ACCESS AND QUALITY OF LONG ACTING FAMILY PLANNING SERVICES FROM NGO SUPPORTED FAMILY PLANNING OUTLETS IN NEPAL

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUITEMENT FOR THE DEGREE OF MASTER OF SCIENCE IN PUBLIC HEALTH (MScPH)

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The work done by others, which has been used from either printed source, internet or any other documents had carefully acknowledged and referenced according to adopted referencing requirement.

This thesis "Access to and Quality of Long Acting Family Planning Services from NGO supported family planning outlets in Nepal " is my own work.

Signature

Table of contents

Contents

List(s) of tables, figures and maps.

Glossary

Implant: Implant is known as *"Kati" "Pakhura ma Rakhne" in Nepal*

***IUCD**: IUCD is known as "kapar T"*

ANM: Assistant Nurse Midwife (ANM) is a person (female) with education in 18 month course designed to prepare competent ANM especially in midwifery, reproductive health (MCH/FP) and community health in Nepal.

Staff Nurse: Nurse with Proficiency Certificate Level (PCL) nursing study, 3 year extensive course designed for students after 10th grade.

***Didi*:** Community women working at the community as social mobilizer.

8/8 integrated service: 8/8 service is an integrated package by Family Planning Association of Nepal (FPAN). It includes sexuality counseling, contraceptive service including emergency contraceptives, safe abortion, RTIs/STIs, HIV AIDs, gynecological services, pre and postnatal and sexual and gender based violence services.

Provider Behaviour Change Communication (PBCC): PBCC is approach, which takes place during ongoing and regular one-to-one conversations with providers. PBCC trained staff use PBCC techniques to identify individual motivators and barriers to performing the desired behavior. At the same time it provides solutions to address them during these conversations.

Quality of Care: Quality of care (QoC) is approach focused to provide family planning services that respect, protect and fulfill basic human rights to the highest attainable standard. QoC approach focuses that care should be based on relationships between providers and clients, and services delivered in line with the needs, values and preferences of the clients, and with compassion and empathy.

FP outlets: Family planning service outlets in Nepal. These outlets are supported by I/NGO for family planning service delivery. Some of them are operated by for profit providers and some of them are operated by NGOs.

Long Acting Reversible Contraceptives (LARC): Family planning methods. Implants and IUCD collectively expressed as LARC.

Abbreviations

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
DH	District Hospital
EDP	External Development Partners
EPHS	Essential Package of Health Services
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FP	Family Planning
FPAN	Family Planning Association of Nepal
GDP	Gross Domestic Product
GON	Government of Nepal
HF/HP	Health Facility/Health Post
I/NGO	International/Non-Governmental Organisation
IEC	Information Education and Communications
IUCD	Intrauterine Contraceptive Device
LARC	long Acting Reversible Contraceptive
LMIC	Lower Middle Income Country
MoH	Ministry of Health
MSI	Marie Stopes International
NMICS	Nepal Multiple Indicator Cluster Survey
NMS	National Medical Standards
PBCC	Provider Behaviour Change Communication
PHCC	Primary Health Care Centre
PI	Principle Investigator
PM	Program Manager
PPP	Public Private Partnership
PSI	Population Services International
QA/QI	Quality Assurance / Quality Improvement
REC	Research Ethics Committee
SPN	Sunaulo Pariwar Nepal
THE	Total Health Expenditure

Abstract

Background:

The unmet need for FP services is 25.2% in Nepal (2014). High-unmet need is one of the biggest challenges for successful family planning programme in Nepal. The Government of Nepal (GON) made strategy to collaborate with International Non-Governmental Organisations (I/NGO) and private sectors for comprehensive Family Planning service.

Objective: This study aimed to explore the access to and quality of LARC service provided by NGO supported FP-outlets in Nepal.

Methods: This study is done through literature review and qualitative field study. An adopted framework from Bruce and Jain T. Bertrand guided the study. A purposively selected sample participants, Managers, service providers and clients were interviewed in Kavrepalanchowk and Makawanpur districts in Nepal.

Findings: The LARC service from these outlets are concentrated in urban settlements; mostly in the district headquarters. Distance to the outlet is a barrier to access LARC. Management aspects and opening hours varied by supporting NGO. Multiple ways are in place to establish contact with clients. Some administrative rules and regulations are hindering the expansion of outlets. NGOs are organizing outreach camps to increase the access. LARC service from the outlet is of good quality in perception of providers and clients. Gap in some aspects of quality—complete information to clients; issue in service report, availability of all choice of methods is identified. A good relationship between the GON and NGOs is observed.

***Conclusion and recommendation*:** In spite of the contribution from NGO supported outlets and perceived better quality of LARC service provision, its access is limited to clients from urban settlements around the location of these outlets. Minimize duplication of support, and flexible rules and regulations to increase the number of outlets, arrangement of flexible hour of service, creating strong reporting mechanism, integration of LARC in outlets with other health services, improvement in counseling and a study to explore the impact of NGO support for LARC are recommended.

Key words: Access, Quality, LARC, Nepal, NGO funded, outlets

Word counts: 12955

Introduction

The Government of Nepal aims to support to maintain family size and assist healthy spacing by improving access to rights-based FP services and reducing unmet need for contraceptives. Regardless of the overall progress in FP, gaps in access to desirable method and quality is still visible among different sub-regions, and specific population groups such as adolescents, poor and marginalized women. As per Nepal Multiple Indicator Cluster Survey (NMICS 2014), unmet need for FP is 25.2% for women in Nepal.

The Principal Investigator (PI) of this study has more than 20 years of work experience in the maternal child health and Family planning in Nepal. As liaison manager for the Family Health Division (FHD) of the Ministry of Health (MoH), PI gained interest to understand the country's FP program and devise strategies and interventions that will enable accelerated progress towards ensuring increased and equitable access to and quality of FP services by all—and in particular poor, vulnerable and marginalized populations.

Opportunity to attend MScPH course in Royal Tropical Institute (KIT) and approval for conducting thesis in this area allowed to explore more on this area. The purpose of this study was to explore access to and quality of LARC service provided by NGO supported FP-outlets in Nepal. In response, this study aims to make due recommendations on key actions for improving access and quality of LARC in Nepal.

The first chapter is about the background of Nepal. The second chapter describes the problem statement, objectives and the research question. Chapter three is about the methodology and framework chosen for the study. In chapter four, the study findings are presented. Chapter five is about discussion on the findings of study and literature review in Nepal and other parts of the world about the topic. Final chapter six covers the conclusions and recommendations of the study.

CHAPTER 1: BACKGROUND

1.1 Country Information

Nepal is a Lower Middle Income Country (LMIC) of Asia. It is small in size (147,181 square kilometers), landlocked country, located in between China and India. Geographically, it is divided into three regions- Mountain, Hill and Terai, each stretching from east to west across the country. It is divided into 75 districts. Districts are distributed across the different ecological zones and development regions(1).

According to the recent administrative changes in September 2015, Nepal is divided into seven federal states. Each state is sub-divided into urban and rural areas. 59% of the total population live in the urban areas (1). Women literacy in Nepal is 57.4 (2). Around 84 percent of women aged 15–24 years are literate (3). Almost 16 percent women aged 15–49 years are first married before the age of 15, and nearly half (49%) of women aged 20–49 years are married, before the age of 18. The socioeconomic status of women in Nepal is very poor. The majority of communities in Nepal is patriarchal, the decision of women is determined by the patriarchal social system, values, and influenced by male and in-laws in family(4).

1.2 Health System

Modern Health System (HS) was introduced in 1956 in Nepal. It has expanded primary health care approach in order to reach basic health services to the grassroots level. Health post is the lowest level of health care facilities available at the periphery(5). The Government of Nepal has defined Essential Package of Health Services (EPHS) for four basic programmes (safe motherhood and family planning, child health, control of communicable disease, and strengthened outpatient care).

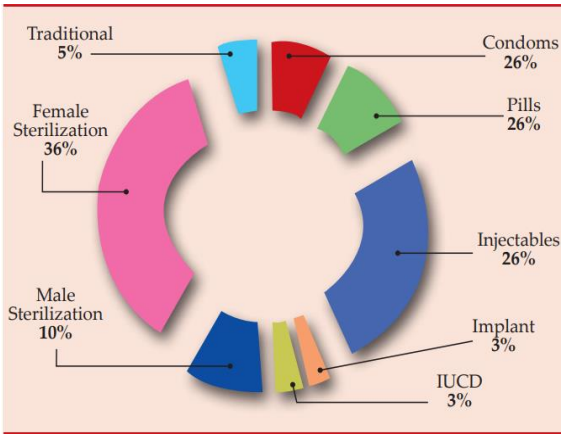
Health sector budget managed by the Ministry of Health on a historical basis. The Government of Nepal pools funds from tax and non-tax revenue and external development partners and pays providers (hospitals, health posts, sub health posts, primary health care facilities, etc.). External Development Partners (EDP) finance nearly half of Government spending on health. Total Health Expenditure (THE) was 5.8% of Gross Domestic Product (GDP) in 2014(6). More than 55% of total health expenditures was financed through out-of-pocket expenditure by households at the time of service 2014(6).

1.3 Reproductive Health Information

Nepal is a signatory of the International Conference for Population and Development (ICPD) (7). Modern Family Planning service is one of the oldest services in Nepal, which was first

introduced in 1968. Different types of modern methods of family planning[1] are available in Nepal(1). Short term methods are commonly available across all FP service sites; however accessibility of LARC is relatively low from government health facilities as well as private facilities.

Figure 1: Family Planning Method Mix



Source: (NMICS, 2015)(3)

1.4 I/NGOs and Private Sector

The GON had introduced a health policy to encourage public-private partnership for affordable, accessible and quality services in health sector. The private sector has rapidly progressed for health care services in Nepal (8). Family Planning Association of Nepal (FPAN), Marie Stopes International (MSI), Contraceptive Retail Store Company (CRS), Population Services International (PSI), and Nepal Fertility Care Centre (NFCC) are providing support for expanding comprehensive FP services (9).

Table 1: Reproductive Health Indicators

The Total Fertility Rate	2.3 children/woman
Maternal Mortality Ratio	258/100,000 live birth
Infant Mortality Rate	33/1000 live birth
Under five Mortality Rate	38/1000 live birth
The Adolescent Birth Rate (at the age of 15-19 years)	71/ 1,000 women
Use of contraception (any methods) (by 15-49 year women)	50%
Use of contraception (modern methods) by 15-49 year women	47%
Contraceptive Prevalence among women aged 15–19 years	19%
Unmet need for contraception among all women	25.2%
Unmet need for contraceptives among 15-19 years	35%
Unmet need for 45-49	11%
Antenatal Care by Skill Birth Attendants (SBA)	68%
Delivery attended by SBA	56%

Source: Family Planning Method Mix(NMICS, 2015)(3)

[1] Intrauterine contraceptive device (IUD), implants, injectable, oral pills, condoms, and lactational amenorrhea method (LAM) and female and male sterilization

CHAPTER 2: PROBLEM STATEMENT AND OBJECTIVES

2.1 Problem Statement

Unmet need for family planning is 25.2% in 2014 in Nepal(1). Unmet need is highest among younger women, rural women, and women living in the mountain(1). Highest among younger age 15-19 years (48%) (3). Women with no education have the lowest unmet need (18%)(1). Women from lowest wealth quintile had higher unmet need (27%)(1)

Short term methods are commonly available from government facilities, private medical sectors and NGO supported clinics(1). However, accessibility of LARC is relatively low from government health facilities as well as private facilities(3). Collectively, use of LARC is 3% for IUCD and 3.2% is for IUCD.

Studies on the use of family planning from Nepal, explored many barriers in accessing quality FP services. These barriers were client, provider and health system related factors. Client related factors were; poor knowledge about family planning methods and services, low economic status, myths and misconceptions and concerns and experience of side effects(10). Provider related factors; lack and unavailability of competent providers and limited client counseling skill in providers (9,11–14). System related factors were poor coverage from health facilities, lack of outreach services, lack of supply and unavailability of choice of method mix and service related equipment, distance to the facility, staff retention and shortage of trained health personnel (especially in remote areas) (9,11–14).

Providing LARC through NGO supported outlets is one of the current policy of the Government for comprehensive FP services(15). However, the access to and quality of the service yet to explore.

2.2 Study Justification

Quality and accessible family planning (FP) services can bridge the gap between unmet need unintended pregnancy. LARC methods are considered as high effective methods for spacing and limiting births. In addition, the benefits extend to avert maternal morbidity and mortality, unsafe abortion; spacing and limiting (16).

Family Health Division allowed trained staff nurses and Assistant Nurse Midwives (ANM) to provide long-acting family planning methods, i.e. IUCD and Implant in Nepal (8,17).

There were some attractions for accessing private clinic/medical shop for child health services in Nepal. The reason for the attraction were; longer opening hours, shorter waiting times, better counseling and availability of service in credit (18).

The Government of Nepal adopted a public-private partnership (PPP) and engaged NGOs and private sectors to increase access to comprehensive family planning services(8,12,14,17).

FPAN, MSI, and PSI are providing support for expanding LARC services from PFP outlets. Such LARC services providing outlets are more than 700 in Nepal (17,19). FP clients access 6% of modern contraceptive service from the NGO sector in Nepal(1). Thus, this study was done to generate answers to what is the access to and quality of service from I/NGOs supported outlets.

The study findings can be beneficial to the Government, supporting NGOs, and service providers for addressing barriers and improving access to and quality of LARC service. Recommendations will further guide to adapt the different aspects to increase access and quality of service from such outlets.

2.3 Research Question

What is the access to and quality of LARC service from NGO supported FP outlets in Nepal?

2.4 Objectives of the Study

2.4.1 Overall Objective

To explore the access to and quality of LARC service from NGO supported FP outlets in Nepal and recommend the government of Nepal, supporting NGOs and service providers the next steps to increase access to and quality of LARC services.

2.4.2 Specific Objectives

Study was conducted with following specific objectives:

- To explore access to and quality of LARC service in Nepal and internationally
- To analyse the perspectives of managers, providers and clients about factor enable or hinder access to LARC services
- To assess the perspectives of managers, providers and clients about the quality of LARC services
- To recommend government of Nepal, supporting organizations and providers to improve the access and quality of LARC service in Nepal.

CHAPTER 3: METHODOLOGY

This study was done through a combination of two methods: literature review and desk study; review of government and supportive organizations published and unpublished documents and a field study.

1. Literature review
2. A small qualitative field study

3.1 Literature Review

Literature search was done from different text books, journals, reports, published/ unpublished policy documents of Government, supporting I/NGOS and existing promising practices and gaps in FP services. Search included in VU data, PubMed, and Google scholar.

Key search words like 'family planning' 'contraception' 'quality of care' 'family planning determinants' 'contraceptive choices' 'health financing' 'migration' 'access' 'private sector', 'Socio economic' 'franchise' 'Global trend', LARC, "Health System", "public private partnership 'Migration" were used as key word for searching the relevant articles.

3.2 Methodology for Qualitative Study

This subsection describes the methodology chosen for a small qualitative study conducted in Kavre and Makawanpur district of Nepal in July 2017. The detailed study proposal approved through KIT Research Ethics Committee and Nepal Health Research Council is included in Annex.

3.2.1 Study Design

This was a qualitative study design.

3.2.2 Study Population

Three segments of population were included in this study; programme managers, service providers and clients from two selected districts. Total of 22 participants were selected for the study. Out of them six were service providers from six selected outlets. Twelve clients/ LARC user from the same outlets and four managers from government and supporting NGOs were planned to enrolled in the study.

3.2.3 Study Variables

Access to the quality of care is vague and relative terms in health service. Understanding of access and quality may vary by different segments of population. Different types of

respondents may define quality and access differently. In this study access to and quality of LARC service was defined as per the elements described in framework. "Quality of care" and "access to care" were dependent variable in this study. Independent variables are elements in the framework.

3.2.4 Study Settings

Two hilly districts of Nepal, Kavrepalanchowk (also called Kavre) and Makawanpur are chosen as study district. Data was collected in the outlets of both districts. Kavre is about 30-KMs east of Kathmandu and Makawanpur is located to the southern part, about 70 KM from Kathmandu. Data collection was planned in each selected outlets. These outlets in two districts are similar to other districts where I/NGO are supporting. Three selected outlets in each district were supported one by each organization (MSI PSI and FPAN).

