no proper counselling." — Health facility in-charge, Phukot.*

The level of knowledge of women at EPI clinics about child spacing was fairly good, although knowledge of when fertility returned was poor, with more than half of women interviewed not realising that non-exclusive breastfeeding could lead to fertility returning within 6 months even after attending group health education (table 5) (see data on the evaluation's findings on client's knowledge at Annex 4). This is an important finding because it tells us that a large number of women attending EPI services do not know they are at risk of pregnancy. These women would not have been seeking family planning services from other locations, so any demand among these women would have been newly created and had the potential to be met as a result of this operational research. Quality group education sessions were an opportunity for these women to realise that they are at risk, particularly through providing specific information about lactational amenorrhoea method during health education sessions.

Table 5: Women's views of time taken to conceive again after delivery *(source: EPI client women survey)*

	Participated in group education	
	Yes (n=64)	**No (n=36)**
Right answer	23.5%	11.2%
Wrong answer	59.5%	63.8%
Don't know	17.2%	25.0%
Total	100%	100%

4.2 EASIER ACCESS TO FAMILY PLANNING SERVICE DELIVERY POINTS FOR WOMEN

The majority of women attending the EPI services (87%) were aware of the EPI/FP integration programme. Two-thirds were aware because they were attending EPI services with a few hearing of the service from other community sources such as friends or FCHVs (16%), while the remainder had found out about the integrated service from health facility in-charges (17%). There were still 13% who were unaware that family planning services had become available at EPI clinics.

Of the women interviewed who were family planning method users, 56.3% had obtained family planning from an EPI clinic, 34% from a health facility and, interestingly, almost 10% still purchased family planning from medical shops even though family planning is available free at health facilities (Table 4). More exploration is required to find out whether the 56% of users were new users or had transferred from another service provider.

The EPI clinic was recognised as a convenient location for accessing family planning:

> *"I prefer this integrated EPI clinic as I can complete my child's immunisation as well as get family planning services for myself from the same clinic." — Woman, Kumalgaun VDC;*
>
> *"It is near to my home and saves me time. Otherwise I had to walk for an hour to reach the sub-health post." — Woman, Chhapre VDC;*
>
> *"I like the latest kind because I can get immunisation for my child and family planning for myself from the same place." — Woman, Kumalgaun VDC;*

Of the women who did not currently use family planning, for around a third of all the women interviewed, the primary reason for not using family planning was stated to be 'irregular menstruation period' i.e. their periods had not returned to normal since childbirth (Table 6). This was identified by 57% of women while 10% did not feel the need for family planning. It is important to note that these women are at a high risk of unplanned pregnancies. Only 10% of women identified Lactation Amenorrhea method (LAM) as a method.

Table 6: Reasons for not using family planning methods (EPI clients)

	N	%
Irregular menstruation period	39	57.4
Husband not at home or dead	13	19.1
Using LAM method	7	10.3
Did not feel necessary	7	10.3
Expecting birth of boy child	5	7.4
Not allowed by husband or other family members	1	1.5
Male health worker providing services	1	1.5
Total	**68**	**100.0**

These issues were explored further with health workers during FGDs. These groups said that women did not want to take decisions on their own as they wanted to discuss family planning choices with their husbands and family members; indeed that women did not have the decision-making power to choose whether to use contraceptives alone.

"Few women complained that their husbands were not sensitised about [i.e. not aware of the importance of] family planning services and methods." — SHP, Daha;

"The sex of the child also determines the stage where women use family planning methods. If they have a boy child then women tend to use family planning methods earlier than compared to when they have given birth to a girl." — SHP, Malkot;

"There is a rumour that Depo Provera leads to obesity." — SHP, Pakha.

Some health workers felt that some women hesitated to use contraceptives because they feared side effects including discontinuation of menstruation and fertility issues (although around half the women interviewed, and some other health workers, reported considering discontinuation of menstruation to be an advantage. Other factors identified by health workers, but not in interviews with women, include a prevailing preference for having a son which health workers felt was a strong factor affecting contraceptive use.

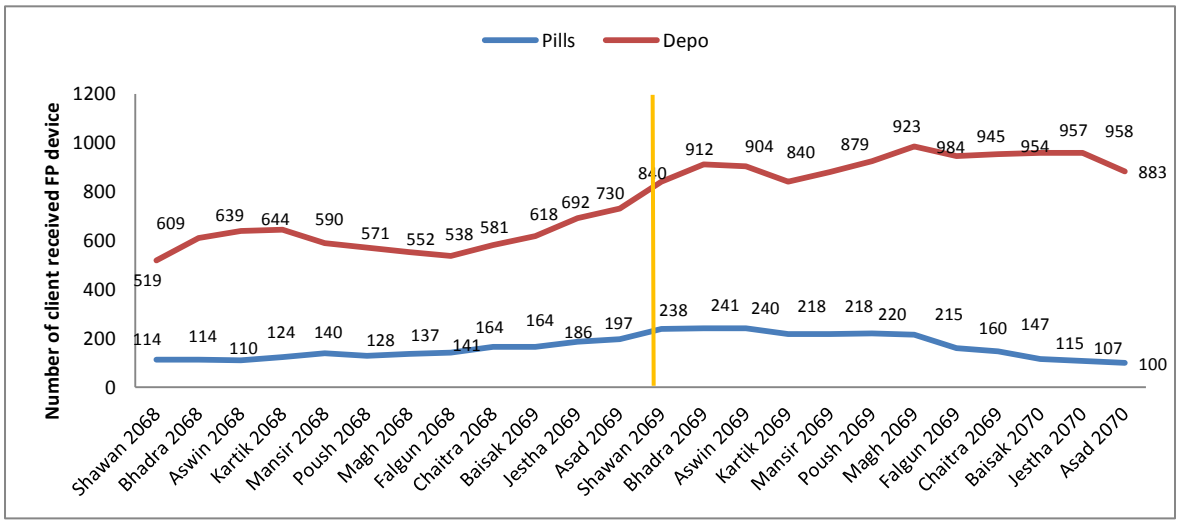
4.3 INCREASED UPTAKE/UTILISATION OF FAMILY PLANNING SERVICES

4.3.1 Increased uptake of family planning

Data about utilisation was available from health facility registers, EPI service statistics and also from the women's survey.

Figure 3 shows total use of family planning methods in Kalikot district during the period of the 9 month period of the operational research, including data from static clinics, PHC Outreach Services (PHC ORC) as well as the integrated FP/EPI service. The operational research began in Shrawan 2069 (mid-July 2012 — yellow vertical line on Figure 3), following a period of the rising use of pills and Depo across the district over the preceding year. The rising trend continued after the project began (Figure 3).

Figure 3: Trend in total family planning utilisation in Kalikot district pre- and post-operational research implementation – static clinics, PHC ORC and EPI clinics (Source: HMIS)

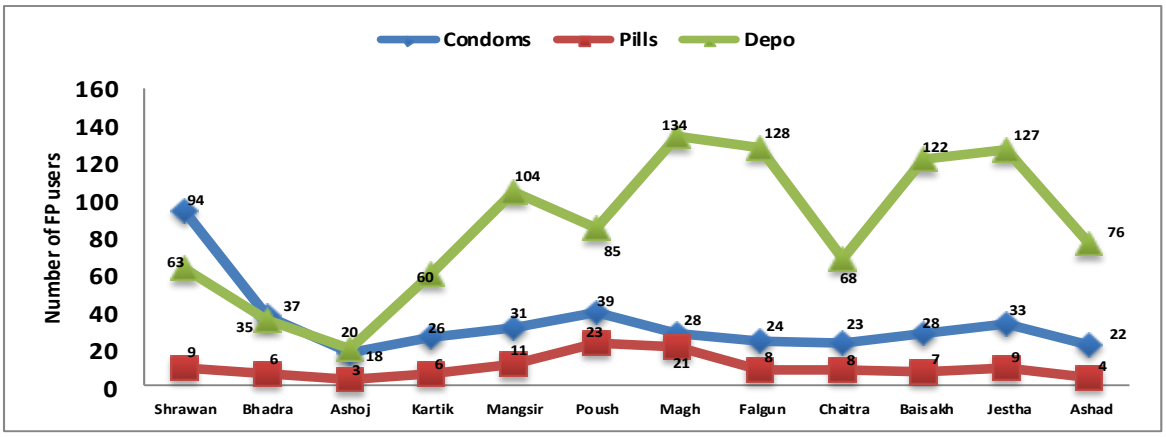


According to FP registers at EPI clinics, a total of 1539 women in Kalikot accessed FP services from integrated FP/EPI clinics during the 12 months of the operational research. Figure 4 shows monthly family planning method uptake at EPI clinics in Kalikot provided by 28 of the 30 VDCs in Kalikot (all of which participated in the project). (No data was available Pakha VDC and one VDC is not

implementing integration due to local problems). This data suggests a considerable contribution to increased uptake of Depo during the period of the operational research. There was no substantial difference in performance between the 20 sites receiving focused monitoring and the remaining health facilities.

Depo was also the most popular family planning method among EPI clinic users. The uptake of pills and condoms remained fairly stable throughout the 12 months of the project, while Depo use rose from month 4 onwards and fluctuated in line with immunisation.

Figure 4: Monthly family planning method uptake at EPI/family planning clinics



Women were only given one pack of pills at the EPI clinics and were told to access more from the FCHV in the village (so women who access pills at EPI would not be expected to return to EPI for supplies).

The exact number of women who attended EPI clinics during the 12 months of the OR is not available but an estimate of 3197 is based on the number of children who received BCG during the same period. The estimated use of FP methods among women who attended EPI clinics was 48% (1539 users/3197 women). Among women accessing FP at EPI services 58% were new users (Table 7).

Table 7: Family planning methods used by registration category (Source: family planning registers at Kalikot EPI clinics)

Registration category	Total		Condom		Pills		Depo	
	n	%	n	%	n	%	n	%
New client	891	57.9	336	83.2	77	67.0	479	46.9
Old client	460	29.9	34	8.4	25	21.7	401	39.3
No data	188	12.2	34	8.4	13	11.3	141	13.8
Total	**1539**	**100.0**	**404**	**100.0**	**115**	**100.0**	**1021**	**100.0**

Note: The total number of clients does not match in the table as one client received both condoms and Depo at the same time.