3.2.5 Study Methods and Tools

The study method consists of a qualitative approach using semi-structured interview (SSI), In-depth interview (IDI), and client exit interview (CEI). Programme Managers were interviewed using SSI, Service Providers were interviewed using IDI and clients were interviewed using CEI with a topic guide. The Topic guide was pre-tested in two outlets in Kathmandu similar to the study sample and appropriate modifications were made as required.

3.2.6 Inclusion and Exclusion Criteria

Program Manager with less than 6 months working experience in the organization were not included in this study. Service Providers with less than 3 months in that outlet were excluded. For clients: Clients using LARC, either currently or in the past were included.

3.2.7 Data Collection Procedure

Principal investigator directly engaged in collection of data by visiting respective study sites. Procedure of data collection includes; a) meeting with FHD official, b) Visits officials of supporting NGOs, c) schedule data collection, and d) field visits to study district and data collection. Detailed information about the study was provided and informed consent was obtained from each participants. Interview were pre-scheduled through telephone or/and e-mail with Program Manager and Provider.

3.2.8 Ethical Approval

Ethical approval was obtained both from the university Research Ethics Committee (REC) at KIT and Nepal Health Research Council (NHRC). In addition, a verbal approval was obtained from the concern supporting organizations. Likewise, written consents were taken from all participants.

3.2.9 Data Analysis

All SSI IDI, CEI were recorded using a tape recorder and also noted in Nepali. They were transcribed and translated into English and entered in MS Word. The data were grouped according to the study elements. The data were analyzed manually. Quotes and interesting points were kept and mentioned in the report. New information from the interview was also noted.

Analysis of the data was done based on framework. To ensure quality of the data one sets of recording (one from client, provider and program manager) was retranslated by another person. Translations from PI and the other person were reviewed by third person. Commonalities from both translations were continued and differences were noted for next translation.

3.3 Limitation of the Field Study

Selection bias: The selection of client for the study was planned with them who actually accessed the service. Especially, for the element the selection of respondent was bias. Their expression for barrier to accessing service may not be that extensive compared to those who did not accessed the service.

Sample size bias: Because the selected sample were small size. Their views and perspective may not be true representation of the all managers, providers and clients.

Methodology bias: Only qualitative method for study was selected. If it was possible to do mixed method more information could have explored i.e. number of staff actually following the checklist during procedure. It would have been stronger compared to only perspective of provider regarding their competencies.

Interviewer bias: past experience of the interviewer about subject matter may have influenced. Researcher's experience could have influenced respondents' responses.

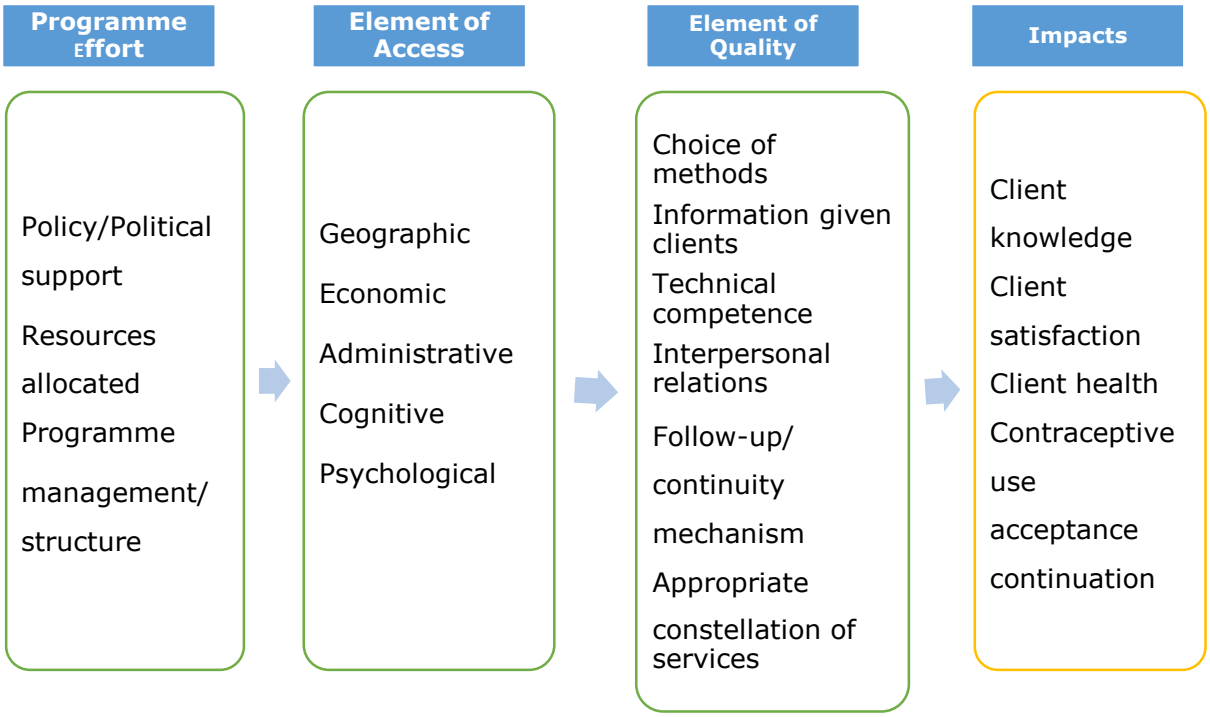
These limitations affect the external validity of this study.

3. 4 Conceptual Framework

This study was based on theoretical framework ***from Jene. T. Bartrand, (1995) for*** studying the access barrier and measuring the quality of family planning services **by Judith Bruce (1990)**. Access determines where a client is able to reach/contact service provider for service. Quality of care determines the client's decision to select, accept and continue the method they choose.

The adopted framework is divided into four parts. First part starts with programme effort, which includes the policy and political environment for service provision. Second part is element of access. These elements act as barrier or enablers to reach outlets for service. The third part is elements of quality. The clients and providers experience and description in these eleven elements are vital to define access to and quality of service from their perspective. Fourth part is impact of the service provided to clients. First three part of the framework were focused in this study. This study did not cover the impact study.

Figure 2 : Framework for Access and Quality of LARC Service



Source: Quality elements adopted from Bruce, 1990(20) ***and Access element adopted from Jene. T. Bartrand, 1995***(21)

3.4.1 Program Effort

Policy and political environment in this study refers to existing policy and environment from government and I/NGOs for family planning service provision in Nepal. Further this covers the allocation of financial and human resources for LARC services and programme management and structure to deliver it.

3.4.2 Access Element

Access elements were added to the Bruce framework to determine whether client makes contact with the providers. When there is enabling environment for reaching to outlet,

likelihood of accepting the method for family planning increases. Element for access (Figure **1 – elements of access**) are a) geographic; b) economic; c) administrative; d) cognitive; and e) psychological (21). In this study is centered to explain the existence or absence of the access element which enabled or hinder clients to access the LARC service.

Geographic Access in this study is the location of outlet and distance from the population from client and provider perspective.

Economic Access in this study referred to the cost for accessing LARC from outlet i.e. cost for registration and services, the indirect cost i.e. cost for transportation to reach the outlet and the cost for the work need to compensate to reach to outlet.

Administrative Access in this study referred to the rule and regulations which helps or hinder client to access the FP service they want. It also includes the procedure in outlet, waiting time and timing for service from qualified provider.

Cognitive Access referred to the client's awareness about the outlet and its location prior to visit.

Psychological Access in this study is about the client's preparedness with the rumors, stigma, psychological or attitudinal or social factors for seeking family planning services.

3.4.3 Quality Elements

In the 1990s, Judith Bruce and Anrudh Jain developed a framework for conceptualized quality as "client oriented" care for measuring the quality of family planning services. The Bruce–Jain framework focuses on clinical provision of family planning, and defines six elements of quality (**Figure 1 – elements of quality**): a) choice of methods; b) information given to clients; c) technical competence; d) interpersonal relations; e) follow-up and continuity mechanisms; and f) appropriate constellation of services (20). These six elements of FP services together constitute quality of care.

Choice of Method is referred to the availability methods including LARC in the outlet. It was also considered whether LARC methods are made available to different subgroups different age groups i.e. adolescents, socioeconomic group. Does the methods are imposed by provider or focused by programs to achieve targets.

Information given to client in this study, it is referred that the source and mechanism through which information may reach to the client. Study will cover the outlet penning time, available methods, existence of qualified service provider and approximate cost to enable them to decide, accept and continue the method that is suitable and satisfying to their needs.

Technical competencies factors associated with provider's technical ability to provide LARC to client as per protocol. The service offered to client must be safe, effective and suitable to the clients' needs.

Interpersonal Relation is the personal dimension of the service. Strategies to establishing contacts in between client and provider.

Mechanism to encourage continuity is about plan in place to support client for continuation of method they adopt.

Appropriate constellation of service is the arrangement of services to respond the need of service integration. For example, existence of Maternal and Child health and other services from outlet.

3.4.4 Program Impacts

Study of the program impact from the framework was not done in this study.

CHAPTER 4: STUDY FINDINGS

This section highlights the findings from literature and documents review that relate to access to and quality of family planning services.

4.1 Literature Review

Findings from literature on access and quality of family planning is presented in this sub section. First, part is context specific information about Nepal. Then, information of programme factors that contribute to quality service delivery is presented. It is followed by evidence of findings according to the eleven elements of framework. Some of the findings from literature for access are overlapped with element of quality. For example, if there is good provision of information given to client it will enhance possibility of accessing service. Therefore, there is notable, but necessary overlap in the presentation of finding below. Review search was for factors and intervention to increase access and quality of LARC.

Nepali context:

The context in which service provision has been made is a place with difficult geographic terrain. Here, in spite of universal knowledge of one form of family planning, unmet need is high(3). Migration associated spousal separation is high, women are dependent to husband or other members in family for financial matters and decision making.

DHS 2016 survey in Nepal found unmet need for family planning is 25.2% 2016 in Nepal(1). Need was 10% for spacing and 15% for limiting. Unmet need is highest among younger women, it was 48 percent for 15–19 years to lowest for women aged 45–49 years (11%)(3). Women in urban areas are more likely to use a contraceptive method than women in rural areas (55% and 49%, respectively) (1).Women with no education have the lowest unmet need (18%)(1). Women from low wealth quintile had higher unmet need (27%)(1). NDHS shows that unmet need for women living with their husbands is 16%, while it is 58% for women whose husband has lived elsewhere for more than a year (22).

In Nepal, the contraceptive prevalence rate (CPR) among married women differs with age, rising from 23% among women age 15-19, peaking at 69% of women age 35-44, and then slightly declining to 65% among women age 45-49 (3).

Unmet need of Family Planning is 5 % higher in Nepal (25.2) compare to India (20.5%) and 13% higher compare to Pakistan (11.6%)(23). Use of LARC is around 3% each for IUCD and Implant(1).

Program Effort

Short term methods are commonly available from government facilities, private medical sectors and NGO supported clinics(1). However accessibility of LARC is relatively low from government health facilities as well as private facilities (3). All together LARC (3.1% IUCDs and 3.2% implants) contributed for family planning method mix in Nepal. IUCD (16.5%) and Implant (12.8%) were provided through NGOs in Nepal(1).

Policy program support, allocated resources, program management structure, etc. are very important aspect for success of any program(3). In a study conducted in Nepal had shown success to uptake LARC in its program area from 0.8% in 2006 to 3% in 2014 (3,17). Efforts providers training, monitoring and supervision in IUCD insertion and removal, demand generation using community health workers to educate women and dispel myths were reason stated for success(17).

Program support to increase access to LARC

- Provider training
- Mentoring provider skill
- Demand generation
- Awareness in myth and misconception
- Availability of method mix
- Working through NGO

To mitigate the barrier of access a pilot study in one rural hilly district of rural Nepal with visiting provider approach was found. The approach resulted uptake of LARC by 1,123 additional LARC users with 4,327 additional CYP through 'Visiting Provider' approach. Study district had lower than average use of family planning (Herd unpublished report -2016)(24). However, the study was implemented in one district as pilot.

In Chad and Demographic Republic of Cango (DRC), in spite of state of crisis, implementation of focused set of interventions with allocation of resource to improve access to and use of modern contraception showed a sharp increase in the uptake of LARC(25). In Chad, Implant reached to 50% in 2015 from 0% in 2011, similarly IUCD increased to 12% in 2015 from 0% in 2011. In case of DRC, Implant increased to 40% in 2015 from 30% in 2011. IUCD reached to 40% in 2015 from 2 % in 2011. Same study found working through NGO for ensuring availability of method mix, high quality and free family planning service, expanding access, training providers for LARC and awareness to increase knowledge in client leads to LARC uptake (25).

The GON has adopted a public-private partnership (PPP) for scaling-up FP services. The GON had partnered with I/NGOs for comprehensive family planning services (15). Many I/NGOS are supporting government of Nepal for family planning services(9,26).

Access

Geographic access and the distance to the place where LARC service available was found as an important factor for the use or nonuse of services(10). In a study conducted in Nepal had shown that long acting FP methods users are 10 times more likely to travel for more than one hour as compared to the short acting methods. Same study found, use of LARCs was slightly higher among those who lived less than 60 minutes travel time from a health facility in comparison to those living more than 60 minutes away (12). Survey reports and studies had shown that prevalence of LARC is low (2.3%) among rural women in Nepal (8,12). Though the availability of services is an important factor for increasing the access to services, it was found that physical access is not such a severe barrier as is sometimes claimed, perhaps poor quality of services is the most important constraint (27). However, most of these studies were focused for all FP methods in which som factors were found for LARC specefic.

Socioeconomic status and use of LARC has the relative importance. The utilization of LARC services is low especially among the low income quintile population in Nepal(22)(28). Cost of lost work, cost of travel and indirect cost in facility were found as barrier to access service in Nepal (10,11,29). Similar finding were found in other literature as well; one prospective cohort study of 10,000 women conducted by Choice project in US found that when 14-45 years of women provided IUCD free of cost, to all potential client as option, two-thirds chose LARC. However, the study had also compensated participants with financial incentive(30), another study also state cost as barrier for access LARC among substance user women (31).

Status of family planning report Nepal states that husbands support as important role for use of LARC in Nepal (19). Culture and religious ties such as a strong son preference, religious beliefs and concerns about side-effects as substantial psychological barriers are found in Nepal (3)

As administrative access barriers staff retention and issues around commodity supply were found as barrier for use of LARC in Nepal(11–13,17). Findings from study from Malawi and Senegal showed that long waiting times and inconvenient hours as administrative barrier which prevented many women from seeking family planning services (32).

Factors affecting accessing LARC

- Location of the service point
- Staff retention
- Travel time
- Service quality
- Women's economic state
- Cost (cost of lost work, cost for travel and cost for service)
- Son preference
- Support from male partner (husband)
- Myth and misconception about LARC
- Waiting time and inconvenient hours

Literature were not found specific to psychological, and cognitive administrative access barrier distinctly. These barrier linked with accessing quality service, selecting method, decision making thus findings were grouped under respective subheading under quality.

Quality

Choice of Methods

When clients get their choice of methods, it leads to retention and continuation of method they choose (33)(29).

Overall, 53% of currently married women use a method of family planning in Nepal. Among them 43% using a modern method and 10% using a traditional method(1). The most popular methods are female sterilization (15%), injectables and withdrawal (9%), male sterilization (6%), and the pill (5%) and LARC (Implant 3.2% and IUCD3%)in Nepal. (1)

Factors affecting quality of LARC

- Availability of LARC in the service point
- Lack of knowledge and skills in provider for LARC
- provider attitudes
- Poor or incomplete counselling
- Low client demand for LARC
- Fear of side effects
- Myth and misconception about LARC in client and provider
- Providers time, interest and willingness
- Integration of LARC with other service

NMISC survey reports showed, the preference for use of contraception was higher in women with children than those without children in Nepal. Only 15 percent of those without children used contraception compared to 33 percent of women with one child and 54 percent of women with two children in Nepal (3). Male child is generally preferred in Nepal. A study from India on male perspective on use of contraceptive for spacing shows desire for an additional child and a specific gender of child are basic and widely prevalent reasons for use of contraception. If desired number of children is achieved along with the preferred sex combination, then a couple might use contraception and limit their family size(34)(34).

Reproductive health report found weak counseling and not providing complete information to client as barrier to access LARC service in Nepal (19).

In inaccurate knowledge of provider for LARC and insufficient insertion training for IUCD from provider side and stigma, misperception of infection (for IUCD), unacceptable side effects and cost from client was explored as barrier for selecting in spite of higher effective methods for fertility protection LARC were stated in literature from outside Nepal (30,31). Study from Turkey and Uganda found availability of methods (IUCD and Implant) and its service in place as primary step to ensure choice (29,35)

Information Given to Clients

Counseling sessions are an opportunity for providers to deal with myths, ensure understanding of instructions and follow-up, well designed tools and build relationship required for future interactions (27). Information given to client is directly associated with clients cognitive ability to access and accept the service and greater range of contraceptive methods choice (22)(17).

Studies have revealed that women have universal knowledge on at least one contraceptive method in Nepal. Expression of an unmet need was found positively associated with education of a woman. Only 19% of women with no education compared to 32% percent of women with higher education had expressed unmet need in Nepal (3).

Lancet present the association of use of technical language from provider during counselling and level of clients understanding through structural observation. However, the study was about post abortion counseling the finding still considerable for family planning counseling (36). Other studies found that provider time, willingness and interest as major barrier for limiting opportunity to provide complete and correct information to the client(29,30,36–38).

Further, other studies found in interviews with providers and their managers that, provider faced many challenges in the provision of quality counseling. However, many providers simply do not view counseling as a priority and essential component of their job. In interviews, providers expressed time limitations and apathy as the main barriers to providing counseling (29,30,36–38).

Technical Competencies

Technical competencies of is important aspect of clinical services (10). Nepal adopted task shifting approach and allowed middle level health professional (Staff Nurse and ANMs) to provide LARC after receiving Skill training on implant and IUCD insertion(15). Having more skilled service providers present at facility was found associated with increased use of methods of contraception in Nepal (17). Unavailability of trained female service provider was found as barrier for access to LARC in Nepal (19).

Providing LARC via technically competent range of provider cadre was found as a reason for raise in the popularities of LARCs in papers presented at the 2016 international conference on family planning (24).

Interpersonal Relation

Focusing on the interpersonal contact between providers and clients can address some gaps in family planning programs(17). One of the study in Nepal shows that the quality of services provided to clients using Implant, IUCD, Pills and Depo-Provera was generally high. However, the result show that the providers do not strictly adhere to government clinical protocols and clients do not always follow the recommendation of providers (27).

Mechanism to Encourage Continuity

Follow-up services and counseling would affect continuation of contraception directly (15)

Appropriate Constellation of Service

Study from other part of the world revealed the importance and positive outcome of integrating family planning with a program in a non-health development sector. One intervention study from FHI 360 from India, Kenya and Uganda found family planning use for all methods increased significantly from 40% at baseline to 69% at end line, the unmet need for family planning declined from 42% to 12% during intervention period (39). However, study associated integration of LARC to and its impact was not found.

4.2 Findings from Field Study

This section presents the findings explored through field study on access to and quality of LARC services provided through NGO supported FP outlets. Study findings were summarised based on element of the framework. Program support is discussed in relevant section, i.e. support for onsite coaching in technical competencies and social mobilization under information given to client element.

4.2.1 Socio Demographic Characteristic of Respondents

Table 1: Summary of study participants

	Kavre.	Mak.	Total	Education	Age	gender
Programme Managers	-	-	4	MPH -3 Bachelor-2	35-45	2 Male 2 female
Service providers	3	4	7	ANM-2 Staffnurse-5	<30 = 3 >30 =4	Female
Clients	5	4	9	Literate		Female
Total	**8**	**8**	**20**			

Out of 22 respondents aimed to enroll enrolled in the study, 20 actually enrolled. Three clients reduced and one provider added in the study.

Program managers

Four program managers were interviewed. Two of them were female and two male. FHD, FP focal person is 15 years of work experience in family planning. Three program managers represented each supporting organisation. They had around 5 years of work experience in family planning. All had Public Health qualification.

Providers

LARC service providers were from different age groups, education background and work experiences. Out of total seven interviewed, two were freshly graduated, one of them had more than 20 years of experience and rest of them had less than five years of experience. Five of them were staff nurse and two of them were ANM. Providers from FPAN and MSI supported outlets were fulltime workers and paid by those organization. PSI supported outlets were managed by provider themselves so they do not take salary as such. One additional provider working in geographic difficult location was enrolled in the study to get more information associated to access in remote.

Clients

Total 9 LARC users were interviewed. They were of different age groups; one was adolescent, remaining 8 were between age 20-40. All 9 clients were literate and married. Six of them were housewives; one was a student and two of them were working in retail shop and hotel. Two clients from one outlet reduced from plan as no service record for LARC was found. One client rejected to participate after request for consent. Two of clients were interviewed at home as there was no client on the day of visit in outlet. All client were adult, aged 20 and above except one participant was 16 year old adolescent and married. Married adolescent at age of 16 consider adult in Nepal however, as precaution consent was also obtained from her companion (mother in law). Findings were summarised based on study framework. Summary of the study participants is included in appendix for reference.

4.2.2 Elements to Enable or Hinder Access to LARC Services

Geographic

Collectively, PSI, MSI and FPAN are providing support to outlets in 48 out of 75 districts of Nepal. Three of them are collectively supporting in 18 more accessible districts. No presence of organisation to support outlets was explored in 27 geographically challenged hilly and high mountain districts. In the study districts, all outlets were found located in urban setting.

Additionally, outlets are located within the same geographical area and easily reachable by road. FPAN and MSI expressed their strategy to serve in remote part is by camp and outreach setting. Whereas PSI shared strategy to open 5-12 outlets in one district for LARC service provision.

It means that the more difficult to reach areas/ people are not benefited by this support. It raised a question how this support enhances to increase access. All interviewed clients and providers expressed closeness to facility and location as important factors for accessing LARC service. Controversial expression noted from managers that the support limited to accessible area.

Figure 3: Map of Nepal - Outlets for LARC

FHD focal person said,

"In many cases NGOs support focused for addressing the barriers of FP services. Though it is limited, the LARC programme is effective for reaching unreached, they are serving more clients in the district and community level."

Manager in one supporting NGO said,

"Where we locate our centers is critical. We look for locations that are safe, convenient, easy to find and well served by public transport. Location is everything and we make sure they are open at times that work best for people living locally, not for the service provider." ***(39 years manager)***

Key responses from the client were as follows for accessibility;

A 37-year-old IUCD user expressed how the location of the outlets helped her to access the service and how she got benefited by accessing integrated service,

*"The reason I visited this outlet is because it is near, I can plan my visit to the outlet with my shopping schedule. Today as well I am here for shopping for my daughter and immunization to my grandchild have to shop and other work for my grandchild and daughter (**37Client,** **Kavre**)*

In her perspective, location of outlet was not only associated with accessibility but also with integration which enable LARC accessibility. However, one client expanded her thought beyond her own access to the service. She expressed how difficult for other in distance to access similar service. She said,

"*I chose FPAN clinic because it is nearby; only 15 minute-walking distance. I used implant here, which will secure me until I want another baby. But this is not the case in my maternal village Udayapur, which is very far from here. There is no method available to keep in arm and uterus. My maternal village is further far from district headquarter. My sister-in-law wishes for these methods. She says, I wish I could get methods which secure me for longer time; how secure and satisfied I would be. But these are not available there; not nearby my village. If someone can manage a day's walk it might be available. Government health facility only offers 3 months injectable"* (**24 Client, Kavre**)

The same opinion was echoed through the words of a provider, who served from private outlet in remote part of the district in Makawanpur,

*"I think, outlet has to be near and the transport has to be accessible. We have remote location in some part of the district where no access to transportation and walking distance to reach here is 3-5 hours. Most couple had 3-5 children and women are uneducated and belong to lower caste in those settlements "(***32 Provider, Makawanpur***).*

Distance and location of outlet was stated as a reason for choice of outlets. Except one provider who think sometime client visits the outlet from distance because of their past positive experience with outlet. She said,

*"The location is important and need to accessible so that clients were able to come when they need. But, not always location matter to the client who used service in past and had positive experience. I have some clients who come from 5 hours." (**44 provider**,* **Kavre***).*

Economic

Cost for the service was found as supporting element for accessing service for client. Either LARC service is free of cost or provided in subsidized cost from the outlets. FPAN and MSI supported outlets offered service free of cost where PSI supported outlets have different charges for services. Visited outlet in Kavre charges NRs. 200 for IUCD and NRs. 170 for Implant. Even some women who cannot afford the cost, these outlets have some other mechanism to support client who are willing for service. Provider said, FPAN charge only for registration Nrs. 10 and Nrs. 100 for removal. Charging for removal was found as control mechanism for the client who had intention of removal with minimal side effects.

One provider in FPAN outlet said,

*"Clients come from 4-5 hours walking distance, as cost of service is reasonable here, it is subsidized and cheap….charging for removal reduce method switch tendency of client." (**20 Provider**, **Kavre**).*

"We charged approx. 200 NRs. (2 Euro) for IUCD. Sometime clients visit without money with them. Although, in such we provide service to them. I asked NGO to pay for it or schedule client for free camp." (**Provider 20, Kavre**)

Geographic location of the outlet is also associated with cost for service. A provider from remote location of Manawanpur highlighted the importance of cost of travel for accessing LARC service. In her opinion cost of travel hinder some women. She said,

*"Clients willingness and ability to pay for cost of service is not a problem here. They are willing to pay high cost for service. IUCD service is not available in government facilities. Client travelled 2-3 hours in local transport to reach here. Interested client willingly pay higher cost. In my latest experience, Gyne doctor had visited from Kathmandu. Outlet was so rushed with many clients. One client wanted to switch implant with IUCD. Dr. requested to schedule for following day or pay urgent charge. Urgent charge is two time higher than regular charge. Client was willing to pay high charge. Because cost of transport, night stay and travel back was much higher than extra charge. Some settlement from the distance, there are many clients who wished to access the service but because of the cost and time to travel so they are unable access the service." (**32 provider, Makawanpur**)*

Provider expressed the importance of interpersonal relationship to establish contact with client. Cost management for LARC was found associated with interpersonal relationship with client.

*"….though I don't get direct profit by providing LARC service but it provides satisfaction and establishes contact to other service i.e. abortion service or medicine for sick child where I can make more money" Some client can't afford cost. They get services in credit, it is only possible because of personal relation with them. Just 2 day back I got money back for LARC I provided one and half year ago**."(28 Provider, Makawanpur)***

The finding of this study explored that cost for service is not a barrier. which is contradict with the findings from literature, where cost was noted as one of the barrier in in accessing LARC(30,31). It could be due to that LARC are available free of cost or subsidized rate in Nepal. However, the cost for transportation for accessing was expressed by both provider and client in this study. Moreover, LARC service is perceived by provider as link to build contact with client for other services.

Administrative

None of the clients interviewed had negative experience about waiting time and opening hours. In a normal day, outlets are officially open between 10:00 to 5:00 o'clock in the evening with provision of 3-5 pm administrative work in FPAN supported outlets. MSI supported clinics were open Sunday to Friday. PSI supported outlets are providing service in "anytime" basis.

Programe manager said,

" we have our own staff, we had 8/8integrated services clinic, we manage all cost by ourselves…….client has to pay nothing. They are our priority (**39 Male Manager**).

One provider in FPAN supported outlet say with emphasis on no client return policy,

"*……. We usually communicate to come between 10 AM-3 PM however, even clients arrive after 3 we provide service. We also get very seriously concerned for waiting time for clients." (***44 Provider, Kavre***)*

Implant user client of the same outlet verified providers saying,

"*Other places are a bit crowded, requires long waiting time. Here I don't have to wait. Not crowded here. I preferred quick response. I am not sure about exact time, I always come after 10 am and I found it open." (***Female 37, Client, Kavre***)*

One provider in Makawanpur expressed different opinion for waiting time,

"As I also work as mobilizer in my work area, I go to community conduct interpersonal counselling sessions to the potential clients. I may not be available during the hour when

*client may come, however my outlet is open for other purpose so client get information about my return, in such client who come for LARC sometimes need to wait for me." (***28 Provider, Makawanpur)**

Regular opening hour was found hindering on accessing LARC service for house wife and clients engaged in field work. Outlets opening in off hour and Saturday found helpful for them. Regarding to the question about opening time of outlet; one IUCD client in Makawanpur said,

"I am a house wife; I need to go to paddy field, to do a lot of household work. The outlet I visited opens in evening, its opening time make service accessible to me."(a **client 23, Makawanpur)**

Two of the provider found reporting to supportive NGO, district public health office and sometime to local health facility exhausted.

FHD focal person reflects regarding reporting,

"..we are facing a lot of problem on reporting form NGOs. Sometime they are missing, sometime they double reported."

Program manager of supporting NGO said,

*"in spite of provision in policy the service did not reach to all level of health facility, especially in semi urban location do not have access for LARC service. Additionally we provide, compensation against referral (NRs. 100) to government facility staff, to medical shop owner which is little higher than the possible amount local medical shop can charge for the method that access with them (i.e. NRs 50 for DMPA). It provides opportunity for client to get access to choice of more method. At the same time, quality could be maintain."(***Male Manager 39***)*

Two of the provider and one program manager expressed that rigid rules and regulation for opening outlets hinder to increase access to service. One program manager also said,

*"We have provision to support 5-12 outlets per districts. However, the rigid rule for registration in DDA is hindering the expansion of service. They want us to find a registered medical shop for expand as outlet and it is very hard to find such in remote setting." (****Female manager, 38****)*

In the finding of the study waiting time was not found as administrative barrier for accessing service. Which is contrast with the findings from study in Malawi and Senegal which present that long waiting times and inconvenient hours as administrative barrier which prevented

many women from seeking family planning services (32). However, reporting, opening hour, expansion of outlet were found as administrative barrier in this study.

Cognitive

Clients are aware about the location and availability of the service in outlet. They all expressed about changing literacy level of women in the communities. Further, there were aware of multiple source for communication through local FM station, Face book, and internet allowed them to know about the location, service provider and available service. Literature were not found specific to explaining about client level of cognitive with access to service.

Provider from Palung, who work in outlet as part-time from Makawnpur said,

*"Most women had access to net and mobile now a days. I usually update the information in face book about service. Women says when they get similar information from face book and FM they ensure the service time, type and outlet" (***32 Provider, Makawanpur)**

A client who recently used IUCD answered to the question how women know about outlets providing LARC service,

*"Time has changed now a days, we can read. FM frequently announced about the location and service, I know our Female community Health Volunteer (FCHV), SM and Didi they provide information about service and outlets frequently. They are easy to reach and they respond with friendliness." (****29 client, Makawanpur)***

Comparison of women's cognitive ability to decide for LARC is discussed under choice of method and information given to client.

Psychological

Among nine interviewed clients expressed their decisions to use LARC was depend on their past experience with provider-2, heard experience from friends who used methods -4, information from social mobilizer-7. Some clients get information from multiple sources.

Both provider and clients expressed their thought that there is changes in society for women in decision making ability, they are empowered, increasing education making them psychosocially strong. Furthermore they said rumors about methods are decreased compare to past. One client said,

"it is changed now. We are different then our mothers, we discuss together, we take decision together but I sometime need to convince my husband. Because it is me who has to carry children. But not all women are lucky like me. Many women in my village wanted to stop more

*child but they cannot decide because they do not get permission from their husband and in laws." (***33 client, Makawanpur)**

Manager, provider and client had agreed on reduction of method specific stigma. However, they heard one or more form of myth associated with methods I.e. IUCD travel to heart, it cause cancer of uterus, difficulties in sex (IUCD). Similarly, implant it circulate with blood and effects each organ in body where it visits etc.