Table 8: Comparison of reported FP acceptance from FP/EPI registers and client survey (Source: FP registers at Kalikot EPI clinics and client survey data)

	Data from FP/EPI registers			
Registration category	**Condom**	**Pills**	**Depo**	**Total**
New client	336	77	479	891
% of estimated users of survey (n=3197)	11%	2%	15%	28%
	Data from client survey			
Registration category	**Condom**	**Pills**	**Depo**	**Total**
Accessing FP at EPI service*	4	0	14	18
% of women surveyed (n=100)	4%	0%	14%	18%

**assumed to be new users. 32 women in total reported using FP in the client survey but only 18 accessed FP at the integrated FP/EPI service.*

The majority of women accepting FP at EPI clinics chose Depo, followed by condoms and then pills. The total proportion of women accepting FP from the EPI service according to EPI registers is 28% which is considerably higher than the 18% reported by the client survey, however the difference is solely in reported acceptance of condoms. In both EPI registers and the client survey, around 14%-15% of EPI clients are reported as new users of depo from the integrated FP/EPI service.

If the FP/EPI registration data is assumed accurate, the 891 new clients would translate into a 3.3% rise in the CPR of Kalikot district if they continued to use family planning.

Among women interviewed, 93.5% of women asked the question, reported that EPI services are a convenient location to receive FP services.

In-charges also reported that there were more users of Depo than other methods. And this was not only for family planning purposes. It is interesting to note that a few women were using Depo to delay their menstruation because they wanted to avoid staying outside of their homes (in menstrual seclusion), especially during winter time.

> *"During menstruation, women [traditionally] need to stay outside of their home. A few women visit the health post to get Depo Provera to stop them menstruating so they will not have to stay outside their homes during the winter season." SHP, Malkot.*

Service data tells us that 22% of prospective family planning clients were referred on to other health services, mainly because their pregnancy status was unclear. These women may have decided to take family planning services from the health facilities where they had got the pregnancy tests done. In the FGDs, health service providers stated that the referral mechanism is weak and that referrals for long acting contraceptive methods are yet to be established as most health facilities in Kalikot were not providing long acting methods.

4.3.2 Reaching the most marginalised

Of the clients who received family planning methods around three-quarters were from the so-called upper castes (Brahmins and Chhetris) and a quarter were Dalits (ex-untouchables) (see Table 9 for a breakdown of this data by health facility at Annex 5). The proportion of Dalit users thus closely matched the actual proportion of Dalits in the district (Dalit proportion among population 24.1% and users 25.9%), suggesting that Dalits were not excluded from the service, even if delivery through EPI

was not targeting Dalits. The distribution of methods was similarly distributed between the caste groups, although Dalits were marginally more likely to accept condoms than upper caste clients. This is a good achievement considering that the immunisation coverage of hill Dalit children nationwide is 6 percentage points lower than the average national coverage and the CPR among hill Dalit women is 4 percentage points lower than rural Nepal in 2009 (The Nepal Family Health Programme's mini-DHS in 40 districts).

Table 9: Family planning uptake at Kalikot EPI clinics by method and social group

Caste group	Condom		Pill		Depo Provera		Total	
	n	%	N	%	n	%	N	%
Dalit	115	28.5	33	28.7	250	24.5	398	25.9
Disadvantaged Janajatis (ethnic groups)	1	0.2	1	0.9	2	0.2	4	0.3
Upper Caste	287	71.2	81	70.4	770	75.3	1137	73.9
Total	**403**	**100.0**	**115**	**100.0**	**1022**	**100.0**	**1539**	**100.0**

4.3.3 Factors affecting service provision

Some of the variables affecting the provision of family planning services are explored below. It would be interesting to cross-reference these factors against uptake; but data was not available for this analysis.

Availability of health workers — When two health workers are available, there is a slight increase in provision of two or more family planning services (including the delivery of family planning methods, group counselling, individual counselling) compared to clinics run by one health worker (37% vs. 30%) (Table 10). The provision of family planning services increased dramatically when three health workers were available, reaching 100%.

Table 10: Service utilisation as per number of health workers conducting EPI clinics

No. health workers conducting EPI clinics	% of EPI clinics reporting uptake of FP				Total	
	One family planning service		Two or more family planning services			
	n	%	n	%	N	%
One	49	70.0	21	30.0	70	100
Two	92	63.4	53	37.0	145	100
Three	0	0.0	2	100.0	2	100
Four	0	0.0	13	100.0	13	100
Total number of clients	**141**	**61.0**	**89**	**39.0**	**230**	**100**

Sources: Observation records and Kalikot EPI family planning registers

The human resource realities in Nepal, however, make it very unlikely that more than two providers would attend individual EPI clinics on a regular basis. And most of the Kalikot EPI clinics where three or more health workers were present were at the health facilities.

Two or more family planning services are more likely to be provided when a female health worker is present as women feel more at ease talking about family planning with another woman (Table 11).

The reasons for lower FP uptake when both male and female health workers were present are unclear.

Table 11: Family planning service utilisation at Kalikot EPIC clinics based on sex of health workers (Q1 and 2 data only)

Sex of service provider	One family planning service		Two or more family planning services		Total	
	n	%	n	%	N	%
Male	58	63.0	34	37.0	92	100.0
Female	7	50.0	7	50.0	14	100.0
Both male and female	76	61.3	48	38.7	124	100.0
Total number of clients	**141**	**61.0**	**89**	**39.0**	**230**	**100.0**

Sources: Observation record and Kalikot EPI family planning registers

The involvement of FCHVs at EPI clinics also had a positive effect on family planning service provision (Table 12). Only 27% of EPI clinics provided two or more family planning services when FCHVs were not involved compared to 73% having two or more family planning services when FCHVs were involved.

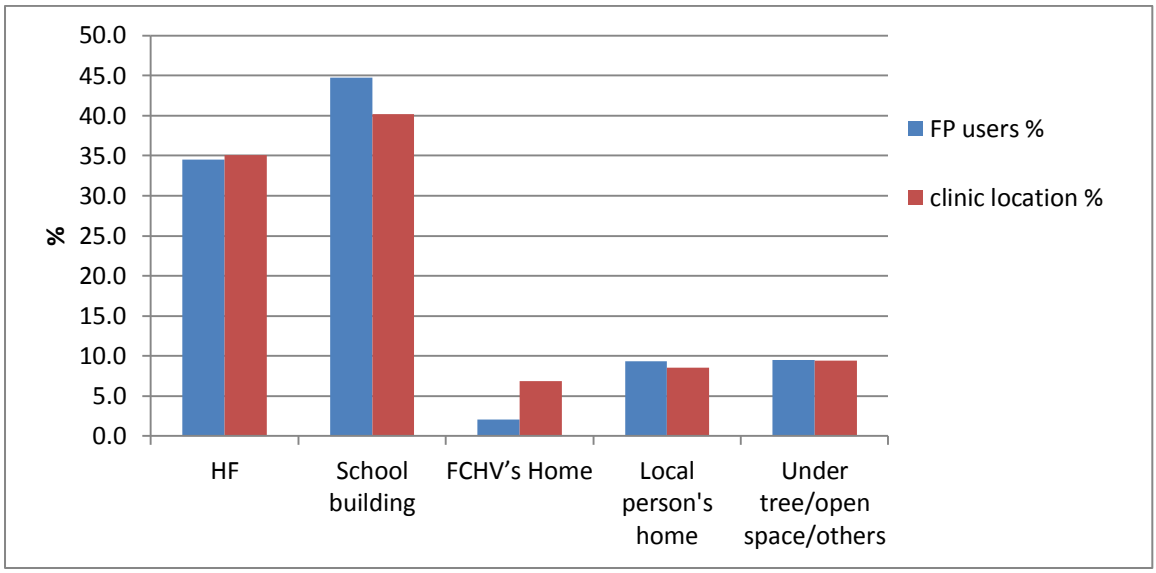
Table 12: Service utilisation based on the involvement of FCHVs in Kalikot EPI clinics (Q1 and 2 data)

FCHV involvement	Service performance				Total	
	One family planning service		Two or more family planning services			
	n	%	n	%	N	%
Involved	68	48.0	65	73.0	133	100.0
Not involved	73	52.0	24	27.0	97	100.0
Total	**141**	**100.0**	**89**	**100.0**	**230**	**100.0**

4.3.4 Factors affecting service uptake

Figure 5 shows the family planning methods uptake based on the locations/venues of EPI clinics. The uptake of family planning methods was highest when EPI clinics were conducted in school buildings, followed by in health facilities, although provision in school buildings is often affected by time constraints related to the need for classes to take place.

Figure 5: Family planning method uptake based on the location of EPI clinics (Kalikot)



4.4 STABLE PROVISION AND UPTAKE OF EPI/FAMILY PLANNING SERVICES

4.4.1 Stable coverage/uptake of EPI services

One concern at the outset of this operational research was that the introduction of family planning services could remove the immunisation focus from EPI services, resulting in a negative effect on coverage.

Figures 6 to 8 show the uptake of immunisations at Kalikot EPI clinics in 2012/13 (2069/70) compared to 2011/12 (2068/69). The total number of EPI users (all vaccinations: BCG, DPT 3 and Measles) increased in 2012/13. However, there were fluctuations of service use from month to month in 2012/13 with use declining in the last 3 months of the year. This study is not able to verify this as the evaluation had been completed by that point. There was a fall in the number of children immunised against measles, and these months coincided with the Measles Rubella Campaign. Children immunised in this campaign were separately recorded and are not reported in the HMIS.

Figure 6: Number of children immunised with BCG vaccine in FY 2068/69 BS (2011/12) and 2069/70 BS (2012/13), EPI registers

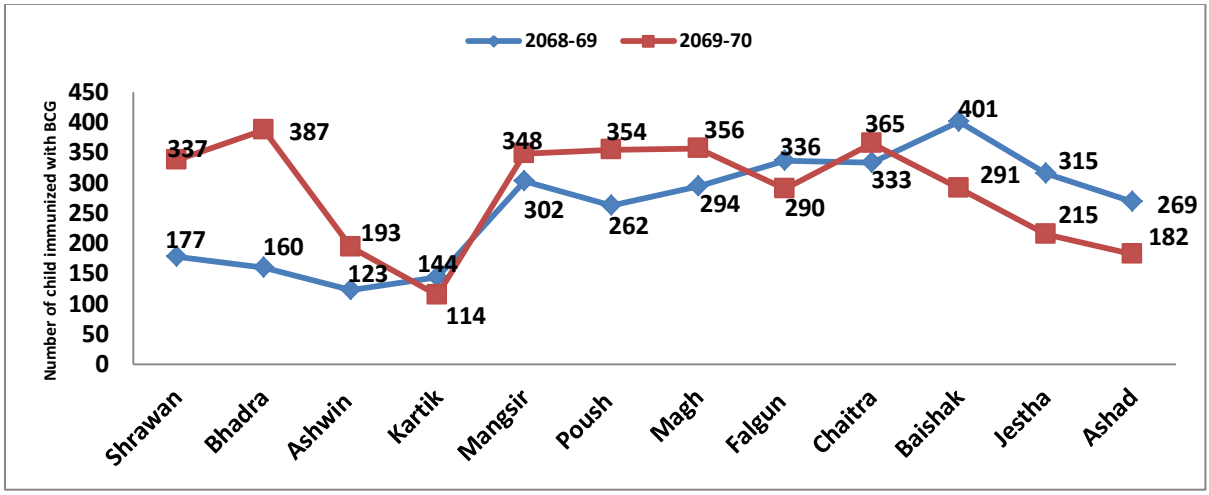


Figure 7: Number of children immunised in Kalikot with DPT3 vaccine in FY 2068/69 BS (2011/12) and 2069/70 BS (2012/13), EPI registers

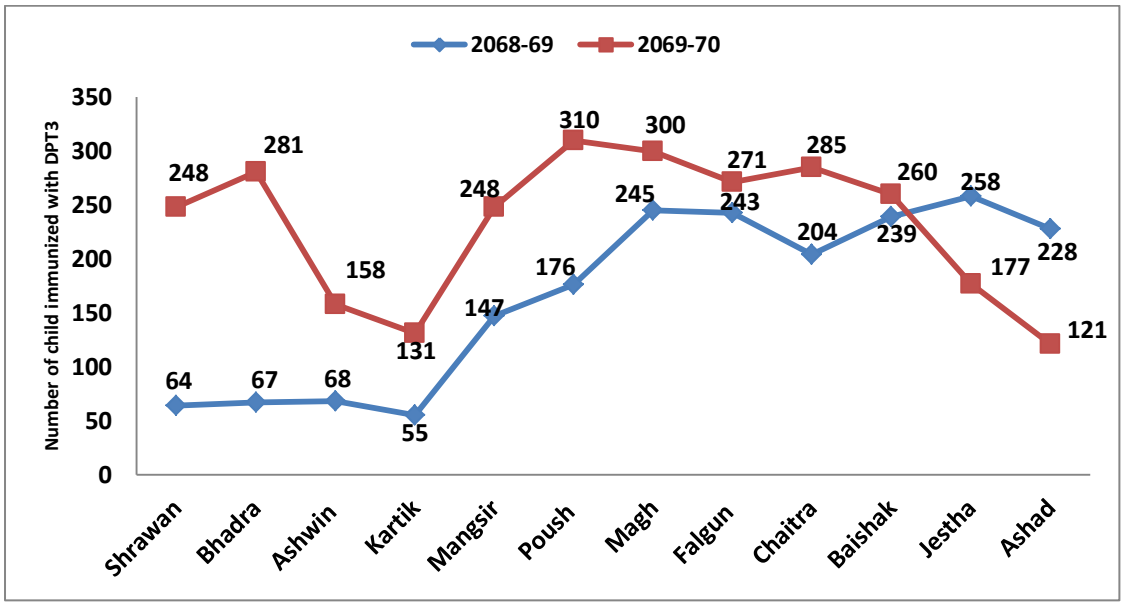
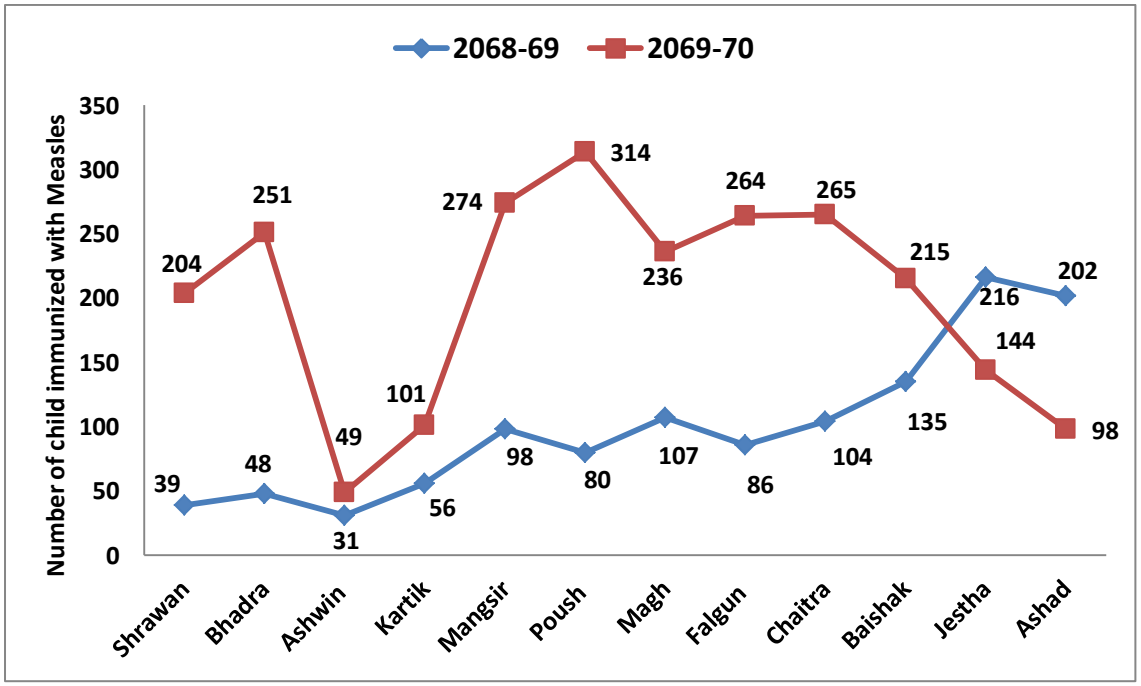


Figure 9: Number of children immunized in Kalikot with Measles vaccine in FY 2068/69 BS (2011/12) and 2069/70 BS (2012/13) based on EPI registers



Of the women interviewed at EPI clinics, all stated that they would have gone to the clinic for immunisation regardless of the availability of the family planning service— the provision of family planning had neither prevented them attending nor had it been the primary reason for attending for any of the woman interviewed:

> *"The EPI clinic is near to my house and immunisation will result in good health for my child. So I would have gone there on scheduled days even if no family planning services had been provided." — Woman, Mehalmudi VDC;*

"We can get family planning and counselling services whenever we want, but completing child immunisation is more important for us for the time being. I will definitely go to EPI clinic for my child's health." — Woman, Kumalgaun VDC.

The study findings suggest that communication between health service providers and women visiting the EPI clinics had improved after integration; however it cannot be proved that this improvement was due to integration itself or the additional support associated with integration, including increased supervision and additional training on health communication.

Client dissatisfaction around waiting times for vaccinations and poor information on side effects appear to have been common at EPI services prior to integration.

The interviews with women, and the FGDs with service providers, suggested that total coverage of immunisations can be affected by traditional beliefs. However, EPI records show immunisation in Kalikot to be very high (BCG is 99% of target) and in the sample of women interviewed for this evaluation there was only one immunisation drop out case. All the other women strongly expressed their willingness to complete their children's immunisation.

"Health workers from EPI clinics suggest we complete the immunisation; thus I am thinking of completing the immunisation of my child." — Woman, Kumalgaun VDC;

"If we do not complete the immunisation, then it is said that the immunisation which was previously given will not work as well." —Woman, Khina VDC.

Women who had visited the EPI clinics both before and after integration were asked about their views on the integrated EPI/FP service. The majority said that the integrated clinic was better because of the enhanced range of available services, including health education:

"When I was in the EPI clinic, health workers were giving education on family planning and rearing and caring of the child along with that." — Woman, Kumalgaun VDC;

"I feel very good when visiting the EPI clinic to vaccinate my child because health workers not only immunised my child but also talked about family planning." — Woman Kumalgaun VDC.

Some women also suggested that an improved quality of immunisation information was provided following integration.

"Before, we had to wait a long time. They did not provide enough information on immunisation. Sometimes when I missed my child's immunisation, they immunised my child with more than one vaccine and I was scared of the side-effects due to my child getting several vaccinations at once." — Woman, Chhapre VDC;

"Now they are providing health education from EPI clinics… that's why it's a bit different than previous ones." — Woman, Phukot VDC.

Women were asked to identify ways in which the integrated service could be improved. The most common issue (which also arose during field monitoring) was the late arrival of health workers to run the EPI clinics, resulting in women having to wait for a long time, and health workers' hurry to leave at the end of vaccination sessions.