One client in Kavre said,

*"I was implant user. Today I am here for abortion service. I thought I gained weight because of it, so I removed with believe that removing it will reduce my weight. My weight remain same but I got pregnant. I had abortion and had 'Kati' my arm again. I never want to have the one in uterus. My friends says I should never use that because that cause bleed all the time, it come out without knowing and hurts during sex." (***24 client, Kavre)**

Clients in exit interview revel interesting expression in the way the women deal with the matter of family planning with their spouses. Some client found who decided that they wanted to space the children and then inform their husbands. Exit interview client symbolizes this situation*,*

*"I made the decision on my own and then informed my husband who did not object". (***24 client, Kavre)**

The second expression is client where husband does not wanted more children after having two daughter. She wanted to try for boy. She discontinued contraceptives in between till they had 5th child as boy. Even after having boy she did not want to take risk of having permanent FP. She is having IUCD without her husband will. She concluded her narration by saying,

*"……but it is me who has to listen all about not giving birth to boy child and that is why I interrupted contraception to become pregnant again " (***37 client, Kavre***)*

Newly married adolescent said,

*"I just get married, not discussed with my husband, it is too early to discuss …but it is me who will suffer and that is why I came for family planning services. I share this to my mother-in- law and she bring me here for contraception." (***16 client, Makawanpur***).*

The adolescent shared the concept of suffering and viewing pregnancy as unnecessary burden repeatedly during interview. Rest of the participants in exit interview confirmed that decisions

were easy to implement when both the husband and wife agreed the need about limiting and space births.

Psychological state of the women, rumor, myth barrier result on choice of method and its continuation. Study findings and literature findings are discussed under choice of methods and information given to client.

4.2.3. Elements that Affects Quality of Service

Choice of Methods

Five forms of modern contraceptives were available in visited outlets except in one outlet. That particular outlet had no implant service because provider of the outlet was not trained in Implant. Provider said they provide opportunity to choose the method that client likes and suitable for their health condition. Provider claim they referred the client if the choice of method is other than available in the outlet. However, FHD person had doubt on it. They expressed,

Program manager said,

"Some of our supported outlets offer only IUCD as LARC. However, we support inform choice policy. We emphasis for referral if clients choice is for implant."

FHD Focal person said,

"…I think, sometimes, informed choice is not followed and clients are compelled to take/ accept the service, available in their center (outlet)."

Seven out of nine interviewed clients were aware about the health dangers, difficulties associated with many births and importance of LARC for spacing and limiting. Two accept LARC as suggested by peer. Five clients were using LARC after the birth of the first child. Three clients were using LARC after termination of unplanned pregnancy. They thought they had enough children. One among interviewed adolescent client was seeking for LARC just after she got married.

Provider in Makawanpur said,

"Perception of using LARC after birth of a first child had changed".

One recent married adolescent had expressed;

"*I am 16 year and got married yesterday. I know that we should not have child in our very young age. We both are 16. I know about FP methods from TV. I do not like other method so I am here to get implant." (***16 year Female Client, Makawanpur***)*

A study from Nepal found that LARC method were not accepted due to myth associated with method(19). In this study, women expressed there is reduction in extreme myths associated with LARC however, two of them found they switched method because of weight gain and another never wanted to use IUCD because her peer said, it create obstacle in sex (*refer client saying under psychological barrier section*)

Similarly, In Turkey, women's concern and fear of side-effects was found as a main factor preventing use of oral contraception's(35). In the same study in Turkey found male users of withdrawal almost always cited negative effects of modern female contraceptives as a reason for using withdrawal(35).

Rumors and myths determine care-seeking behavior by supporting or discouraging the use of services. Such Myth and misperceptions are not only barriers to use safe and effective means of contraception i.e. IUCD but are also reason for adoption of less-effective method or resulting in unintended pregnancy(35).

Information Given to Client

This study revealed, information regarding outlets, providers and service reached to the clients. NGOs had supported multiple channels to raise the awareness about location of outlets, provider and availability services. Information via local radio/FM stations, community health workers, beauticians with referral card in beauty salon (MSI), medical shopkeepers, mobilization of didi and IPC (PSI), social mobilizer (FPAN) are in place. Most of the clients expressed that, they usually get information from multiple sources; in group meetings, door to door visit from mobilizers and social media. The quotations below show how information in advance influenced clients to come to the outlet for seeking LARC.

37 year 5th para client in Kavre district expressed how interaction with provider helped her to choose the suitable method for her,

*" I was waiting for a boy child. My society preferred male child, when I had four girl finally we had baby boy …. the doctor who assisted during my fifth delivery told how much my health is critical. The team helped me with advice on taking FP methods. Then I take DMPA for long time which had side effects on me. Staffs are so friendly here, I asked something different and ended up having IUCD last year. I am happy for their help for my selection (***37 years IUCD user, Kavre***)*

Sometimes the decision wasinfluenced by the social mobilizer as explained by one current IUCD user who changed from injectable.

"I had some problem with my period and weight gain after using injectable. I was concerned and consult with 'didi'. She asked what method I wanted to use and I replied I want to change which work on me for longer time. She took me to outlet, than provider asked whether I wanted IUCD and I said yes". (**23 client, Makawanpur**)

Relatives and peer were found influencing role to initiate or discontinuation of contraception. Some of them play such an important part that women will go to great lengths with recommended method in spite of side effects. One client had told by her friend that IUCD is not good method. In-spite of having side effects, she had used injectable for longer time, then shift to implant. As it has continued effects then dropped that method. She then got pregnant. Even after abortion she used implant again. However she was found reluctant to use IUCD as her friend said it is not good.

One client with IUCD who come for follow up for a year back said,

*"I am satisfied with this method. I was hesitant before I use it because I heard a lot negative rumor about this method. Provider explained most of it to me without asking, some I asked with her. Rumor were about difficulties during sexual act, difficulties for hard work and bleeding. I got very good information from provider. Now as I am using cupper T for more than a year, I did not experience any of those." (***24 client, Kavre**)

Most of the client recalled that provider had briefed about many methods, then displayed and educated them on the method of their choice. However, two client in exit interview recalled that the speed of explanation was so fast and hard to remember.

Two provider said, it is difficult to give information to client especially when client came with methods in their mind and when client wants provider to decide method suitable for them.

Provider from the same location, agreed that,

*"Clients most of the time visit outlet with method in mind. The method they choose may not be suitable for their other health condition. In such, we have to counsel them for their informed choice. Even though, often women ask us to decide for them."(***42 provider, Kavre***)*

Provider recalled that, they provide information to client about the potential side effects, follow up, removal and contact details in case of complications.

Finding of the way provider speak fast which client do not understand what she says is consistent with the finding from a study done in 2006 by using structured observation of counseling sessions with post-abortion clients found that most information provided to clients

was relayed in technical language, which was may not necessarily understandable by clients(36). However, in another study incomplete knowledge about family planning methods and services was stated as barriers prevent the use of family planning in rural Nepal(10).

Technical Competency

All seven providers were trained in IUCD, and six of them trained in implant skill training. All of them had received the training before providing LARC service. They all concur that they received some kind of refresher on their job. Three of them said they receive two quality assurance visit per year. Another three said that they attended refresher training in last 6 month.

One provider said,

*" …..QA visits are good, it helps to recall all the step by step but …I always feel the QA visit day as exam day. I don't think I need to be tested two time every year for the work I am doing regularly." (**28 Provider Makawanpur**)*

Program manager's information was found consistent with the information from provider regarding QA visits. He further explained about the process of maintaining technical quality by QA visits. QA visit comprise of involvement of trained qualified trainers visit to assist and maintain technical quality of provider. National Health Training Center (NHTC) is official government body to provide the skill trainings for all service providers. Both IUCD and Implant training are skilled based training organized in accredited training sites and qualified trainers.

FP focal point from FHD (MoH) said,

"The training to private service providers are regulated by the National Health Training Center (NHTC) and FHD. It is standardized by the government through provision of follow-up and Onsite coaching. Counseling and follow-up of the clients are very much effective."

In the similar way manager from NGO stressed much importance to maintain technical competencies in provider; which is more focused on clinical aspect of service delivery.

"*We kept our provider in three level. We do not allowed level three provider to deal with clients till they reach to level one. We provide onsite coaching, skill checked using skill checklist and work under supervision when they in level two and level one provider who are proficient LARC provider they independently deal clients with their clients FP need.*" (**Female 47 Manager**)

The provider who work more than 20 years said,

"We follow all steps of infection prevention technique to provide LARC service. It not limited to the service provided from outlet. We maintain it in mobile outreach camp service too. We take autoclave and all necessary item in case we need it…in summary we do not compromise with quality" ***(44 Provider Kave)***

Similar view was presented by seven providers. In contrast, two providers expressed their view that they only prepare decontamination solution when there is client for IUCD. Four of provider added, in addition to technical skills and following protocols, the methods specific knowledge, sufficient equipment and supply, is required to define service of good quality. Technical competencies from provider perspective was found as clinical aspect for quality of LARC.

One provider from Makawanpur said,

"Skill training itself does not make provider competent. I used checklist in my outlet to assess whether we are following each step properly. I learnt it from coach training. Onsite coaching help a lot to keep up to date skill for LARC."

In contrast, client perspective were found based on their experience on the responsive of provider in process of accessing service. Client expressed they could not properly distinguish the ranks of providers, and they did not have information about providers qualifications. However, some client expressed satisfaction that providers performed the procedure in very qualified way. Some clients make their own judgments about the provider's technical competence. Most of the client linked technical competencies with provider's attitude and responsiveness.

One client said,

*….I was here for abortion service. I was stressed, hesitating to express to provider. She was so friendly thus I was able to continue talk about my desire for family planning when she asked.. Her hand was so smooth and skillful during implanting" (**24 client Kavre**).*

One provider recalled and express how the providers attitude toward client impact the service the received.

" *this outlet provides abortion service up to 12 weeks foetus. One client came to us in 14 weeks. We referred. Client came back to us .. She was so disappointed with the responsiveness in referral site. She request us not to refer any client there*"

Providers included in this study thought that they are technically competent for LARC service. However this finding is not consistent with the findings in other literature. Findings in the literature explored that provider had knowledge and perception gap in LARC(17)(31) (10).

Interpersonal Relation

This element guided to explore the personal dimension of the service. Discussion with manager was focused toward the program goal and strategy which allows the provider interact with clients. Interview with providers was focused to explore empathy, trust, assurance of confidentiality, and sensitivity with them to meet the client's needs and expectations.

NGOs had supported to hire/mobilize local females as social mobilizer, 'didi', FCHV and peer educators. Mobilizers had found key role to establish contact with clients, raise awareness and generate demands for LARC service. Sometime mobilizers extend their work and become companion to client to visit outlet for service.

Client who used IUCD last month said,

"……..i may not had adopted IUCD if 'didi' did not come to outlet with me ……She is from my village, I can ask anything with her when I need to know about family planning."

Three provider among seven interviewed found residing in the same locality where they serve. One provider is serving to area since last 20 years.

Provider who serves in tribe location of Makawanpur district since last 8 year said,

"My father is ex-army from medical department, he own this outlet as medical shop. When I completed my assistant nurse midwife course, I started to work here. NGO supported for my LARC training. I visits my community. I am aware of reproductive need of women from different social class, or cultural or economic status. They are comfortable to communicate with me. We had informal relation." (**28 Provider Makawanpur)**

Multiple approaches were found to initiate contact with potential client. As an example, one organization support to orient the females working in beauty salon to talk with women about their reproductive need and refer them to outlet if they found any need. Beautician provide information and referred clients and in return receives Payment for referral.

NGO program manager said,

"Informal talk during activities in beauty salon about their fertility preference, FP method use, ….then if the need for service (FP, Abortion) felt, the oriented beauticians provide voucher

with information about outlet and its service. Once a client reach to the outlet for any service they can access other service any time in future." ***(44 Male Manager, Kavre)***

All visited outlets have average LARC client were found between 4-17 per month/ outlet. One provider in each outlets was found in PSI supported outlets where as MSI and FPAN supported outlets had 2-4 providers.

All interviewed provider they give 30 min to hour time for LARC client. They expressed that the time required for Implant clients is less compared to IUCD because of technical procedure.

All providers expressed that, during the government reporting days they get busy because of reporting requirements but all said did not have overwork.

One Provider said,

".....no no specific of LARC we don't have any load (laugh).. we have only 10 client per month. We are four in this clinic."

Interpersonal relation among client and provider in the visited outlets was found good. This study explored much more opportunity to establish contact with potential client then most of the article reviewed. Finding on articles discuss about the interpersonal relation during service provision only(29,30,36–38). This is the positive finding of this study.

Mechanism to Encourage Continuity

All six visited outlets had system of follow-up for the LARC clients. They found having set standard protocol for asking client to come up for follow up after service i.e. one time mandatory follow up of implant after a week of implant and within six week for IUCD clients. In addition to that, client may visit outlets anytime in case of complication.

Three provider said that they make follow up calls to the client by phone if they did not visit on the scheduled day. However, other providers said, clients were schedule for follow up after providing LARC. Most of the client come for follow up as scheduled but they do not have any system to make follow up for provider side.

One clients said,

"*…why to come for follow up if there is nothing health problem due to method to complain …"* when asked if follow up is important.

In regards to continuity of LARC views of client themselves, relatives, social mobilizer, FCHV and provider were found crucial. One provider said,

"Some clients were so sensitive to the side effects. Further they listen all the rumors from their relatives and friends. Many time they come back with request for removal. In such our role as provider is very important. More information about the effects, further counseling and assurance helps client for continuation…which I believe charging to removal reduce removal*"(***42 provider, Kavre***)*

Appropriate Constellation

Respondents said that service for immunization, consultation for STI services in outlet was a comfortable feature. Further, two of the clients expressed preferences for outlets that have laboratory facilities are helpful to reduce referral for lab test. One client was happy and like outlet because she had LARC follow during her visit for dental checkup. One in Kavre expressed,

*"Today I am here for immunization of my grandchild. It is great opportunity to have follow up of the method (IUCD) I kept last year. It is not bothering me but good to be followed up." (***37 Client, Kavre***)*

This study found the value of LARC service integration to other health service. Literature also shown about importance of FP service integration. One study shows importance of integration beyond health sector for family planning(39).

4.2.4 Findings from Study (Addition to Elements in Framework)

Five providers found satisfaction from "task sharing"—being able to provide LARC as that was previously reserved for physicians. One provider express the happiness when she got certificate from NHTC for allowing IUCD insertion.

"…….can not express how happy I was ..when I got IUCD certificate." (**20 provider ANM Kavre**)

A provider from Makawanpur expressed about feeling of social recognition by providing LARC service in the community.

"*…I feel proud …they (client) respect me..as I provide LARC in community."* ***(29 Provider, Makawanpur)***

FP focal person from FHD in regards to coordination between FHD and supporting organisation said,

" All three organizations, you are referring are implementing the activities with prior approval and in close coordination at the central level. All these three represent in the FP-Sub

Committee, the apex committee of FHD to guide FP programs both from the public and private sector."

4.2.5 Summary of Program Manager, Providers and Clients Perspectives

This summary list was develop on the basis of positive and negative features identified by manager, providers and clients during interaction for outlet and LARC service. Most of the list is similar to each other however some differences in the way they had expressed. Key distinct perspective summarized in *table* 3. Finding of list is longer to the positive aspect compared to negative aspect. In this perspective, difference in view is due to their respective role. I.e. for programme manager access and quality defined when it is supportive to the program. Similarly, provider visualize more from clinical aspect of quality. For example, authorization to provide LARC is perceived very positively by providers. All three groups visualized geographic barrier as main barrier to access service for client. Program manager and provider both admit issue of reporting and problem in expansion as negative aspect. For client, distance, outlet opening hour and language is some of the negative aspects. Further, client thinks they do not need to come for follow-up if there is no complain and health need.