Other improvements called for by the women clients included:

- Health workers should be better trained;
- The provision of basic infrastructure at the EPI clinics such as benches and chairs:

  "It is good to have EPI clinics at a well-managed place where there are chairs to sit on " — Woman, Chhapre VDC;

- The wider dissemination of information about EPI–family planning integrated service availability;
- The provision of family planning sterilisation services at certain times of the year;
- Female (not male) providers for family planning services as women do not feel at ease talking to men about family planning:

  "It is good to have female providers to talk on family planning. Also, it would be good if information is provided somewhere else in a private room rather than in open places." — Woman, Ramnakot VDC;

- The continuity of services with vaccines made available throughout the year in EPI clinics;
- More community awareness on family planning services, including advantages and disadvantages of family planning

4.4.2 Involvement of other community actors

Health workers appreciated the support of FCHVs and their contribution to EPI clinics. At a few health facilities such as Kumalgaun and Spikhana, the FCHVs were directly involved in providing group education as they were from the same community and the women trusted them. FCHVs also provided support with seating arrangements, kept women at the clinic for group health education, informed mothers of their immunisation schedules and generated demand for the services:

"At least two FCHVs participated in every clinic and they conduct group health education as the women felt comfortable with them and understood their problems. Health workers gave additional inputs, whenever required."— SHP in-charge, Kumalgaun;

"FCHVs support in inviting women and children from their wards to visit the clinics for the family planning services and immunisation. They also provide health education to the women." SHP, Pakha.

Prior to the current operational research implementation, HFOMC representatives from each health facility were orientated on the integrated services to gain their support. However, this orientation did not mobilise the majority of HFOMCs except where they were already actively involved. The quote below describes a situation where support was provided:

"HFOMC members include school principals and other community leaders. So they monitor the clinics on a regular basis. If health workers did not conduct EPI clinics then HFOMC informs local people through the local FM radio. Thus, this forces health workers to conduct EPI clinics. Apart from monitoring, they also told school children about EPI days to convey the message to the parents." — health facility in-charge, Siuna.

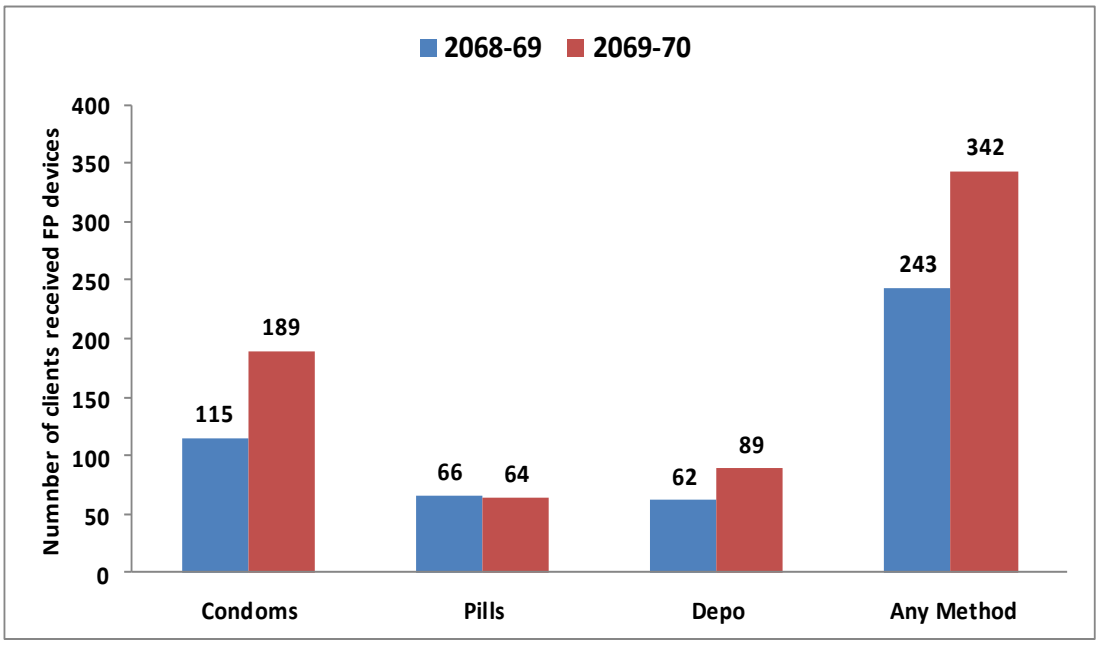
4.5 STABLE PROVISION OF PHC-ORC SERVICES

The potential impact on primary health care outreach services (PHC-ORC) services of introducing family planning into EPI clinics was also raised as an issue prior to the operational research. However there appears to have been no adverse impact on the functioning of PHC-ORCs as a result of integrating family planning services into EPI clinics.

During 2069/70 (2012/13), four VDCs (out of the 20 monitored VDCs) did not provide PHC/ORCs. The PHC/ORC registers from 2068/69 were not available in seven VDCs. Therefore, complete PHC/ORC data for two years were available only in 11 VDCs.

The total number of clients served during 2069-70 increased by 550 (approximately one third) compared to the previous year's performance suggesting that PHC/ORC had not been affected by the introduction of family planning services at EPI outreach. Utilisation of family planning also increased from the previous year. Health workers were unable to explain the slight improvement in service function over the previous year. The increases in the three main types of family planning methods in PHC-ORC services during the two years are shown in Figure 10.

Figure 10: Number of clients served at Kalikot PHC/ORC clinics in 2068/69 (2011/12) and 2069/70 (2012/13)



Nevertheless, the number of women offered family planning via PHC/ORCs was very low. Only 89 clients took Depo from PHC/ORCs during 2012-13/2069-70 (although this was an increase on the previous year). This compares to 479 doses of depo via the integrated FP/EPI service. This suggests that the integrated EPI/family planning service is already serving more women with family planning relative to existing PHC/ORC performance.

B. Key Findings

1. The model successfully increased access to family planning:

- During the 12 months of implementation of the integrated clinics in Kalikot district, the registration data shows that 1539 clients received family planning from these clinics, which is more than the number of family planning users from primary health care outreach clinics in the previous 12 months in Kalikot.
- Thirty-two percent of women attending the integrated clinics reported using a family planning method with 56% of them having received the method from the integrated clinics. The model has successfully increased access to family planning information and counselling for the women who attended EPI services.
- Two-thirds of the women attending the integrated service accessed the group health education provided at the clinics. The research found that some clients feared the side effects of family planning and did not have accurate information on some family planning issues.
- The women who participated in the group education strongly appreciated it.

2. Group information is critical to the success of the integrated model especially as many women who access EPI services are unaware that they are at risk of getting pregnant:

- Half of the women interviewed did not realise that they were at risk of pregnancy if they gave children supplementary food — nearly 60% gave 'irregular menses' as a reason for not using family planning.
- The women who did not recognise they were at risk of pregnancy are unlikely to be seeking family planning information or counselling or services from any other source. Group education is an opportunity to provide family planning information to women who are vulnerable to unplanned pregnancies.

3. The integrated service did not affect the uptake of EPI:

- EPI performance did not suffer as a result of the integrated family planning/EPI service, with performance remaining in line with or above the previous year's performance for the duration of the research.
- The women clients reported that integration had no negative impact on their experiences of the service. In fact they reported a better experience of immunisation services.

4. The integrated service did not affect family planning performance at Primary Health Care Outreach Services (PHC/ORCs):

Family planning uptake at primary health care outreach clinics (PHC/ORCs) in Kalikot increased during the period of operational research implementation relative to the previous year performance. This suggests no negative impact on uptake at PHC/ORCs as a result of FP integration into EPI services.

5. Women liked accessing family planning at the EPI clinics:

- The women clients reported that they liked the ability to access family planning and EPI at the same place.
- The EPI clinics were seen as convenient places to go for family planning services, although no clients reported that they would attend the clinic for family planning alone.

6. Depo Provera was a particularly popular choice for the women who attended the integrated FP/EPI clinics:

- Ensuring the availability of Depo Provera must be a priority as this is the method chosen by most women and is not available through FCHVs. If shortages of Depo are experienced by women, there are risks to the reputation of the service.
- Over half of women reported that they particularly like Depo Provera because it stops menstruation.

7. Underserved groups are using the service:

- Twenty-six percent of family planning users were Dalit, who represent 24% of Kalikot's population. This suggests that this group is not marginalised from the service —rather the integration increased their access to family planning services.

8. Important human resource characteristics of integrated FP/EPI services with a high family planning uptake and good service provision were:

- more than one health worker staffing the clinic;
- there being at least one female member staffing the clinic (to encourage women to adopt and use family planning methods); and
- all staff having received training on this approach.

6 CHALLENGES

Analysis of both the monitoring and process evaluation data identified the following key implementation issues and challenges to provision of an integrated family planning services/EPI service.

6.1 HUMAN RESOURCE CONSTRAINTS

Both health workers and district stakeholders identified a number of human resource barriers to effective operationalisation of the combined service. These affect the quality of service provided, restricting availability of both group education and individual counselling, both of which are essential to delivery of family planning.

1. Inadequate number of vaccinators — Insufficient vaccinators were available for the first half of the operational research as they are hired on a short-term basis and contracts were ended at the end of financial year. They were only rehired five months into the study.

2. Staff transfers — Trained staff were transferred to new posts and new staff were not orientated about the new service, although some newly hired staff received training several months into the operational research:

> *"The newly recruited in-charge and ANMs have not received training on the integrated EPI/family planning services. The trained staff have to travel frequently and therefore time has not been managed properly to provide the training to the new staff." — SHP, Rupsa;*
>
> *"Newly recruited ANMs feel shy while providing group health education sessions. They are immature and poorly present the content to clients. Proper training is required for them to strengthen their capacity and confidence." — health facility in-charge, Daha.*

3. Too few providers and inadequate provisions for field work — The integrated clinics were staffed at most locations by only one health worker, which negatively affected family planning provision. Even when sufficient staff were available at the clinic, they were not mobilised to support the integrated service. For example, in Bharta there were 2 ANMs, but their job descriptions did not include the provision of outreach services or field allowance entitlement (which other designations of health worker are eligible to receive). Staff hired on a short term basis are also not entitled to field allowances:

> *"The ANM and vaccinators who are hired on contract are not entitled to field allowances. On the other hand, village health workers get field allowances. Due to this situation, ANMs and vaccinators refused to go and conduct EPI clinics. I experienced this in Mehalmudi when I was there to conduct training." — Statistical assistant, DHO;*
>
> *"An ANM was complaining that why she should be conducting EPI clinics if someone else is getting field allowances?"— health facility in-charge, Daha.*

6.2 OTHER CONSTRAINTS

4. Stock outs of commodities and late supplies — Stock outs of family planning commodities were identified during FGDs held with in-charges and service providers. Health workers at Kumalgaun

reported buying additional Depo supplies, while health workers from Malkot had had to borrow Depo from another facility on two occasions. Irregular supplies from the DHO also hampered the operation of some EPI clinics:

> *"Vaccine supply from the DHO is not regular. Vaccines should reach the health facilities on the second of each Nepali month, but they come only after the fifth of each month. Vaccines don't come on time and the EPI clinics had to be closed because of that" — SHP Pakha.*

If combined EPI/family planning services are unable to supply essential contraceptives such as Depo Provera they risk developing a reputation as unreliable suppliers of family planning services. This research has demonstrated a demand for services and an opportunity to reduce unmet need for family planning.