Table 3: Summary of perspective for LARC from outlets

Respondent	Positive aspect	Negative aspect
Program Manager	• Addressing barrier for FP • Reaching for unreached • Sharing to community • Location of the outlet; easy to find, for client not for provider • Free of cost • Multiple ways to reach to client • Compensation on referral good approach for assuring quality • Literacy, changing in technology	• Problem in reporting • Low client • Rigid rule for expansion
Provider	• Accessible with transportation • Sometime effective service is more important than distance • Client load • Residing to same location • Location and cost matters access • Clients ability and willingness to pay for LARC • Free service • Allowing them to provide LARC • Social recognition and respect	• Distance and location of outlet • Lengthy reporting • Rigid rule for expansion of outlet • Frequent visits for quality assurance check • client come with method on mind which is not suitable for them • clients demand to decide method for them • QA visits to access provider skill
Client	• Location of facility • Integrated with other service • Availability for method choice • Outlet is only place for LARC • Provider responsiveness • Less waiting time • Motivated provider • Clean • Less crowded • Privacy • Non discriminated service for all age group • Multiple way of getting information through mobile and local FM • cost – when needed getting in credit	• Distance to the facility (for those who cannot access • Outlet opening hours • Provider language speed for speaking • Need for follow up even there is no health complain

4.3 Reflection

In spite of past experience of involving in qualitative study it was my first experience to manage all study alone. Past experience of conducting focus group discussion, in-depth interview and exit interview assisted a lot for the process. Being researcher, data collector, analyst and interpreter had benefits. It was very easy to connect between steps. Some of the reflection may be useful for future;

- It is great learning to go through different research committee approval process for research
- Conducting a study in a short time period is very challenging.
- In spite of prior communication and emails one organisation showed reluctance to provide information. However, it delayed the process did not impacted the data collection.
- Obtaining written consent from clients was another faced challenge. When asked to provide written consent they become uncomfortable. One client refused to participate because she was asked to sign on the consent form. In Nepal obtaining written consent is considered only for some serious reason i.e. property transfer issue.
- In Makawanpur, one outlet was found well equipped and trained provider but no client for LARC service on that month.
- It is limited to only seven provider and nine client from NGO supported outlets, comparative information from other non NGO supported outlets or public/ government supported outlets study could have reveled depth of findings.
- Some findings were explored during the study which were not matching directly with the framework guided elements. They were also noted at the end of finding sections

CHAPTER 5: DISCUSSION

The section continues with a discussion to provide insights into the current access and quality issues for LARC service from NGO supported outlets. This section is guided through the objectives of the study.

Accessing quality of services has become a more important issue than ever. Improved quality of service encourages people in need of family planning to seek services and increases contraceptive prevalence, however, also create new demands for family planning services(8). Perceived good quality LARC service is offered from outlets. However, location of the outlet is found as barrier to access LARC. While much attention has been focused at improving the clinical aspect of LARC from the outlet, findings from the study (refer quote from a *provider and manager in technical competencies*) and literature (29,30,36–38)ratify that geographic barrier hinder accessing LARC services in Nepal.

The study results highlight existence of opportunities to mitigate access barrier, without focusing and act upon those opportunities increasing access will not be possible. Some alternative is discussed below from the PI's perspective, study findings and findings from literatures. In case of support duplication, organisations are supporting outlets with the approval of government, but they are serving in same and easy to reach locations. Government should take some strong decision to reduce duplication.

In regular existing practice client need travel to the outlets for LARC service because it requires; skilled provider, aseptic technique and wider space (for IUCD) for service. Reaching to the demand side (women) who choose LARC through evaluating and adopting already initiated approaches, i.e. outreach clinic, mobile camp and visiting provider (25). Making such arrangement may further benefit to reduce the cost of travel barrier for women for accessing LARC.

Some outlets are found managed by private (for profit) ANMs and providing LARC in a local setting. They are intrinsically motivated because they are allowed to provide LARC by law. They may not directly financially benefited by providing LARC service, it provides opportunity to establish contact for other service. They are satisfied with their work. They managed their own facility, and had good relation with communities. Moreover, production of ANM is higher compared to absorbing capacity in Nepal, they are available in the Market (41). In the long run provision of LARC from trained ANM from their outlet may be relevant, feasible and

sustainable in the context of Nepal for increasing access to quality LARC services. There is a need to identify strategies/regulations that support to increase the number of such outlets for LARC services.

Global consensus has been reached that women should be empowered to choose contraceptive methods they prefer. Women who make informed choices on the basis of accurate and relevant information are better able to use family planning safely, effectively and consistently(40). Enabling clients to make informed choices is a key to good-quality family planning services (40). This study also explored how the community environment influences reaching to the potential client in different ways. Clients choose LARC based on peers past experience, provider interaction at the community and options for payment. Specified barriers for accessing LARC in the literature cost(31), method specific skill and knowledge gap in providers, and stigma and knowledge gap with clients (31,32) were not consistent with the study findings. Rumors and myths determine care-seeking behavior by supporting or discouraging the use of services.

In this study, women expressed there is reduction in extreme myths associated with LARC. However, some of them switched/discontinued LARC because of fear of weight gain, obstacle in sex and another never wanted to use IUCD because her peer said. Similarly, In Turkey, women's concern and fear of side-effects were found as a main factor preventing the use of oral contraception's (35). Such Myth and misperceptions are not only barriers to use safe and effective means of contraception i.e. IUCD but are also reason for adoption of less-effective method or resulting in unintended pregnancy(40). Providers may play an important role providing detail and factual information to the client in a manner they understand.

Such Myth and misperceptions are not only barriers to use safe and effective means of contraception i.e. IUCD but are also reason for adoption of less-effective method or resulting in unintended pregnancy (40). Providers may play an important role providing detail and factual information to the client in a manner they understand. Study found administrative some issues associated with outlet management. Some NGOs managing the outlets on their own cost and providing incentives for referring. Such provision may support temporarily in accessing quality service, however, it raised issues of sustainability. This also raises the issue of cost effectiveness. Further, PI of the study thinks the attractiveness of outlet itself may have worked as a barrier for women to approach for LARC service.

The study acknowledges that reporting of service is a major issue. Many potential factors may responsible for it; provider may not familiar with reporting mechanism, too many forms and format to fill or could be program driven need to over reporting to show program achievement.

As the issue of reporting is acknowledged by manager, provider and government official there is a need for special attention.

Relevance of the Framework

Many researchers have tried to define quality within the health-care setting. Donabedian identified three categories "structure", "process", and "outcome for assessing quality within the health system(41). The adopted framework from Bruce, which is the conceptual framework that have been used most frequently since the early 1990s to assessing the quality of family planning services conceptualizing quality as "client oriented" care.

More recent efforts have expanded to examine quality of care including other health services. Considering the barrier of accessing service directly lead to quality, in this study added access element from Jain T. Bertrand assisted the explore barrier factors that determine quality of care in family planning services. These elements influencing access to services and its quality.

In term of framework, it guided me to the study process. When I critically examine my study, I realize;

- For a master thesis project I select very wider area for study. Because of the limited time and resources it was not possible to explore in-depth in the area selected from framework.
- Selecting a wider component from framework, my study become superficial.
- More importantly, I realize the selection of respondents to evaluate access barrier was not relevant, those client who accessed service may not able to explain barrier to access elements.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

Conclusion and recommendation in this study are based on the findings from primary data and literatures.

6.1 Conclusions

Many of the outlets were concentrated in the district headquarters or cities, with high population density. This study also revealed that the outlets from three different supporting organizations were located in the same area. This study concluded that outlets supported by NGOs were less effective for increasing access to LARC however, there are many alternative approaches to reach potential client and establish interpersonal relation. In order to increase access a few NGOs were conducting mobile clinics and outreach campaigns. This study did not explore access to and quality of this approach.

The study revealed the perceived quality of LARC services offered is according to the defined quality from the outlets. Almost all of the NGO supported service outlets had maintained many aspects of the quality except issue of reporting, counseling and scheduling follow-up. The service providers from all outlets were well aware of such components. They stated that they consider all these aspects while providing service to the clients. In spite of quality services from the outlets, uptake of LARC use was found low in this study. This finding is contradictory to other studies that improving the quality of care increases the number of services users.

Almost all of the clients were found satisfied with the service provided from the outlets. This study also covered the perception and knowledge of the clients towards family planning. The clients, who were using LARC, were aware of the potential risk and difficulties of multiple pregnancies and child births. They stated that LARC is a method of choice for spacing or limiting birth. This study showed that comprehensive FP services with choice of all methods were not available in all outlets. The findings were consistent with other studies in Nepal.

This study also studied the management aspects of the clinic. The management support was varied by the organizations. Opening hours was mostly the official hours (10:00- 5:00 pm) for FPAN and MSI. PSI supported outlets were open even in the unofficial hours. Therefore, the clients, who could not come to receive service in off-office hours found benefited. FAPN and MSI were covering all cost for running the outlets such as administrative cost, physical set-up and paying incentive for referral. As a result, their physical structure and set up were attractive than PSI supported outlets. However, this approach may question for sustainability of LARC services after phasing out the Project's funding.

Study found a very good coordination and communication with the Government and NGO sectors. Such relationship existed in all level, community, district and central level. Local level communication and coordination were managed by the outlets but supporting NGOs also were engaged in district and central level coordination. The GON officials also were engaged in monitoring of the outlets for ensuring a quality of services according to the quality of services. Some provider were unsatisfied with multiple quality checks and QA visits. The outlets were keeping records and continuously submitting reports to all concerned NGOs and GON. Sometimes, reporting is not provided on time, which is one of the area need to improve.

6.2 Recommendations

Based on the study findings following recommendations have been made. Recommendations are grouped by the stakeholders; for example, the government (MOH/FHD), supportive organizations and providers. These recommendations are proposed in order by priorities.

Recommendation to GON

- Since both the supporting organization and FHD are in the RH working group, they should set alternative mechanisms enabling timely and correct reporting.
- Government must approve for opening a new outlet in order to minimize duplication of funding and increasing geographical coverage of LARC. Government must not allow to open any outlets if I/NGO supported outlets already exist. Support should focus on new location.
- Government should evaluate the other innovative alternatives such as LARC service through mobile and outreach camp for increasing service access towards the hard-to-reach and deprived population.
- GON rules and regulations regarding expansion of outlets should be flexible for increasing access of services in close coordination with the concerned departments. Administrative and operational guidelines should be service friendly and client-oriented.

Recommendations to supporting organizations

- Recommended to ensure provision of service availability of all temporary method mix in supported outlets.
- Supporting organization should focus to support more to those outlets which were opened by individual providers at local level. This approach will help to establish inter-personal relationship between the clients and service providers. It will provide more opportunity for client to informed about LARC and sustainable in long run.

- Supporting organizations should pay consideration to select outlets with existing of other health service (integrating LARC) when they plan to expand their outlets.
- Supporting organizations should expand their support to outlets to those district where LARC service is limited and hard-to-reach population. Special, attention should be paid to avoid duplication of support.

Recommendations to providers

- Quality of LARC service has appreciated by clients, such quality are recommended to maintain the by providers.
- Some clients found provider giving information too fast which hinder client understanding – recommended to pay attention when counselling to the client.
- Program manager and providers are recommended to consider and adopt opening outlets in off hour to increase access.

Recommendation for further study

- A large scale study is suggested to explore the impact of the support from I/NGOs and its outcome in LARC service provision in Nepal.

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This study would have never completed without the information from client, provider and field staff of visited outlets in Kavre and Makawanpur district of Nepal. I am thankful for their information and cooperation.

Without my husband and children's sacrifice it would not possible to achieve this success. I am heartily acknowledge their support and contribution.

Appendices

1. **List of Study Participant**
2. **Topic Guide for Study**
3. **Participants Information Sheet**
4. **Research Approval letters**
5. **Framework**
6. **Summary of FP Outlet Supporting Organisations**
7. **Full Research Proposal**

List of Study Participant

Location	Gender/age	Org/Outlet	Education	Type of interview	Identification
Kathmandu	M/45	FHD	MPH	SSI	Male, 45 Manager
	M/39	FPAN	MPH	SSI	Male, 39 Manager
	F/47	MSI	Bachelor	SSI	Female, 47 Manager
	F/39	PSI	Gynaecologist	SSI	
Kavrepalanchok	F/20	PSI	ANM	IDI	Female, 20 Provider
	F/37		Litrate	EI	Female, 37 Client
			Litrate	EI	-
	F/44	FPAN	Staff nurse	IDI	Female, 44 provider
	F/24			EI	Female, 24 Client
	F/22			EI	Female, 22 Client
	F/35	MSI	Staff Nurse	IDI	Female, 35 provider
	F/32			EI	Female, 32 Client
	F/23			EI	Female, 23 Client
Makawanpur	F/32	PSI	Staffnurse	IDI 1 (Palung)	Female, 32 provider
	F/28		ANM	IDI 2 (Hetaunda)	Female, 28 provider
	F/33			EI	Female, 33 Client
	F/29			EI	Female, 29 Client
	F/27	FPAN	Staff Nurse	IDI	Female, 27 Provider
	F/29			EI	Female, 29 Client
	F/16			EI	Female, 16 Client
	F/23	MSI	Staff Nurse	IDI	Female, 23 Provider
				EI	-
				EI	-

Topic Guide for Study

Participants Information Sheet

Interviews with informants and/ with respondents

Hello, My name is **Geeta Sharma.** I am student at Royal Tropical Institute Netherlands. As part of my study I am conducting researc to understand the family planning services provided by FP-outlet in Nepal. Many factors influence the provision of Long Acting Reversable Ccontraceptives(i.e. Intrauterine device and Implant) services. We would like to learn from this study. We hope that this information will help to find different issues which will be helpful for future program planning.

Procedures including confidentiality.
If you agree we would like to interview/ have a discussion with you about Long Acting Reversable Ccontraceptives (i.e. Intrauterine device and Implant) family planning services provided by FP outlet.
The interview will take place in a private space where no body can hear us and lasts about an hour.

To make sure that we do not forget or change what you are saying I will tape record the answers you give. Everything that will be said, written down will be kept totally confidential. The data you provided will be kept for 6 month after finalization of the report and will discarded then after. Your name will not be recorded or written down. Notes will be kept in a locked place. Only the team of researchers will have access to the notes. In reports and/or publications, the findings will be attributed to the services in general and not to your particular area so that nobody can recognise the setting.

Risk, discomforts and right to withdraw
You are free to refuse to answer any question for any reason. Refusing to take part or withdraw during the interview will not in any way affect the services you receive or provide.

Benefits
This study may not help you directly but the results will help to improve access to family planning service for Nepali women and men.

Sharing the results
After the study is completed, we will be sharing the results with you through district health office.

Consent and contact
Do you have any questions that you would like to ask?
Are there any things you would like me to explain again or say more about?
Do you agree to participate in the interview?

DECLARATION: TO BE SIGNED BY THE RESPONDENT

The purpose of the interview was explained to me and I agree that …….. (Name of person) is interviewed.

_____

Signed Date

If you have any questions or want to file a complaint about the research you may contact:

Contact information: Geeta Sharma sharmageeta224@gmail.com	Contact for Ethics Committee

Research Approval letters

KIT | Health

Contact
Meta Willems
Telephone +31 (0)20 568 8514
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KIT Health) P.O. Box 95001, 1090 HA Amsterdam, The Netherlands
BY E-MAIL:
sharmageeta224@gmail.com

Our reference KIT Health Amsterdam, 30 May 2017

Subject Decision Research Ethics Committee on Proposal S81

Dear Geeta,

The Research Ethics Committee of the Royal Tropical Institute (REC) has reviewed the proposal entitled "Access and quality of long acting family planning services from NGO sector supported family planning service outlets in Nepal"

The decision of the Committee is as follows:
The REC has reviewed your amendments and clarification submitted on 9 May 2017 and your proposal has now been approved on the condition that the exit interview survey would be changed to an exit interview guide, this as conducting a survey with 10 respondents without an adequate sampling frame would not generate useful information.

Kind regards,

P. Baatsen,
Chair Research Ethics Committee, KIT

Government of Nepal
Nepal Health Research Council (NHRC)
Ref. No.: 2327
29 June 2017

Ms. Geeta Sharma
Principal Investigator
Royal Tropical Institute (KIT)
Amsterdam, Netherlands

Subject: Approval of research proposal entitled Access and quality of long acting family planning services from NGO supported family planning service outlets in selected districts of Nepal

Dear Ms. Sharma,

It is my pleasure to inform you that the above-mentioned proposal submitted on 05 June 2017 [Regno. 176/2017 please use this Reg. No during further correspondence] has been approved by NHRC Ethical Review Board on 28 June 2017.

As per NHRC rules and regulations, the investigator has to strictly follow the protocol stipulated in the proposal. Any change in objective(s), problem statement, research question or hypothesis, methodology, implementation procedure, data management and budget that may be necessary in course of the implementation of the research proposal can only be made so and implemented after prior approval from this council. Thus, it is compulsory to submit the detail of such changes intended or desired with justification prior to actual change in the protocol before the expiration date of this approval. Expiration date of this approval is July 2017.

If the researcher requires transfer of the bio samples to other countries, the investigator should apply to the NHRC for the permission. The researchers will not be allowed to ship any raw/crude human biomaterial outside the country, only extracted and amplified samples can be taken to labs outside of Nepal for further study, as per the protocol submitted and approved by the NHRC. The remaining samples of the lab should be destroyed as per standard operating procedure, the process documented, and the NHRC informed.