5. Lack of space — A lack of space and appropriate locations for EPI clinics is a challenge throughout Nepal. EPI providers have found many innovative ways to overcome this. On some occasions health workers reported sending students out of class to make school premises available, which health workers acknowledged is not a long term solution in terms of the effect on students and the quality of clinics which will be rushed to ensure students are not away from their lessons for too long.

One example was provided of support from a HFOMC which addressed the issue of location. While support from the HFOMC is encouraging, paying for a location may not be feasible in most VDCs and is certainly not a long-term solution:

> *"We used to conduct the EPI clinic in a local person's home in ward 5, but last time they did not allow us. We discussed this issue with HFOMC and they decided to provide NPR 100 to the house owner." — health facilities in-charge, Phukot;*

> *""There is no space for the EPI clinics. We can get room at school only on Saturday" — SHP, Pakha.*

The problem of finding a location for clinics is particularly severe during the rainy season. In warmer weather, clinics can be held outside but there is a risk that vaccines can be ruined under harsh sunlight.

Confidentiality is a particular issue with regard to family planning services and delivery of the service indoors can increase (although by no means guarantee) the likelihood that women can have private conversations about their family planning needs.

6. Record keeping — It was noted by field monitors that many EPI clinics did not keep a record of family planning services provided by their clinics. Health workers stated that they were confused by the recording and reporting requirements of the operational research as it was different to their routine monitoring procedures. Due to changes in family planning reporting guidelines during the last two years, there was a lot of confusion as to how family planning users are being reported in HMIS. Lack of supervision and monitoring from senior staff contributed to this problem as there was no high level oversight of records and reporting.

7. Limited supervision and monitoring — The original integration model included periodic supervision and monitoring by district supervisors, and district officials had prepared supervision plans for the overall programme. However, their busy schedules meant that very few visits took

place. One district official visited two health facilities and observed integrated EPI/family planning services, but officials acknowledged limited capacity and a more realistic supervision from health facility in-charges was required. Health facility in-charges are often away at meetings or trainings, so they also visited the integrated clinics only rarely and health workers said that their work was neither praised nor punished. Health workers reported that more supervision would have helped them to learn and get feedback on their work.

7 CONCLUSIONS AND RECOMMENDATIONS

7.1 CONCLUSIONS

This operational research found considerable evidence that the integration of family planning into EPI service provision can increase access to family planning information and services for EPI clients, without affecting the quality and uptake of EPI services. The research also identified some aspects of the model that could be strengthened in order to improve the quality of the family planning service provided. The provision of quality care is essential if the service is to be trusted by potential women clients.

A recent value for money study conducted for this integration showed that the cost of integration of family planning services into EPI clinics is high in the year of integration when compared to the international benchmark of US$2 per user per year. However, the cost would fall towards this benchmark if the service continued for at least 10 years, or coverage increased from the current 18% of women using the integrated service identified in the client survey (28% if EPI register data is used[3]) to 50% of FP use among women who visited EPI clinics. Nevertheless, a primary conclusion of this study is that the provision of an integrated EPI/family planning services is still very cost-effective in terms of DALYs, even under the most costly scenario.

The main outstanding question with regard to the future of the service, (that was not addressed in this research), is where women should go for their subsequent Depo injections. If women clients will return for subsequent child immunisation services then it is reasonable to expect them to access family planning at subsequent integrated EPI/family planning. But if they do not, then is it best for them to get future Depo injections at the integrated clinics, or at a PHC/ORC or at health facilities. The natural choice for women who do not live close to a health post or sub-health post would be nearby PHC/ORCs, which often also offer EPI services. However, the KIIs report that PHC/ORC clinics tend to be unreliable both in terms of frequency and commodities available and as a result attendance at PHC/ORCs is often low.

7.2 CONTEXT-SPECIFIC RECOMMENDATIONS

The following recommendations address the key findings and challenges found by this study. While these recommendations are specific to introducing integrated EPI/family planning service provision in Kalikot district and similar areas of Nepal, many also apply to the delivery of other types of integrated outreach health services including PHC/ORC.

1. Scale up the provision of integrated EPI/family planning services in remote mountain and hill districts where the contraceptive prevalence rate (CPR) is low.

The research has been successful in increasing the number of family planning users among the population of women who attend EPI clinics in Kalikot district without negatively impacting on EPI or PHC-ORC services.

2. Develop and test a model to integrate family planning services in EPI clinics in Terai districts.

[3] The integrated FP/EPI value for money study quotes 24% as the study is based on EPI register data from the first two quarters of implementation only

This integrated approach has resulted in increased use of family planning services by women in their extended post-partum periods. As birth intervals are also short for many women in the Terai, it should be considered to introduce or test an integrated service provision model in Terai districts.

3. Develop the skills of health personnel to strengthen the group health education component of the integrated EPI/family planning model.

Most of the women clients had a positive response to the group education component of the integrated service. These sessions identified significant gaps in knowledge on fertility return. The skills of health workers need enhanced through training to improve the impact of these sessions. This training should involve demonstration and role-play as well as support for using IEC materials. This should improve the quality of care at EPI, PHC-ORCs and health facility-based services. Note that there is evidence that group education is effective for imparting information especially where one-to-one counselling is difficult.

4. Mobilise and enable health workers to provide quality integrated service.

- Carry out human resource mapping prior to implementing integrated services to identify staffing gaps and risks in advance.
- Incorporate orientations to the new service within rolling training plans for related health personnel.
- Give multi-year contracts to contracted staff to reduce discontinuities in their service.

5. Create a supportive environment for delivering integrated EPI/family planning services

Changes to established ways of working are more successful when they are visibly supported by senior managers. District officials need to take ownership of integrated service provision and lead discussions with HFOMCs and local managers on how integrated services can be operationalised and local implementation challenges overcome. Health facilities should be encouraged to take pride in integrated service provision, perhaps by the sharing of the resulting numbers of new family planning users across facilities.

6. Review infrastructure requirements for the integrated EPI/family planning service and use community networks to improve accommodation for outreach services

The availability of adequate infrastructure is a challenge for many outreach clinics. Poor infrastructure and, in particular, the lack of privacy for family planning counselling reduces the quality of care and affects the motivation of health workers. This could be partially addressed by identifying suitable locations and supportive local organisations with the potential to support the infrastructure needs of the expanded service prior to implementation.

7. Ensure reliable and adequate levels of contraceptive supplies for EPI/family planning clinics.

The integrated clinics were hindered in one place by insufficient supplies of Depo Provera, and in many places by poor availability of condoms. This could well undermine the reputation of the integrated services. District level managers must be made responsible for ensuring that EPI/family planning services are fully stocked. Also, the 'pull' mechanism should be strengthened so that health workers are able to report low stock levels to their district health offices, which should then respond promptly by providing additional supplies.

8. Strengthen routine reporting and monitoring on the services provided at integrated clinics through practical training and constructive feedback

Do this by training/orientating health personnel on the recording and reporting requirements including practical exercises. For this to be successful, district supervisors must provide constructive feedback on the quality of reports and ensure reports are included in HMIS. The current revision of the HMIS and associated training may have a positive impact on general FP recording and reporting.

9. Establish a strong referral service at the integrated clinics for required family planning services

District managers need to ensure the availability of long term family planning methods at PHCCs and health posts as proposed in NHSP-2. This can also be encouraged by strengthening PHC-ORCs to provide regular support to women who have adopted family planning methods from integrated clinics.

10. Undertake targeted marketing of the integrated service to increase access for marginalised groups (augmented with overall promotion through radio and other media about availability of family planning services at EPI clinics)

The promotion of the integrated service should be integrated into the district wide family planning services information and awareness activities including through FM radio and FCHVs.

11. Strengthen PHC/ORCs to provide women who have adopted Depo at integrated clinics with a convenient means of accessing subsequent supplies

Despite a small rise in distribution of FP at PHC/ORCs during the last year, uptake remains low primarily because the service is considered unreliable. Unless the perception of the service among communities is strengthened through guaranteed availability of contraceptive supplies and consistent functioning of outreach clinics, there is a risk that women will be reluctant to visit PHC/ORC for follow-up services. It may require a concerted marketing campaign to overcome resistance to accessing the PHC/ORC.

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ANNEX 1: EVALUATION METHODS, SAMPLING AND TOOLS

a. Women's interviews – random survey of EPI clients

Tools: Interviewed using separate semi-structured questionnaire

Sampling: Systematic random sampling method was followed to select 100 women from different monitored VDCs. Among 20 monitored VDCs, 50% of the VDCs were randomly selected by following the steps below:

- All 20 VDCs were arranged alphabetically and numbered 1 to 20
- From the first two VDCs, one was withdrawn by lottery method and number two VDCs were selected
- All the even number VDCs were selected, they were: Chhapre, Manma, Khin, Kumalgaun, Mehalmudi, Odankhu, Phukot, Ramnakot, Sipkhana and Bharta

Women selected proportionately on the basis of expected number of infants less than one year of age visiting EPI clinics within 10 selected VDCs. The criteria of selection of 100 women were that the women should have visited the EPI clinics for immunization of their child.

b. Women's interviews – interviews with 20 family planning clients

Tools: Interviewed using separate semi-structured questionnaire

Sampling: Women who had visited the integrated EPI/family planning clinics for early immunization of their child were purposively selected from sampled VDCs. Furthermore, they were stratified into two groups: 10 women having only one child and 10 women having two or more than two children. The selection of 20 women was based on the exit client interview4 conducted by the Field Monitors during their routine visit.

c. Key informant interviews – FCHVs

Tools: Semi-structured questionnaires

Sampling: Two FCHVs were purposively chosen from non-monitored sites so their views on the integration process could be incorporated into the evaluation

d. Focus Groups – health facility in-charges, service providers and DPHO stakeholders

Tools: FGD guides were developed to collect data. The instruments were flexible for the respondents to express their views. A FGD guide was developed for conducting the FGDs. The instruments were originally developed in English and then translated into Nepali. All the FGDs were audio taped with consent from the participants.