Further, the researchers are directed to strictly abide by the National Ethical Guidelines published by NHRC during the implementation of their research proposal and submit progress report and full or summary report upon completion.

As per your research proposal, the research amount is NRs 90,000.00 and accordingly the processing fee amount is NRs 10,000.00. It is acknowledged that the above mentioned processing fee has been received at NHRC.

If you have any queries, please feel free to contact the Ethical Review M & E section of NHRC.

Thanking you,

Dr. Anjani Kumar Jha
Executive Chairman

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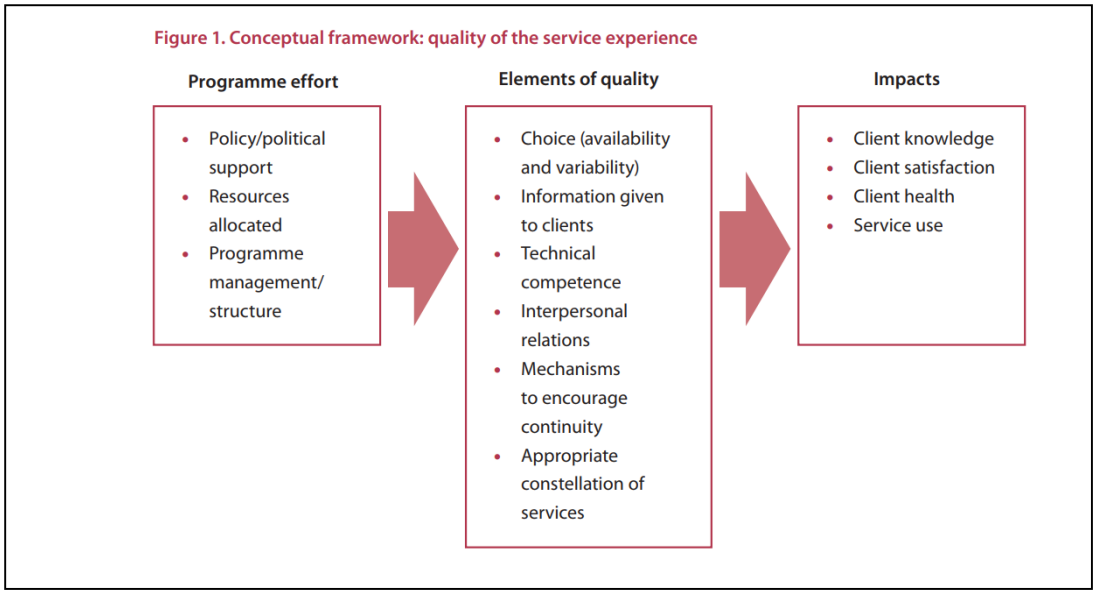
Website: http://www.nhrc.org.np, E-mail: nhrc@nhrc.org.np

Framework (Bruce 1990)



Summary of FP Outlet Supporting Organisation

Marie Stopes Nepal (MSI)

MSI Nepal is one of the leading organisation to support sexual and reproductive health programine in Nepal. It also support the Government of Nepal in its goal to increase the prevalence rate of the use of modern contraception. MSI works through diverse channels (centers and outreach) to ensure that women have accessible and affordable family planning services. MSI works through National NGO called "Sunaulo Pariwar Nepal". MSI has 3-4 staff in one outlet to provide services. It has 36 outlets (Centres) in 32 district out of 75 districts in Nepal. In addition to providing comprehensive family planning service, centres play an important role for training and refresher for staff technical skills. It also act as a logistics hub for outreach teams and community-based distributors for sterilise equipment for family planning services and re supply of clinical items to maintain stocks. MSI has strategy to organize outreach to increase access to service in hard to reach community. This channel assists to reach with family planning service for many people living in remote areas or urban slums. It aim to offer family planning choices where access (administrative and geographic) is challenged. In order to expand contraceptive choice, MSI's approaches focus on adding long-acting reversible contraceptives (LARCs) to franchisee clinics' in existing service platform, alongside strengthening counseling and short-acting method provision. MSI claim to provides same quality services regardless of service provided in static centres or the mobile choice camps. In addition MSI adopt QOC approach to maintain the quality of care for the service they provide.

Population Services International (PSI)

PSI, a non-profit organization based in Washington, D.C. Nepal is one of the recipient country. It works with the private sector to address the health problems of low-income and vulnerable populations. PSI/Nepal started working in Nepal in early 2002 with the work in area of family planning in support of Government of Nepal's National Reproductive Health and HIV/AIDS Prevention Strategies. PSI currently work in 40 out of 75 district through six implementing partner through approx. 230 outlets.

PSI adopted Provider Behaviour Change Communication (PBCC) approach with aim to ensure and increase quality service delivery through changing provider's behavior. This approach consider three broad categories of factors (Opportunity, Ability and Motivation) that influence provider behavior and act open that. In addition, to maintain technical quality of the LARC service and competencies of provider PSI supports technical skill training and QA visits for

providers. Similarly, for demand generation PSI adopted activities like Didi mobilization, voucher for client, home visit, and provider client interaction.

Family Planning Association of Nepal (FPAN)

Family Planning Association of Nepal is one of the biggest national nonprofit making voluntary NGOs in Nepal. FPAN established in 1995. It works in 37 out of 75 districts of Nepal. FPAN provides all type of temporary and permanent family planning services in Nepal. It adopted concept of 'informed choice' policy in family planning services. FPAN initiated sexual reproductive service including family planning services for adolescent.

FPAN provide family planning services from 22 family health clinic and 101 community health clinics through around 500 professional staffs. Family planning services is integrated in its 8/8 integrated services.

Full Research Proposal

FOR OFFICE USE ONLY	Date of submission	Date considered	Approval granted?
Application Number			Yes/no
Signatures			(Chair)

THIS FORM MUST BE TYPEWRITTEN

KIT | Health

RESEARCH ETHICS COMMITTEE

APPLICATION FORM FOR ETHICAL APPROVAL

ALL QUESTIONS MUST BE ANSWERED. ANY FORM STATING "SEE PROTOCOL" WILL BE RETURNED.

(This form must stand complete in itself)

PLEASE PROVIDE ONE COPY OF THIS FORM AND OF THE ORIGINAL PROPOSAL AND A TABLE OF ACRONYMS AND REFERENCES

AS FAR AS POSSIBLE YOU SHOULD RESTRICT ALL ENTRIES TO THE SPACE PROVIDED ON THIS FORM

Please use a typing front which is easily distinguishable from the questions of the form

NB This form is available on diskette from the Secretariat.

Have you submitted this proposal to the Royal Tropical Institute before?:

No [×] Yes [ ] Date and outcome:

If you are re-submitting a proposal, you need only provide the title of the project and complete those sections of the form where changes have been made. Please emphasize how the proposal has been amended in the light of previous recommendations from the Royal Tropical Institute Research Ethics Committee.

If this proposal was proposed before to the KIT REC or elsewhere what was the outcome?

Accepted [ ] Pending [ ] Rejected [ ] Date:

NAME OF APPLICANT: Geeta Sharma

If this proposal is for work that will go towards a higher degree (e.g. MSc or PhD), please state name and Area of Supervisor *(The supervisor needs to sign signifying agreement with submission)*:

NAME & SIGNATURE OF SUPERVISOR: Zwanikken, Prisca

NAME & SIGNATURE OF LOCAL SUPERVISOR:

PARTICULARS OF PROJECT AND INVESTIGATORS

1. Project title

ACCESS AND QUALITY OF LONG ACTING FAMILY PLANNING SERVICES FROM NGO SECTOR SUPPORTED FAMILY PLANNING SERVICE OUTLETS IN NEPAL

2. Principal investigator(s)

Names: *Geeta Sharma*

Positions: ICHD/MPH Student

3. Institution responsible for the research

Name: Royal tropical Institute *(KIT)*

Postal address

E-mail and phone numbers:

.

4. Collaborating institutions

List all collaborators (Please include all overseas collaborators and give their affiliations, qualifications and role in the study).

Co-investigators, affiliation and role

Contact details

SECTION A

STUDY OUTLINE *(To save paper the form provides the issues you need to address. You can use more space than is provided in the form)*

A.1 TITLE OF PROJECT

Access and quality of long acting family planning services from NGO sector supported family planning outlets in Nepal.

A.2 EXECUTIVE SUMMARY

Give a short overall summary of the proposal using lay terminology (Background and justification, purpose and design of the study).

The Government of Nepal (GON) has put high priority on Family Planning (FP) for improving maternal and child health in Nepal. The policy statement confers providing comprehensive FP services at all level. The third health sector strategy (2015-2018) gives emphasis on access to health including FP services both from the public and private sectors. The short-term FP methods are widely provided by the public and private sectors. However, Long Acting Reversible Contraceptives (LARCs) services are limited to selected sectors of both. The unmet need for FP services is 24% in Nepal.

Providing comprehensive FP methods is one of the strategies to address unmet need of the FP services. However, there is a huge gap in access between short-term and long-term methods. LARC is made available from government health facilities up to primary health care centers and limited health post. The same services are provided through mobile camps which involve government, private hospitals and I/NGOs. On top of these, I/NGO supported medical shops and small clinics also provide LARC services. Here after, NGO supported medical shops will be called as Private Family Planning (PFP-outlet) in this study.

Different studies show that there are gaps both in access to and quality of LARC services in Nepal. Some examples are: distance between the service facility and users' residence, lack of trained providers and related equipment. In order to increase access of LARC, the GON has committed to partner with private sectors and NGOs. In terms of contribution among the LARC users, service from NGO supported outlets are significant (Demographic Health Survey, 2016 report).

In the above pretext, the purpose of this study is to explore the quality and access of LARC provided by NGO supported PFP-outlets in Nepal. In response, this study aims to make due recommendations on key actions for improving access and quality of LARC from PFP outlets.

The study design is cross-sectional and qualitative in type. There are over 700 PFP outlets supported by NGOs (Nepal Family Planning Association, PSI, MSI) in Nepal. The research population will be service providers of the outlets, users and the programme managers. They will be purposively selected: 6 service providers, 12 service users and 4 managers (government and NGOs) who support FP services at the district level. Selection of three types of respondents will provide opportunity to triangulate findings of the research. The research method employed will be in-depth, exit and semi-structured interviews based on different topic guides. The dependent variables of the study will be: Access & Quality, and Distance to facility, Cost, Service hours, Waiting time, Client Counseling, Use of Information Educational Communication (IEC) Materials to assist client for decision, Privacy & confidentiality, Motivation & Behaviors of the service providers as independent variables.

The research sites will be purposively selected PFP outlets in Kavre and Makwanpur districts. The researcher will visit these outlets, conduct and record the interviews which will be transcribed in Nepali and translated in English. All the data will be thematically coded and analysed using data reduction method.

The research findings will be disseminated at Royal Tropical Institute (KIT), national and international level. Policy recommendations will be shared to the GON stakeholders for effective implementation of LARC.

A.3 INTRODUCTION; BACKGROUND AND JUSTIFICATION

Give a brief summary of the literature review, including references and search strategy. State the relevance of the research and how it will be used. Provide references at the end of this sections

Background

1.1 Health system in Nepal

Modern Health System (HS) in Nepal was introduced in 1956. It has expanded primary health care approach in order to reach basic health services to the grassroots level. Sub-health post (recently upgraded to health posts) are the lowest level of health care facilities available at the grassroots. The policy provision states that each district will have at least one hospital and each constituency one PHC. In the tertiary care level, zonal, sub-regional and regional and specialized hospitals are offering services. (1). Under the primary health care system, the Government of Nepal has defined Essential Package of Health Services (EPHS) for four basic programmes (safe motherhood and family planning, child health, control of communicable disease, and strengthened outpatient care). These programmes aim at providing health services from the health posts and above (1).

Modern Family Planning (FP) services is one of the oldest services in Nepal, which was first introduced in 1968. Ministry of Health (MoH), Family Health Division (FHD) developed National Family Planning Guidelines (NFPF) in 1997, which has been being updated periodically(2). Nepal as a signatory of the International Conference for Population and Development(ICPD) decided to increase contraceptive choices after the NFPF (3). Nepal has made a good progress in FP over the past two decades. Total Fertility Rate (TFR) has decreased

from 5.3 (in 1998) to 2.3 (in 2016)(4). Contraceptive Prevalence Rate (CPR) with modern methods has increased to 49.6% (in 2016) from 24% (in 1990) (5)

Modern methods including female sterilization, male sterilization, intrauterine contraceptive device (IUD), implants, injectable, pill, condoms, and lactational amenorrhea method (LAM) are available in Nepal. Condoms, oral pills or injectable are commonly available across all FP service sites. However, access to LARC is limited due to unavailability of skilled providers and service related equipment, distance to the facility (6). Issue associated with gap in accessing LARC is limiting the choices for FP methods (7). Therefore, Family Health Division allowed trained staff nurse and Assistance Nurse Midwifes (ANM) to provide long-acting family planning method i.e. IUCD and Implant in Nepal(8)(6). Hence, the GON has committed to partnering with NGOs to scale-up comprehensive FP services (9)(5)(8)(1).

NGOs started to work in Nepal to reduce population growth since 1950(10). The GON introduced a health policy to encourage public-private partnership for affordable, accessible and quality services in health sector in different phases. The Health Sector Support Program I and II (2004 to 2014) also put high emphasis in health (11). Private sector has rapidly progressed for health care services in Nepal(8). They are a major recipient of out-of-pocket spending by all income groups in Nepal for all health services(8). Medical shops/pharmacies are first point of contact for seeking health care in Nepal. Usually these shops are located in accessible places to the average population. The major reasons for the first point of contact are: long opening hours, availability of service with the possibility of credit in case the client does not have money to pay then and/or in kind payment and familiarity(12). Such shops are widely scattered all over Nepal, mostly in rural and roadsides (12). Some of them extended their services for family planning including LARC. These outlets are established for profit services. Extra space for counselling, insertion bed (for IUCD), provision for IP, availability of trained providers are some of the prerequisites to be a PFP outlet(6).

These days, many I/NGOs provide support to medical shops, small clinics and individual providers for expanding FP services from PFP outlets. Some of the supporting organisations are: Family Planning Association of Nepal (FPAN), Marie Stopes International (MSI), Contraceptive

Retail Store Company (CRS), Population Services International (PSI), Nepal Fertility Care Centre (NFCC). These I/NGOs manly provide support to service providers with skill training, service related equipment and quality assurance visits(6) (13), set-up a quality FP service sites, counseling, mentoring and in-service training and IEC/BCC corners. Such outlets providing LARC services are more than 700 in Nepal (6)(13). 25% of modern contraceptive users access FP service from the from PFP- outlets (14).

1.2 Literature Review

To find out the existing promising practices and gaps in FP services from the private sector, I searched relevant literatures in the internet and reviewed the policy documents of GON. I searched in VU data, PubMed, all fields, journal articles and Google scholar. I used key words "Family Planning", "Private sector", "Nepal" , "franchise" "outlets", "Family Planning" "Contraceptive Access and Quality", LARC "Nepal Health System", "public private partnership" " access" "quality" "contraception" for searching the relevant articles. I searched in VU data, PubMed, all fields, journal articles and Google scholar. In addition, I reviewed current policy documents of the GON related to FP. Findings of the research article are summarized in background information, formulating research questions and developing a conceptual framework.

Unmet need of FP is higher in Nepal compare to India (20.5%) and Pakistan (11.6%)(15). The GON adopted from multi-pronged approach through public-private partnership (PPP) to increase the utilization of service. 16.5% Intra Uterine Contraceptive Device (IUCD) and 12.8% Implants is provided from NGO supported family planning service outlet. Furthermore, The GON has allowed middle level health professional (Staff Nurse and ANMs) to provide LARC from PFP outlet(11). However, the quality and access of the service provided yet to be defined(16).

Providing effective FP services still face a lot of challenges in Nepal. Lack of access to FP services in remote areas with shortage of trained health providers, commodity supply issues, staff

retention, and distance to the facility are contributing to high unmet need for FP (7) (17)(18)(19). Several studies have revealed that women have universal knowledge on at least one contraceptive method (14). However, the utilization of services is low, especially among the low income quintile population (14) (20).

Access to a range of contraceptive methods is another challenge in Nepal. A study has shown that prevalence of LARC is low (2.3%) among rural women and uptake of LARC is low(7)(8). In this context, the GON has adopted a public-private partnership (PPP) for scaling-up FP services. The GON has allowed NGOs/INGOs) to support PFP outlet(11).

Studies have demonstrated the role of access, quality, availability of method of choice elements on adoption and continuation of family planning use. Clients are more likely to stop seeking care if they do not receive the method of their choice (21)(22). Furthermore, studies also found that providing accurate and complete information leads to better retention of clients if they get their choice of methods (22). In addition to this, findings of a study from Malawi and Senegal (2016) showed that long waiting times and inconvenient hours prevented many women from seeking family planning services (23).

Study conducted in Uganda to get the provider perspective for quality of service depend on supply, availability of choice of methods, workload, their knowledge and skill affects the quality of service they offer(22).

This study will examines the provider and client perspective on key elements of access and quality of service on family planning focusing on LARC from PFP outlet. This will be done through in depth interview with service provider and exit interview using interview questionnaire with the client. Program managers from public health office and supporting NGOs will also interviewed using semi structure questionnaire.

II. PROBLEM STATEMENT WITH CONTRIBUTING FACTOR

2.1 Problem Statement

The Government of Nepal adopted a public-private partnership (PPP) and engaged NGOs to support eligible PFP outlet for family planning service scale-up (11), there is limited research in regards to quality and access of the LARC services from the outlets.

Unmet need for family planning is 25.2% in 2016(4). Lack of access to FP services in remote areas with shortage of trained health personnel, commodity supply issues, staff retention, and distance to the facility are contributing to a high unmet need for family planning(7) (17)(18)(19).

The contribution of the private sector in FP is significant in Nepal. In regards to FP, they are more attracted towards the short-term FP methods such as injectable and oral pills. Nearly 25% of the clients seek FP service from the private sector, less than half of them are LARC user(4). Another study conducted in Nepal, similar outlets are found more accessible for child health services because of the longer opening hours, shorter waiting times, and easily availability of the service providers and better counseling, the clients are attracted towards the local medical shops(17). Studies have shown that people have a lot of myths and misconceptions related to use of LARC, low interaction between the service providers(6).

The quality and access of services at a PFP outlet, can be defined by the competency of the service provides in counseling and providing service, waiting hours, infection prevention practices and ensuring privacy of the clients. However, limited studies have been conducted in Nepal in this field. This study will assess the concerns both from providers and clients perspectives for assessing the quality and access from PFP outlets(6).

2.2 Study Justification

The GON has allowed to provide LARC from PFP outlet. Many I/NGOs in Nepal are providing technical assistance to strengthen comprehensive FP, especially LARC from those outlets. Such

technical assistance include, training of service providers, supply of basic equipment's, on-site coaching and mentoring, and improving recording/reporting systems. In additions, support has been provided to increase demand for services through inter-personal communications, med-media activities and clients-providers interactions. The reason behind this support is to increase the access of basic FP services towards the deprived communities.

This study is targeted to PFP outlets, who are providing LARC services. This study can answer how effectively the outlets are providing services in terms of the quality and accessibility. Additionally, this study can answer the perspective of user for the service from outlets. It will further cover the client's perspective suggestions, where many stakeholders at the national and international level could benefit(24). Furthermore, this will also gather the answer from government and NGOs for future plan, sustainability and scale up. The study findings can be beneficial for the policy-makers, supporting NGOs, owners of the PFP outlets and services providers for addressing barriers and improving LARC. Recommendation will further guide to adapt the policy on PPP module by using such outlets(24).

2.3 Study Question

Why women are seeking LARC service from a PFP outlet in Nepal?

A. 4 OBJECTIVES

Overall goal of the research

The overall goal of this study is to explore the quality and access of LARC service from PFP outlets in Nepal and formulate recommendations to the government of Nepal for planning next steps for LARC service from outlets and actions for further improvement of these services.

Specific objectives of the research:

This study will explore the provider and client perspective on access and quality of family planning service focusing on LARC from PFP outlets. Study will be carried out based on the

theoretical framework (Annex II) for measuring the quality of family planning services in 1990 by Judith Bruce. In the framework element of access has been added from Jene T Bartrand. Study will be conducted with following specific objectives:

- To access the perspectives of planners, providers and clients about access and quality of LARC services provided by PFP outlets
- To explore the reasons for similarity or differences in understanding among planners, providers and clients in regards to access and quality of LARC services provided by PFP outlets
- To investigate the reasons for selecting PFP outlet for LARC services by the clients
- To recommend government of Nepal for planning next steps for LARC service from PFP outlet in Nepal.

A.5 METHODOLOGY

Outline how you intend to achieve the objectives of the study.

Guidance notes:

For each objective:-

- *define the issues/ variables to be explored*
- *define the techniques to be used (e.g. structured, semi-structured interview, focus group discussion)*
- *define the target population*
- *describe the rationale for each of the data collection methods.*

Give some detail on how methods are already validated (e.g. literature, earlier use) and how you will pre-test/ pilot them

Please provide the draft research instruments in the annex

Study Framework

- This study will be based on the theoretical framework for measuring the quality of family planning services by Judith Bruce (1990) adding the element of access from Jene T Bartrand. The framework was developed specifically for family planning— which separates access from quality and sets out to answer a question "Can clients reach FP services and supplies"

and includes the psychosocial domain of access(25). This framework from Jene. T. Bartrand added geographic or physical, economic, administrative, cognitive and psychosocial access. The framework has been guided by the Bruce-Jain theoretical framework for measuring the quality of family planning services in 1990. Which outlines six elements of quality a) choice of methods; b) information given to clients; c) technical competence; d) interpersonal relations; e) follow-up and continuity mechanisms; and f) appropriate constellation of services. Similarly, element for access will be a) geographic a) economic c) administrative d) cognitive e) psychological.

In this study access is defined as the level to which family planning services may be obtained at the level of effort and cost that is both acceptable to and within the catchment population. Cost refers to the level of the population can afford. Access further defined operationally in terms of presence or absence of preferable method of contraception to satisfy the need and preferences of clients(24). Please refer Annex- I for this framework.

Specific Objective 1:

To access the perspectives of planners, providers and clients about access and quality of LARC services provided by PFP outlets

Quality of care is a vague and relative term in health service. Understanding of quality may vary by different segment of population. In this study, I will involve three segments of population; Planner/district managers, service providers and the service recipients (clients) from two districts. I will use a qualitative method (in-depth interview) to find out service providers and program managers understanding about quality of service in LARC. Similarly, client will be interviewed in their exit using semi structured questionnaire.

Quality of care are dependent variable in this study. Independent variable for this objectives are; types of respondents, choice of FP methods, information provided to the clients, competency of the service providers, interpersonal relations, follow-up or continuity mechanisms, appropriate constellation of services and privacy of the clients. Please refer Annex-I for the detailed elements related to quality of care.

The rationale behind selecting a qualitative method is; it can answer the reasons for differences in understanding on quality of care, it also stimulates new research questions or challenges. Similar information could have been possible to explore through focus group discussion. Anticipating respondents scattered location IDI method is selected for data collection. Further, IDI will also allow researcher to interact in depth with respondent. IDI is already a valid method used in qualitative study and widely used for gathering information from the key people(26).

I will use pre-validated topic guide after pre-testing them in Nepalese context. Topic guide will be pre-tested in one or two similar outlets in Kathmandu. Appropriate modifications will be made as per the findings of the pre-test. Please refer a draft IDI topic guide in Annex- IIIb

Specific Objective 2:

To explore the reasons for similarity or differences among planners, providers and clients regarding their understanding of quality of LARC services provided by PFP outlets.

The second objective is the further exploration of the objective one. Therefore, the same method and tool apply to this objective. In this study, I will further discuss the reasons with all three types of respondents regarding his/her explanation of the quality of care. Program manager will be interviewed using semi structured topic guide. Please refer draft semi structured topic guide in Annex IIIc

Specific Objective 3:

To investigate the reasons for selecting PFP outlet for LARC services by the clients.

The study population and rationale for choosing this method are same as described in the objective one.

Dependent variable for this objective is accessibility towards the five key areas (mentioned-above). Independent variables include; type of respondents, socio-economic characteristics of the respondents, knowledge and understanding of the respondents.

Accessibility will be defined with five key areas; geographic, economic, administrative, cognitive and psychological. Each areas will be further explained by the key indicators. I will use a pre-validated tool (developed by Bruice, 2000) in order to describe accessibility. Please refer Annex- IIIa for detail interview quistionnare.

I will use a pre-validated guideline with pre-testing in two sites. Modification will be carried out after pretest if may require in Nepalese context.

Specific Objective 4:

To recommend government of Nepal for planning next steps for LARC service from PFP outlet in Nepal.

Objective four is a summative outcome of all four objectives. The rationale for keeping this objective is to suggest the research findings to policy makers and service providers. Based on the findings from all three objectives, the researcher will suggest possible recommendation for LARC services from PFP outlets.

A.6 PARTICIPANTS

Please provide the following information on the participants *with/from* whom you *expect to* be collecting data:

A.6.1 Age / Sex: (please enter the expected number in each of the boxes)

	Neonates (<28 days)	Infants (1-11 months)	Young children (1-9 years)	Adolescents (10-19 years)	Adults (>19 years)
Females					12-15 female Adults (for client exit interview)

Females					5-6 service providers (three from each district)
Males or Female					4-5 (at least two persons ar district>

Summary of participants

	Kavre	Makawanpur	Total	Remarks
District Managers	2	2	4	Either male or female, one from Government office and one from supporting NGO
Service providers	3	3	6	Female
Clients visiting to LARC for service or follow-up	6	6	12	Female

Guidance notes:

This age/sex breakdown helps convey how vulnerable the participants will be

If you are unable to give precise figures, state estimates and give an explanatory sentence in the space below

All participants in this study are adult, aged 20 and above. They consist of the representative from Government, supporting I/NGOs, PFP outlet service providers and the LARC service users from these sites. All the participants in this study consist of adult population and there is no risk for joining in this study. The participants will receive detailed information about the research study before they enroll in the study.

A.6.2 Describe how the participants are to be recruited?

Guidance notes:

You should outline the procedures for recruitment of each group op participants, include details on:

- *the setting (e.g. on the ward, out-patient department, factory floor, in the home)*
- *inclusion and exclusion for selection, if relevant (e.g. "Women of child-bearing age will be excluded")*
- *who will recruit*
- *If patients are recruited or patient records are used state if the person has routinely access to the patient e.g. treating clinician, nurse*
- *how the recruitment will be carried out in detail*

The Setting: Data will be collected in an official setting. The Principal Investigator (PI) will visit to the office of the district managers for the in-depth interview. Selected PFP outlet will be the setting for study. Both the provider and client will be interviewed in or around PFP outlet. With permission from district public health office PI will recruit participant and visit to the outlets.

IDI with service provider: In order to assess information related to capacity and service provision related to LARC, we will conduct in-depth interviews with Service provider. During interview special consideration will be paid for minimal disturbances in the routine work of the PFP outlets.

SSI with program manager: Program Managers will be pre-informed about the visit through telephone and e-mail. Similarly, the PI will visit each selected PFP outlet at the district level.

Interview with Women: Interview will be performed with a women who come out from PFP outlet after LARC service or follow up. A standard pre-tested exit interview topic guide will be used for collecting the data (annex IIIa).

Exclusion Criteria

For Managers: if recruited within 6 months and no knowledge about the PFP outlet works

For service providers: If working in that outlet for less than 3 months

For clients: Clients who use other than LARC FP methods will not be included.

Who and how recruitment will take place?

Principal Investigator (PI) of the study will recruit the participants for study.

Service provider selection: First, a list of the PFP outlets providing LARC service in the district will be prepared in consultation with the Family Planning supervisor from government district

public health office and program manager of supporting NGO. Then, from the list three outlet in each district will be selected for study. The provider on duty during the day of visit to PFP outlet will be interviewed by PI.

Program manager selection: In Nepal, there is one district family planning supervisor in each district, similarly supporting organization has one district manager for program support. Both of the managers from selected district will included in the study.

Selection of the client: During the day of visit to the outlet, clients who come for LARC service and willing to be interviewed will be included in the study.

A.7 PROCEDURES

A.7.1 What procedures or methods will be employed in the collection of data (e.g. patient interviews / focus group discussions) and by whom?

Principal investigator (myself) will conduct all interviews with managers, service providers and clients. In Depth Interviews (IDI) with service providers of the outlet will be conducted. Client exit interviews also would take place at the outlet, who visit outlet for LARC service during the day (exit interview). Similarly, Program managers will also be interviewed using semi structured questionnaire.

Appointments will be made in advance with participants for IDI. They will be interviewed on their pharmacies. They will be interviewed using semi structured topic guide.

Attach additional sheets if necessary

Procedure	To be carried out by (profession):	Experience in procedure:
In-depth Interview	Principle investigator	Past experience of conducting in depth interview

Client Exit Interview	Principle investigator	Past experience of conducting Client exit interview

A.7.2 Please indicate that the persons are competent to carry out the techniques used as identified in A.5.1 are competent to carry out these procedures. List any training of staff which may be required prior to commencement of the study.

The Principal Investigator, myself will engaged in all the process of information collecting, taking appointment, preparation of tools, data collection and entry process. No additional training is planned. All the discussions will be held in Nepali language (national language of Nepal). The IDI guidelines and Semi-Structured Interviews (SSIs) will be translated in Nepali language.

A.8 SAMPLING

A.8.1 Please justify your choice of sampling method(s) and if relevant sample size(s); For qualitative research provide rationale and criteria for the selection of participants for each technique

I will use a qualitative technique for data collection. Purposeful sampling strategy will be applied for selection of site and respondent. PFP outlet in two of the district from semi urban and rural location in Nepal will be sampled as representation of the PFP outlets. This provides an opportunity to explain the process and explore the reasons for selection of the service from outlet.

For selection of district managers, the PI will contact the District public health office and supporting INGOs in the district. With verbal communication to concern organisation, PI will approach directly to the person. If there are more than one supporting agencies in the district, I will conduct IDI with all.

For selection of service providers, with the help of INGOs and District (Public) Health Office, I will make a list of all outlets providing LARC services. Out of these, I would select at least two service sites, which has a higher number of client flow in the past month. Then I will approach to the service provides for enrollment.

For the interview with the clients, I would wait in the outlet to the clients, who would come for service. I would interview them using semi-structured interview. If required number is not available on the day of visit, I will continue visiting to the service sites to collect required number of samples.

DATA ANALYSIS

A.8.2 Explain how you will analyse the data and, if applicable, which software you will use.

Guidance note

- *If applicable explain what statistical method you will use to analyse the data (relate these to each of your objective).*
- *For qualitative data describe the conceptual framework you will use to analyse the data*

Interviews (IDI and semi-structured interviews) will be recorded using a tape recorder and also noted in Nepali. All interviews will be transcribed and translated into English and entered in MS Word by the investigator. The data will be coded according to the pre-defined themes. The data will be entered in excel sheet for manual analysis. Quotes and interesting themes will also be looked into and mentioned in the report. Summary of the interviews will be shared with participants at the end of interviews. Revision will be made in the notes if any.

For designing the topic guide, analysis of the finding of data from respondent Quality of care framework for family planning will be used.

QUALITY ASSURANCE and STUDY LIMITATIONS

A.8.3 What procedures are in place to ensure the quality of the research?

Data management

(sub-questions from protocol USR module)

To ensure the quality of the study, steps will be taken from the design phase. All tools will be developed in English and translated into Nepali. For consistency tools will be reviewed by qualified translators by back translation and correction where needed. Tools will be pre-tested with service providers and clients in a similar setting in Kathmandu; having similar context of the proposed study districts and participants. Any comments/feedback will be incorporated in the tools (IDI and SSI).

As study will be conducted in Nepal and study require dealing with participants directly. Data will be stored safely till 6 months of study completion. Ethical approval also will be obtained from Nepal Health Research Council (NHRC), host country's ethical committee.

A.8.4 Explain expected limitations of the study design and how you will deal with these limitation

As this study is planned as part of the fulfillment of the master course. Time, resources and funding, methodology and technique are anticipated limitation of the study. The finding from this study may not represent all outlets issues in Nepal; however, it may suggest to guide conduct similar studies at larger scale with method mix. Further, interviewing policy makers, FP clients and other stakeholders could enrich the analysis. Bias of interview – participants may not disclose everything, service providers may not be able to answer all questions. Client may not able to answer all the question asked.