Sampling: A total of 7 FGDs were conducted at various levels, 2 FGDs each (one with health facility in charges and one with service providers) in three Ilaka level health facilities and one in DHO. Four facilities were selected from within the 20 monitored VDCs, and were chosen based on their performance in EPI/family planning integration, i.e.

[4] Exit client interview is routine process done by the field monitors during their visits in the health facilities. Generally, they interview 2-3 women per clinic.

two that had high uptake of family planning and two that had low uptake. The remaining two were randomly selected from unmonitored facilities.

Table A1: Description of FGDS conducted

Level	No. of FGD	Participants
District	One	District stakeholders
Kumalgaun Ilaka (Kumalgaun, Malkot and Rupsa)	Two	One with health facilities in-charges One with service provider
Phukot Ilaka (Phukot, Siuna and Sipkhana)	Two	One with health facilities in-charges One with service provider
Daha Ilaka (Daha and Pakha)	Two	One with health facilities in-charges One with service provider

e. Field Implementation

A one-day training was conducted for eight enumerators on April 29, 2013 at meeting hall of HERD. The purpose of the training was to acquaint enumerators with the operational research, to ensure consistency across the evaluation team and to assure the quality of data collected.

The training included both theoretical and practical sessions, small group mock interviews. The major focus of the training was on clarity in content, skip instructions within the questionnaire, sequencing and phrasing of questionnaire in local language and practice in interviewing using the tool. Enumerators were made aware about the practical difficulties that may arise in the field and how to tackle them.

The team left for the field on April 30, 2013 and returned to Kathmandu on May 14, 2013. It took 15 days to complete the work in the field. A briefing meeting was held with DHO of Kalikot regarding the evaluation objectives and tentative plan was prepared. DHO of Kalikot coordinated all the sampled health facilities and made necessary arrangement for the discussions.

f. Data management, database design, coding, entry and cleaning

Quantitative was managed in the Census and Survey Processing System (CSPro) and analysed using SPSS v12. All data were manually edited, coded and cleaned to ensure consistency before the data entry. Qualitative data- the transcriptions of the FGDs were arranged, themes were identified and analysed accordingly. Informed consent was taken from all the study respondents involved in the process evaluation.

ANNEX 2: FOCUS GROUP DISCUSSION AND INTERVIEW GUIDES

ANNEX 2.1: GROUP DISCUSSION GUIDELINES FOR DHO FOCAL PERSONS

Objectives:

1. Reflect on progress to date, gaps and area of improvement
2. Explore key challenges and potential solutions
3. Identify any adjustments needed for the programmatic approach

Participants:

- DHO
- family planning Focal person
- EPI focal person
- Statistic focal person
- Public Health Nurse
- Store keeper

Respondent details:
Name:
Position:

Topic	Core Questions	Probe Questions
Involvement in planning and training	Were you involved during planning of the family planning/ EPI integration process?	What was your role?
	Were you involved during training of family planning/EPI integration to the health workers?	What was your role?
Implementation issues and strategies	What are the strengths and weakness about this family planning/EPI integration? Why so? What aspects of the approach have been going well? What are the strengths for going well? How is this happening well? What are the reasons? What aspects of the approach have not been going well? What are the reasons for not going well? What should be done for happening well? What are the reasons?	List of components • Group health education session on HTSP • family planning counselling • Distribution of FP methods • Referral services for pregnancy test • Referral services for long acting methods • Recording and reporting Please provide evidence why and how component were implemented well or not?
Challenges and potential solutions	What are challenges or difficulties faced in implementing the integrated approach at the district level, at health facility level and at community level?	Why these were challenges as such? Probe: HR, logistics and supplies, IEC materials, registers, availability of pregnancy test kit, supervision and support, coordination,

Topic	Core Questions	Probe Questions
		recording and reporting
	How these challenges were tackled?	What were the actions taken to tackle these challenges? By whom these actions were taken? What was the result of these actions? Was there any improvement in implementing the integrated approach? Were there any difficulties in implementing these actions? If not tackled, why?
Status of EPI (EPI focal person)	What is the status of EPI (utilization) in the district last year? How is this year?	Are there any changes in the EPI status this year in comparison with last year? Why are these changes (increase or decrease)
	How was the EPI services provided in the EPI clinics before and after family planning/EPI integration?	What have influenced for these changes?
Status of family planning (family planning focal person)	What is the status of family planning in the district last year? How is this year?	Are there any changes in the family planning status this year in comparison with last year? Why is this changes (increase or decrease) What have influenced for these changes?
Quality of services	What is the situation of family planning service delivery in your district after family planning/EPI integration?	How the Group health education session on HTSP conducted in the EPI clinics? How the counselling services are provided at the EPI clinics? Do the service providers follow the counselling process (steps)? Are there any differences on counselling services being provided at the health facility and EPI/family planning clinics? If yes, why is the difference?
Impact	What are the changes observed in the EPI service delivery after the EPI/FB integration?	Changes in the number of service users? Changes in the service delivery mechanism? Explain with evidence (any positive or negative effects on routine EPI services) Are these effects caused due to EPI/family planning integration? Are these effects caused by other factors such as availability of HR, supply of vaccines or other?
Monitoring and Supervision	How do you do supervision in the district?	Regarding this integration, how do you do supervision? What is the process of supervision? Who are in the supervision team? What is the schedule for the supervision? Explain the major observation made during supervision

Topic	Core Questions	Probe Questions
Recording and reporting	Do the health workers report according to the guidelines?	Do you receive the reports regularly? Do you receive the reports timely? (Show the current reporting from the Ilaka)Is there matching in reporting in the EPI registers and HMIS? What are the reasons for this difference? Did they mention "I" in the reports? Is there matching in reporting in the family planning registers and HMIS? What are the reasons for this difference? Was the delay in reporting common (as usual before integration)? Was the delay observed only after the integration? **List the weakness of specific clinics from the monitoring report:** How did you overcome these weaknesses?
Performance /service delivery	In our observation, only one health workers are being providing the family planning/EPI integrated services, what could be the reasons? Although in our observations, two health workers are present in the EPI clinics what are the reasons for not delivering the integrated services effectively? *(Will ask targeted questions as per the health facilities profile)*	What could be the reasons for few health facilities performing well and few not? (show list of well performing and low performing health facilities Probe: Number of health workers, managerial issues, staffs motivation, support from HFOMC, FCHVs, community participation or any other observations. What we should be doing to make things happen?
Major learning	If you were asked to plan about this programme, how would you plan?	What should you have done differently? What should not we do?
Adjustment needed	What adjustment could be made to make the services delivery even more effective? Why and how these adjustments would yield good result?	What feedbacks have you heard from the HP In charges/service providers about this approach?

Note any other events took place which influenced the integrated service utilisation.

ANNEX 2.2: DISCUSSION GUIDELINES FOR HEALTH WORKERS RUNNING EPI CLINICS

Objectives:

1. Reflect on progress to date, gaps and area of improvement
2. Explore key challenges and potential solutions at EPI level
3. Identify any adjustments needed for the programmatic approach
4. Explore client's and community's view perspective towards integrated services
5. Document lesion learnt particularly from service delivery point

Respondent details:
Name:
Position:
Health facility:
Place of EPI clinic:

Topic	Core Questions	Probe Questions
Progress to date	How has the EPI family planning integrated service delivery working?	
Implementation issues and strategies	**Good performing clinics:** What aspects of the approach have been going well? What are the strengths for going well? How is this happening well? What are the reasons? What did you do differently for this aspect of the approach working well? How did you manage/ motivate to work well? **Poor performing clinics:** What aspects of the approach have not been going well? What are the reasons for not going well? What should be done for happening well? What are the reasons?	List of components: • Group health education session on HTSP • family planning counselling • Distribution of family planning methods • Referral services for pregnancy test • Referral services for long acting methods • Recording and reporting. Please provide evidence why and how component were implemented well or not? ***HR management*** Why the family planning/EPI clinics conducted by only one staff? What health facility in-charge could do to make two staffs conducting the EPI clinics? ***IEC materials*** Why there are no IEC materials in the EPI clinics? How could best option to manage IEC materials locally? (if given responsibility to FCHVs would it be ok or other possible place) Why the service providers not using IEC materials?
Challenges and potential solutions	What are challenges or difficulties faced in implementing the integrated approach?	Why these were challenges as such? Probe: HR, logistics and supplies, IEC materials, registers, availability of pregnancy test kit, supervision and support, coordination, recording and reporting , workload, incentives, infrastructure, time management in EPI clinics Does gender of service provider matter for family planning users?

Topic	Core Questions	Probe Questions
		Is there any cultural barrier that hinders in providing family planning services from the EPI clinics?
	How these challenges were tackled?	Explain with evidences If not tackle, why?
Status of EPI	What is the status of EPI users in the clinic last year? What about this year?	Are there any changes in the EPI users this year in comparison with last year? Why is this changes (increase or decrease) What have influenced for these changes?
Status of family planning	What is the status of family planning in the clinic last year? What about this year?	Are there any changes in family planning users this year in comparison with last year? Why is this changes (increase or decrease) What have influenced for these changes?
family planning users	Which age group of women uses the family planning services most?	Which caste/ethnicity uses the family planning services the most? What are the reasons? Are there any caste/ethnicity groups which do not use family planning services? What are the reasons?
	What is the preferred time for women visiting the EPI clinics? Do women preferred to have family planning message alone or in a group? How do women react when you deliver family planning message to them?	Do women have enough time for group health education and individual family planning counselling? Are they comfortable?
Impact	Is there any impact on EPI services due to integration with family planning?	Explain with evidence
Clients perspective on integrated model	What types of responses did you get from the clients?	Express their views in terms of: • Service integration • Service utilization • Service satisfaction (Availability, accessibility, convenient, privacy, behaviour of health workers • Waiting time • Cultural beliefs/stigma • Male health workers providing family planning services (group health education, counselling, methods)
Community's perspective on integrated model	What types of responses did you get from the community people?	Express their views in terms of; Positive and negative aspects of Service integration
	Did you hear any rumours from clients and from the community?	Positive and negative
Monitoring and Supervision	Was there any supervision done by higher authority?	Team composition (HFOMC)/DHO/health facility-In-charge How often do they do supervision? What is the schedule for the supervision?

Topic	Core Questions	Probe Questions
		Explain the major recommendations provided during their supervision visits
Performance	**Well performing Clinics** (Introduce the clinic profile) What motivate you to perform well?	What are your strengths for delivering the services effectively?
	Poor performing Clinics (Introduce the Clinic profile) What are the constraints you faced for performing well?	What are the areas to be improved for delivering effective services?
Adjustment needed	What adjustment could be made to make the services delivery even more effective? Why and how these adjustments would yield good result?	Any amendment needed? Why?
Major learning	If you were asked to plan about this programme, how would you plan?	What should you have done differently? What should not we do? Is this integration feasible (conducting group health education, family planning counselling) Positive and negative aspects of program implementation

ANNEX 2.3 DISCUSSION GUIDELINES FOR HEALTH POST IN-CHARGE

Objectives:

1. Reflect on progress to date, gaps and area of improvement
2. Explore key challenges and potential solutions at health facility level
3. Identify any adjustments needed for the programmatic approach
4. Explore client's and community's view perspective towards integrated services

Respondent details:
Name:
Position:
Health facility:

Topic	Core Questions	Probe Questions
Progress to date	What is the status of the EPI/family planning integration in your health facility?	Family planning service utilization • Service delivery process • Support from HFOMC, FCHV and community • Functionality of the clinics
Implementation issues and strategies	Introduce the individual health facility profile ***Good performing health facility*** Explain the aspects of the approach have been going well	List of components • Group health education session on HTSP • family planning counselling • Distribution of family planning methods • Referral services for pregnancy test • Referral services for long acting methods • Recording and reporting Please provide evidence why and how component were implemented well or not? What are the strengths for going well? How is this happening well? What are the reasons? What did you do differently for this aspect of the approach working well? How did you manage/ motivate to work well?
	Poor performing health facilities Explain the aspects of the approach have not been going well	List the health facility specific components not working well What are the reasons for not going well? What should be done for happening well? What are the reasons?
	Show the layout of the service delivery In your observation, what are the changes needed in this layout?	Is the service delivery layout okay for you?
Challenges and potential solutions	What are challenges or difficulties faced in implementing the integrated approach?	Why these were challenges as such? Probe: HR, logistics and supplies, IEC materials, registers, availability of pregnancy test kit, supervision and support, coordination, recording and reporting ,

Topic	Core Questions	Probe Questions
		workload, infrastructure
	How these challenges were tackled?	Explain with evidences If not tackle, why?
Status of EPI	What is the status of EPI in the health facility last year? What about this year?	Are there any changes in the EPI status this year in comparison with last year? Why is this changes (increase or decrease What have influenced for these changes?
Status of family planning	What is the status of family planning in the health facility last year? What about this year?	Are there any changes in the family planning status this year in comparison with last year? Why is this changes (increase or decrease) What have influenced for these changes?
Quality of services	What do you think about the quality of family planning services delivered in the EPI clinics under your health facilities? From your observations, are the service providers (VHW, ANM, vaccinators) consistently and appropriately delivering family planning services?	Is there any difference between family planning counselling process in health facilities and EPI clinic? What are the differences? Why are these differences? If Yes, what made the service providers to do so? Did health facility In-charge do anything innovative or different? IF no, why the service providers not consistently and appropriately delivery family planning services? Are the service providers consistently marking down the services provided and referral made in their registers?
Impact	What are the changes observed in the EPI service delivery after the EPI/FB integration?	Changes in the number of service users? Changes in the service delivery mechanism? Explain with evidence (any positive or negative effects on routine EPI services) Are these effects caused due to EPI/family planning integration? Are these effects caused by other factors such as availability of HR, supply of vaccines or other?
Clients/community perspectives on integrated model	Did you hear any rumours from clients and from the community?	What are the positive and negative responses you heard on the EPI/family planning integrated services?
Performance	**Well performing health facilities** Was there any local innovation you had to improve performance of EPI/family planning clinics?	What have you done to mobilize two health workers to conduct EPI clinics? What are your strengths for delivering the services effectively?
	Poor performing health facilities What are the constraints you faced for performing well?	What are the areas to be improved for effective service delivery?
Monitoring and Supervision	Have you ever been to EPI clinics for the supervision? How do you do supervision of family planning/ EPI integration?	Did HFOMC participate? How often do you do supervision? What is the schedule for the supervision? Explain the major observations made during supervision What were the actions taken
Recording and reporting	What are you struggling in recording and reporting system?	Registers format, availability of registers, reporting discrepancy between record and reports. Mention 'I"

Topic	Core Questions	Probe Questions
		or not? Are the service providers consistently recording in the EPI register?
Major learning	If you were asked to plan about this programme, how would you plan?	What should you have done differently? What should not we do? What did you learn from this integration? Learning in term of family planning services, EPI services, service delivery, changes in the service utilization, women participation
Adjustment needed	What adjustment could be made to make the services delivery even more effective? Why and how these adjustments would yield good result?	Any amendment needed? Why?

ANNEX 2.4: GUIDING QUESTIONNAIRE FOR WOMEN (100 SAMPLE)

Objectives

1. Explore the knowledge about family planning/EPI integration
2. Identify the clients involvement in the EPI clinics after the integration
3. Determine the use of the family planning services from the EPI clinics
4. Explore the reasons for not using family planning services
5. Explore family planning history

Criteria for selecting women:

- Women must be from functional place (monitored and integrated)
- Women with under one child
- Must have visited EPI clinics for immunization

Question	Core questions	Probe questions
Knowledge on integration		
1	Have you heard that health workers are providing group health education and distributing family planning methods from EPI clinics?	Yes No
2	Where did you hear from?	HP in-charge FCHVs EPI service providers Others (specify)……
3	When did group health education happen?	……specify month
4	Did somebody told you or you saw it?	EPI clinic workers FCHV HP in-charge Family members Other women Involved myself Other (specify)……
Involvement in family planning/EPI integration		
5	Have you ever been there?	Yes No
6	Were you involved in Group health education? *(Did health workers show flex chart)*	Yes No
7	Are you using family planning methods?	Yes No ----------> go to Q 11
8	Did the health workers tell about the	Yes

	benefits of family planning methods, side effects and its management of methods you alone? (*If not using than no need to ask counselling)*	No
9	Do you remember who was the person providing the information?	• VHW • ANM • AHW • FCHVs • Others (specify)……
10	Was the information provided by the health worker clear to you?	Yes No
11	Did the health workers ask you to test pregnancy?	Yes No
12	What method do you use?	• Condoms • Pills • Depo Provera • IUCD-copper-T • Norplant • Permanent sterilization • Others (Specify)……
13	Where did you get family planning methods?	• EPI clinics • health facility • PHC-ORC • Medical shops • Others (specify)……
14	Was method you used available when you visited the EPI clinic?	Available Not available
15	If not available, did they refer you to go somewhere else?	
Knowledge on HTSP		
16	How long after the delivery of one child do you think one should wait to conceive another child for good health of both mother and child?	• 6 months • 1 year • 2 year • anytime
17	If a child is fed with breast milk along with other supplementary food, then how long after the delivery of one child can the women be pregnant again?	• 1 month • 45 days • 2 months • 6 months
If she is using family planning ask these questions		
18	How old is your baby?	……Months
19	How old was he/she when you started this family planning?	……Months
20	Is this (EPI clinic) a convenient place for you to get the family planning services?	Yes No
21	Is there any other place nearby where you	Yes (specify place)……

	can get the family planning services?	No
22	How far is EPI clinic it from your home?	…….. minutes
23	How far is the other place (for getting family planning methods) from your home?	…… minutes
24	Will you come back in the EPI clinics for family planning services or will be using from somewhere else?	Come back Somewhere else
25	Are you satisfied with the services provided from the EPI clinics?	If yes, what are the reasons? If no, what are the reasons?
26	What difficulties did you faced while utilizing the services from the EPI clinics?	
27	What factors have influence you to use the family planning services from the EPI clinics?	
28	What are your recommendations for improvement of the services?	
Previous history		
29	Did you use family planning methods before you have this baby?	Yes No
30	Where did you go for that family planning before?	• health facility • PHC-ORC • EPI clinic • FCHVs • Medical shop • Others (specify)……
31	Did you pay for this family planning methods?	Yes No
32	How much do you pay for the family planning methods there?	NRs…….
For non-users		
33	You said you do not use family planning? Why you did not use family planning?	• LAM -------> confirm with Q • Husband not at home • Male health worker providing services • Other reasons (Specify)……
34	How old is your child?	……Months
35	Has your menstruation returned after delivery of this child?	Yes No
36	How often do you breast fed your child day and night	……times at day …….times at night
37	What are you recommendation for any improvement?	

ANNEX 2.5: INTERVIEW GUIDELINES FOR POSTPARTUM WOMEN (20 PURPOSIVE SAMPLING)

Objectives – To know women's perception of integration, is there any negative impacts on EPI clinic she went to, compare with her previous EPI visits for other children, if she drop-out of EPI clinic – why and was it different/ the same for the previous child.

1. Explore client's view perspective towards integrated services
2. Compare changes in service delivery from EPI clinics particularly in EPI services before integration and after integration
3. Assess effectiveness of integrated family planning and EPI services
4. Explore the learning from IEC materials.

Respondent details:
Name:
Age:
VDC:
Ward:
Place of EPI Clinic:
Number of Child:

Topic	Core Questions	Probe Questions
Confirmation of their participation in EPI clinic		
1	Have you been there before……month?	Yes No
2	Did you remember our field monitors talk with you?	Yes No
3	Did you see health workers providing group health education in the EPI clinic?	Yes No
Experiences on visiting integrated EPI family planning clinic		
4	How old is your this child?	……month
5	What is the sex of your child?	Boy Girl
6	How many times had you visited for immunization of this child in the EPI clinic?	……times Tally the times of immunization with the age of a child Within a month……..BCG In 42 days……DPT/polio1 In 70 days……..DPT/Polio2 In 98 days……..DPT/Polio3 In 9 months……measles
7	From Q 6, if there is drop out in immunization of this child, why? What were the reasons for drop out?	…… …… ……
8	What is your experience visiting EPI clinic for immunization of this child?	

	Probe more:	
9	How long did you wait for immunization of this child when visited last time?	……minutes
10	Were you able to ask questions to health workers regarding your child immunization (probe: side effects of vaccine)	
11	Did health workers remind you for next visit for immunization of this child?	Yes No
12	Are you satisfied with this EPI services recently provided for this child?	Yes No
13	If satisfied, what were the reasons?	
14	If not satisfied, what were the reasons?	
15	Would you like to complete immunization of this child?	Yes No
16	If yes, why and if not why not?	
17	Do you think you would have gone to EPI clinic as scheduled for immunization of your child, even if the health workers were not providing family planning services?	Yes No
18	If yes, what are the reasons?	
19	If not, what are the reasons?	
Please ask for women who have more than one child		
Experiences on visiting EPI clinics for previous child		
20	How old is your previous child?	……months
21	What is the sex of your previous child?	Boy Girl
22	Did you visit EPI clinic for immunizing your previous child?	Yes No
23	How many times had you visited to immunize your previous child?	……times
24	If she visited less than 5 times, what were the reasons for drop out of immunization of her previous child? Probe all possible reasons	
25	What is your experience visiting EPI clinic for immunization of your previous child? Probe more:	
26	How long did you wait for immunization of previous child when visited?	……minutes
27	Were you able to ask questions to health workers regarding your previous child immunization	

	(Probe: side effects of vaccine)?	
28	Did health workers remind you for next visit for immunization of your previous child?	Yes No
29	Were you satisfied with EPI services provided for your previous child?	Yes No
30	If satisfied, what were the reasons?	
31	If not satisfied, what were the reasons?	
Changes observed in terms of providing EPI services after integration		
32	What are the changes did you observe in the EPI clinic while immunizing your previous child and current child? Probe all possible changes	
33	Based on your experiences on visiting EPI clinics for your previous and this child which one do you feel good?	Previous EPI clinic Current integrated EPI family planning clinic
34	For question 33, what are the reasons for feeling good?	
35	What could have done to make the current integrated EPI family planning clinics better?	

ANNEX 3: METHODS AND TOOLS FOR REGULAR M&E OF EPI/FAMILY PLANNING CLINICS

	Methods:	Purpose
A. Routine monitoring		
	Observations:	
1	Observation checklist	• To document how each clinic was implemented, environmental factors affecting service delivery • To record the number of EPI clinics providing family planning services
	Key informant interviews:	
2	Client exit interview	• To understand women's perceptions of the integrated EPI/family planning service
3	FCHVs	• To understand functionality of the EPI clinics in their ward • To record their presence, contribution in EPI clinics
4	Community	• To understand the functionality and provision of family planning services from a community perspective
5	HFOMC representative	• To understand their view on service integration, issues encountered while providing family planning services and HFOMC role in resolving the issues
6	Health service providers	• To understand the overall supply (vaccine, methods) status in the clinics and the issues encountered in providing family planning alongside EPI services
	Health facility registers	
7	Revised PHC-ORC register	• To monitor family planning service provision at PHC-ORC
8	EPI register	• To monitor EPI service utilisation during family planning integration
9	Family planning service register	• To record the family planning service details of the respective health institution • to report the detail of family planning services provided by EPI clinics
10	PHC-ORC register	• To know the trend of PHC-ORC service utilization since this operational research is not supposed to decrease the service utilization from PHC-ORC clinics.
B. The evaluation		
	Survey (semi-structured)	
11	Random survey of EPI clients (100 women)	• To explore the knowledge about family planning/EPI integration • To identify the clients' use of in the EPI clinics after the integration • To determine the use of the family planning services from the EPI clinics • To explore the reasons for not using family planning services • To explore family planning history
	Structured interviews	
12	Interviews with 20 EPI clients who accepted family planning from EPI-ORC (purposively selected)	• To know women's perception of integration, if there is any negative impacts on EPI clinic she went to, compare with her previous EPI visits for other children, if she drop-out of EPI clinic – why and was it different/ the same for the previous child
	Focus group discussions	

	Methods:	Purpose
13	Health facility in-charges	• To explore their perception of integration, challenges and lessons learned from implementation, impact on other services and ways the service could be strengthened
14	EPI-family planning service providers	• To explore their perception of integration and practical challenges to implementation of the integrated services, lessons learned
15	DPHO stakeholders	• To explore strategic implications of integration, challenges and lessons learned particularly with respect to logistical challenges and HR issues
	Key informant interviews	
16	FCHVs (x2)	• To understand support to EPI/family planning integration process and its implementation among FCHVs at non-monitored sites

ANNEX 4: CLIENT KNOWLEDGE ON HEALTHY TIMING AND SPACING OF PREGNANCY

100 EPI clients were interviewed to understand their knowledge about healthy timing and spacing of pregnancy.

Table A4.1: Appropriate spacing between two child for good health of mother and child

Appropriate spacing between two children	N	%
One year	2	2.0
Two years	14	14.0
Three years	27	27.0
Four years	27	27.0
Five years	23	23.0
Six years	7	7.0
Total	100	100.0

Table A4.2: Time taken to conceive again after delivery in case the child is breast fed along with other supplementary food

Time taken in weeks	N	%
4 weeks	3	3.0
6 weeks	16	16.0
8 weeks	9	9.0
24 weeks	32	32.0
More than 24 weeks	20	20.0
Don't know	20	20.0
Total	100	100.0

Table A4.3: Knowledge about regaining fertility by women attending group health education session

Knowledge about regaining fertility	Participation in group health education			
	Yes		No	
	n	%	n	%
4 weeks	1	1.6	2	5.6
6 weeks	14	21.9	2	5.6
8 weeks	6	9.4	3	8.3
24 weeks	20	31.3	12	33.3
More than 24 weeks	12	18.8	8	22.2
Don't know	11	17.2	9	25.0
Total	64	100.0	36	100.0

Table A4.4: Estimated number of clients and actual FP uptake at integrated FP/EPI clinics, during 12 months of operations research

Health Facilities	Number of women used FP device	Estimated number of women who visited EPI clinics (Number of children who received BCG)	Percentage of women received FP devices among who visited EPI clinics
Badalkot	49	72	68.1
Bharta	43	158	27.2
Chhapre	45	104	43.3
Chilkhaya	32	102	31.4
Daha	33	117	28.2
Gela	22	77	28.6
Jubidha	162	74	218.9
Khina	126	219	57.5
Kotbada	47	109	43.1
Kumalgaun	131	109	120.2
Lalu	34	119	28.6
Malkot	127	122	104.1
Manma	57	158	36.1
Mehalmundi	24	135	17.8
Mugraha	4	60	6.7
Mumra	28	80	35.0
Nanikot	47	180	26.1
Odanaku	23	75	30.7
Phoi Mahadev	47	75	62.7
Phukot	47	158	29.7
Rachuli	35	75	46.7
Raku	64	132	48.5
Ramnakot	34	95	35.8
Rupsa	118	99	119.2
Siphkana	52	126	41.3
Suina	50	127	39.4
Sukatiya	20	114	17.5
Thirpu	38	126	30.2
Total	**1539**	**3197**	**48.1**

ANNEX 5: PERCENTAGE OF DALITS FAMILY PLANNING USERS AT INTEGRATED FP/EPI CLINICS, BY VDC (TOTAL FOR 12 MONTHS OF IMPLEMENTATION)

Name of health facilities	Total Population	% of Dalit population	Total Dalit population	# of total FP device users	# of Dalit FP devices users	% of Dalit FP device users
Badalkot	3,304	7.04	233	49	22	44.9
Bharta	7,182	25.7	1,846	43	5	11.6
Chhapre	3,712	11.62	431	45	8	17.8
Chilkhaya	4,610	17.88	824	32	3	9.4
Daha	5,004	19.2	961	33	5	15.2
Gela	3,890	25.67	999	22	8	36.4
Jubitha	407	17.78	72	162	45	27.8
Kheena	3,702	23.11	856	126	29	23.0
Kotbada	3,734	14.84	554	47	26	55.3
Kumalgaun	3,762	14.67	552	131	40	30.5
Lalu	984	14.27	140	34	6	17.6
Malkot	3,752	10.39	390	127	63	49.6
Manma	9,464	47.5	4,495	57	39	68.4
Mehalmudi	4,876	16.55	807	24	6	25.0
Mugraha	497	25.56	127	4	2	50.0
Mumra	3,404	26.94	917	28	4	14.3
Nanikot	973	13.69	133	47	13	27.7
Odanakhu	3,816	12.04	459	23	1	4.3
Phoi Mahadev	3,416	18.11	619	47	1	2.1
Phukot	5,220	41.73	2,178	47	18	38.3
Raku	4,476	29.4	1,316	64	11	17.2
Ramnakot	3,810	21.77	829	34	5	14.7
Ranchuli	422	12.67	53	35	2	5.7
Rupsa	4,040	7.81	316	118	0	0.0
Sipkhana	5,286	36.25	1,916	52	14	26.9
Siuna	5,646	35.36	1,996	50	14	28.0
Sukatiya	887	24.55	218	20	3	15.0
Thirpu	702	12.28	86	38	6	15.8
Total	100,978	**24.09**	24,323	1539	399	**25.9**