A.9 DISSEMINATION OF RESULTS

Please outline what plans you have for dissemination of results.

Guidance notes:

Where possible a mechanism should be in place to inform study participants of the outcomes of the study.

It is important that important study findings are made known to local services / policy makers before they are discussed (e.g. at international scientific meetings)

The study results will be shared with Family Health Division (FHD) and District (Public) Health Office of the study districts. Findings of the study will be disseminated to KIT. Report will be

shared to NHRC and service providers. Press release and case stories will be published in the national and local print and electronic media. Summary of findings will be shared to INGOs and study participants.

A Planning and Time line

Guidance notes:

- *Please provide a time line of the research, indicating the time when it will be carried out,*
- *Please indicate the time needed for the different components*

SN	Activities	Responsibility	Timeline (Month)												
			March		**April**		**May**		**June**		**July**		**August**		**Sept**
			I	**II**	**I**	**II**	**I**	**II**	**I**	**II**	**I**	**II**	**I**	**II**	**I**
1.	Literature and program document review	PI	**X**	**X**	**X**	**X**	**X**	**X**	**X**						
1.	Develop a study proposal	PI	**X**												
2.	IRB and NHRC ethical approval	PI	**X**					**X**							
3	Preparation of research tool/instruments - Pre testing of topic guides - IDI, KII guidelines and study topic - Field equipment's (recorders, topic guides)	PI								**X**					
4	Preparation of research team - Recruitment of data enumerators - Recruitment of translators - Communication to the research site	PI								**X**					
6	Collection of data/field work	PI								**X**	**X**				

7	Transportation of data									**X**					
8	Analysis and processing of data/report writing	PI								**X**	**X**	**X**			
9	Dissemination of findings at KIT Dissemination of findings in Nepal	PI											**X**		**X**

A Financial implications and Budget

Guidance notes:

- please provide a budget for the research
- please indicate how the financial implications will be catered for

B	**Activities requiring cost**	**Budget in euro (approx)***
1.	Travel cost for PI	700
2.	NHRC ethical approval	100
3.	Pre testing of topic guides (exit interviews, IDI, exit interviw guidelines and study topic guide)	100 (local travel, tea and snacks for participant and tool printing)
4.	Printing of topic guides	150
5	Local travel	200
6	Expenses during collection of data/field work	200 (upkeep for the PI. for refreshment to participants)
7	Debrief meeting cost	50
	Total	**1500**

* Cost will be managed by PI

SECTION B ETHICAL CONSIDERATIONS

CONSEQUENCES FOR THE LOCAL COMMUNITY/ENVIRONMENT AND PATIENTS

B.1 State the country (ies) and town(s) / district(s) where the work will be carried out.

Country: Nepal

Districts: Kathmandu (pretest), Kavre and Makawanpur Place of activity: PFP outlet offering LARC in the selected district

B.2 Describe the setting in which the study will be carried out (e.g. community centre / home / village / District Hospital / Health Centre)

Outlet during regular outlet hours or specified days or hours when the service is offered or private providers operating out of their own private facilities.

B.3 Outline the potential adverse effects, discomfort or risks that may result from the study in the following areas:

B.3.1 Participants

Guidance note:

It should be borne in mind that interviews and focus group discussions may sometimes trigger painful or distressing memories (e.g. questions about sexual practice o the death of a child)

Participants may recall unpleasant memories of their work or service experience during the interview.

B.3.2 Investigators

Guidance note:

Social science investigators may be exposed to narratives of violence or severe grief

No risk for the investigator is anticipated in this study.

B.3.3 Members of the public

This study will have direct association with the public or users of the service. Attention will be paid not to effect the service to the public during the interaction and interview with the service provider.

B.4 **OUTLINE WHAT STEPS WILL BE TAKEN TO MINIMIZE THE ADVERSE EFFECTS, DISCOMFORT OR RISKS THE ADVERSE EFFECTS, DISCOMFORT OR RISKS DESCRIBED ABOVE**

B.4.1 For participants

Guidance notes:

It may be necessary to ensure that counselling or other relevant services are available. Please indicate what will be available if relevant, and will be available at the Consent Form.

As the interview will not focus on personal experience in providing health services or focus on traumatic events, most likely the participants of the study will not require any counselling. In the unlikely event that counselling is required, the local counsellor will be involved.

B.4.2 For investigators

Guidance notes:

Where the research may involve adverse experiences for investigators (see B.3.2), de-briefing / support meetings may be important.

NA

B.4.3 For members of the public

NA

B.5.1 What demands will this research place on local health services?

Low

B.5.2 Detail how the design of the research project takes into account the above demands.

As the study is for the fulfillment for the requirement of the course, the finding of the study could be utilized in different aspect. For such Study finding will be shared in different level. However, there will be no direct association with ongoing health services during research period.

B.6 What steps will be taken to ensure privacy and confidentiality for participants?

The participants will be explained the content of consent form. Voluntary participation and measures taken to safeguard privacy and confidentiality will maintain, Participants name will not appear in any place. They can participate or leave the process in between of proceeding. On agreeing they will be asked to a sign consent form in the presence of a witness.

SOCIAL AND CULTURAL SENSITIVITY ISSUES

B7.1 Describe what cultural and or social sensitivities your research raises

The research question under investigation does not address a sensitive topic – neither cultural nor social. As the principal investigator is Nepali herself and like the participants has a clinical background there is very little risk that cultural and social issues are dealt with in a sensitive way. With the participants client will be asked about method preference and cultural and social aspect of specific issues.

B7.2 Explain how you plan to deal with cultural and social sensitivities within your research and how you will minimize potential risk.

GENDER ISSUES

B8.1. Describe how the research addresses a demonstrated public health need and a need expressed by women and/ or men

In the context of Nepal, FP service provider (especially for long acting family planning methods) are female. Exploration about their perspectives on access and quality of family planning services associated with their work and work place will be on the way to deal with the demonstrated public health need of female gender. Additionally, in most of the case the owner of the facility are male.

As by default LARC service user are female. Their access to service will be explored.

B8.2. Explain how the research contributes to identifying an/ or reducing inequities between women and men in health and health care.

The study is to explore the access and quality of services offered to the population. The study findings will be helpful to increase the serve to the underserved, i.e. women and men in hard to reach areas will

have access to the family planning services they choose. As user of the FP services are female gender, this study will directly reach to them.

B.8.3. Does the nature or topic of the research make it important that the researchers are women rather than men or vice versa? Please explain. What is the sex composition of the research team and what are their duties and responsibilities in the proposed research?

Not applicable

B.9 INFORMED CONSENT

Please provide consent forms for every participant group and each instrument.

B.9.1 Information given to *participants*:

Guidance notes

- Please indicate what you will tell the *participants* in simple language. The procedure or treatment which will be applied should be described and reference should be made to possible side effects, discomfort, complications and/or benefits. Provide information to the participant in the research about the purpose, type of research technique, type of questions or issues addressed, time involved and arrangement for privacy.
- State how confidentiality is maintained. For focus group discussions clearly state that confidentiality cannot be guaranteed and that participants should **not** share personal experiences.
- It must be made clear to the participants that he/she is free to decline to participate or to withdraw at any time without suffering any disadvantage or prejudice.
- At the end of the consent form provide space for a signature of the participant. If a signature is inappropriate then a witness should sign on behalf of the participant.
- State name and contact details where complaints can be directed to.
- If applicable provide contact details for counseling or other referral.

Attach the consent forms.

(See Annex I)

B.9.2 Outline who will deliver the above information and how?

For this study purpose the PI will provide information and ask the participants for their consent

B.9.3 Please indicate how consent will be obtained, given local circumstances.

Guidance notes:

In some societies, the concept of giving consent on an individual basis unfamiliar. It may be necessary to obtain consent both at community and individual level.

Obtaining consent from minors requires both consent from the guardian and, where possible, the minor.

Written consent will be required from all participants of the research

B.9.4 Are any inducements to be offered to either participants or the individuals who will be recruiting them? (e.g. improved patient care / cash) (Please tick appropriate box)

Yes/No ×

B.9.5 If Yes, please give details

B.9.6 Outline any hidden constraints to consent.

Guidance notes:

Examples where hidden constraints may be important include:

- *situations where participants are employees of the investigator*
- *women in antenatal care who may feel the health of the unborn child could be compromised if they do not consent to research initiated by their carers.*

B.10 **LOCAL ETHICAL COMMITTEE**

B.10.1 State the name and address of the local ethical committee who is requested for approval

Nepal Health Research Council Ramshahpath

Address: Kathmandu 44600, Nepal

Phone:+977 1-4227460

B.10.2 Indicate a timeline: when is approval expected?

Approval is expected after one month of application.

SECTION C

DECLARATION: TO BE SIGNED BY MAIN APPLICANT

- I confirm that the details of this proposal are a true representation of the research to be undertaken.

- I will ensure that the research does not deviate from the protocol described.

- If significant protocol amendments are required as the research progresses, I will submit these to the Royal Tropical Institute Research Ethics Committee for approval.

- Where an appropriate mechanism exists, I undertake to seek additional local Ethical Approval in the country (ies) where the research is to be carried out.

- I have no conflict of interest in this research

I expect the project to commence on (Date):

and be completed by (Date): August 2017

7 March 2017

Signed Date

Agreement advisor:

I have seen and agree with the application. I have no conflict of interest in advising this research

Signed Date

Additional comments advisor:

Annexes: Please include the following annexes:

Annex 1 Instruments to be used

Annex 2 CV of applicant

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Annexes: I Informed Consent Letters and Study Instruments

Interviews with informants and/ with respondents

Hello, My name is ……. I am student at Royal Tropical Institute Netherlands. As part of my study I am conducting research to better to understand the family planning services provided by PFP-outlet in Nepal. Many factors influence the provision of Long Acting Reversable Ccontraceptives(i.e. Intrauterine device and Implant) services specially LARC by PFP outlets. We would like to learn from this study. We hope that this information will help to find different issues which will be helpful for future program planning.

Procedures including confidentiality.
If you agree we would like to interview/ have a discussion with you about Long Acting Reversable Ccontraceptives (i.e. Intrauterine device and Implant) family planning services provided by PFP outlet.

The interview will take place in a private space where no body can hear us and lasts about an hour.

To make sure that we do not forget or change what you are saying I will tape record the answers you give. Everything that will be said, written down will be kept totally confidential. The data you provided will be kept for 6 month after finalization of the report and will discarded then after. Your name will not be recorded or written down. Notes will be kept in a locked place. Only the team of researchers will have access to the notes.

In reports and/or publications, the findings will be attributed to the services in general and not to your particular area so that nobody can recognise the setting.

Risk, discomforts and right to withdraw
You are free to refuse to answer any question for any reason. Refusing to take part or withdraw during the interview will not in any way affect the services you receive or provide.

Benefits
This study may not help you directly but the results will help to improve access to family planning service for Nepali women and men.

Sharing the results
After the study is completed, we will be sharing the results with you through district health office.

Consent and contact
Do you have any questions that you would like to ask?
Are there any things you would like me to explain again or say more about?
Do you agree to participate in the interview?

DECLARATION: TO BE SIGNED BY THE RESPONDENT

The purpose of the interview was explained to me and I agree that …….. (Name of person) is interviewed.

_____

Signed Date

If you have any questions or want to file a complaint about the research you may contact:

Contact information	Contact for Ethics Committee
Geeta Sharma sharmageeta224@gmail.com	

Annex II: Quality of care framework

Elements of Bruce's evidence-based quality of family planning care framework(27)

Element	Definition	Potential impact
Choice of methods	Number of available contraceptive methods	• Increased uptake of contraception • Increased continuation due to method flexibility allowing switching instead of stopping altogether • Selected method that meets client's specific needs • Increased likelihood that at least one method will be available, especially in settings with frequent stock-outs
Information given to users	Knowledge conveyed about available contraceptive methods including how to use, benefits and risks, and potential side effects	• Increased uptake of contraception due to dispelled myths and misconceptions • Increased continuation rates due to recognition and management of side effects
Technical competence	Correct and consistent application of medical eligibility criteria and routinely completing procedures to a defined standard	• Reduced risk of side effects and complications due to appropriate application of the WHO Medical Eligibility Criteria • Reduced risk of infection and improper placement of subdermal implants and intra-uterine devices
Interpersonal relations	Treating clients with honesty, sympathy and understanding	• Increased uptake and continuation due to being treated with dignity and respect
Follow-up or continuity mechanisms	Establishing when and how clients will return to clinic	• Decreased fertility rates due to increased contraceptive continuation rates
Appropriate constellation of services	Making contraception readily available to clients regardless of where they access care	• Increased access to contraception via service integration, mobile delivery of services, and task-shifting
Element for access to family planning services		
Geographic access	is the extent where Outlet is located so that the family planning client can reach to the	Increased access to service use

Element	Definition	Potential impact
	outlet with manageable effort (30 min walking distance)	
Economic access	the extent to which the cost of reaching outlet and getting the desired service is at manageable cost	Determine the use of service based on its cost and cost to reach to the facility.
Administrative access	It represent the extent with opening hours, presence of the qualified provider during the time client clients want to get the service	It futher determine the access to the service from public
Cognitive access	donates the extent to which FP clients know the location of outlet and availability of the services.	Increased access of the service if potential client know about the location of service site and service offered by the facility
Psychosocial access	Represent extent to which client unconstructed by psychological, attitudinal or social factor for seeking the FP services	In addition to above elements, psychological state of a individual maters for the access to services.

Annex: III Instrument for study

Interview guide for In-depth, exit interviews and semi structure interview

The topics and questions below will be used to guide all interviews. It also can be adapted as necessary to each interview. It will be kept in mind when conducting the interview there will be option to expand the answers provided by the respondent by asking additional questions to those proposed below or adapting to more appropriate questions. Specifically, I will use 3 main approaches to gather more information from the respondent by:

1) Seeking more detail or explanation of a response. By probing or asking such as

- Tell me more about _____
- Can you give an example of _____?
- What happened next?

2) Explore the reasons behind a response.

- What makes you say that?
- What was it about ____that made you decide to_____?

3) Seek clarity and check for inconsistencies.

- Can you explain what you mean by….?
- Earlier you said_____ but it also seems like_____.

Can you explain?

Proceeding

Introduction:

- Thanking the participant for agreeing to be interviewed.
- Informing the amount of time the interview is expected to last.
- Introduction of the facilitator/investigator and explain what will be doing (notes, recording, and asking questions).
- Explain that a tape recorder will be used to keep a record of the conversation.
- Assure the interviewee that the interview will be kept confidential.
- Explain that there are no right or wrong answers.
- Read out the consent script.
- Ask if there are any questions.

Annex III a: Topic guide for exit interview for service user

Access and quality of long acting family planning services from PFP outlet in Nepal

Semi-structured Exit Interview topic guide for the LARC users

1. Screening questionnaire
   Are you currently using LARC?
   If yes, for how long?
   If no, skip to another respondent.

Section 1: Household and Socio-demographic information

SN	Questions	Coding categories	CODE	Skip
101	In what month and year were you born? Write in B.S.	Month [_ _ | _ _] Year [_ _ | _ _] Don't know month ……. 99 Don't know year …….999	DOB101	
102	How old are you? (compare and correct 1.1 and/or 1.2 if inconsistent)	Age in completed years [___ | __] Don't know ……. 99	AGE102	
103	What is your caste or ethnicity? (Write caste in space provided. Do not fill box. Refer CBS code)	…… Caste/Ethnicity	ETH103	
104	What is your religion?	Buddhist Muslim Hindu Christian Other (specify)……	REL104	
105	What is the highest class you completed?	None……... 1 Primary……... 2 Middle/JSS/JHS…….. 3 Secondary/SHS/TECH/VOC…….. 4 Tertiary or above……. 5 DK…….. 99	EDU105	

106	What is your occupation, that is, what kind of work do you mainly do?	Labour ……..…… 1 Agriculture……..……. 2 Private office employee.……...…… 3 Govt. office employee ……..… 4 Small business – sewing, carpentry 5 Shopkeeper …… 6 Others (Specify) _____ 9	OCC106	
107	Age of husband (in completed years)	Age in completed years [___ | __] Don't know ……. 99	HAG107	
108	What is your husband's level of education?	None……... 1 Primary……... 2 Middle/JSS/JHS…….. 3 Secondary/SHS/TECH/VOC…….. 4 Tertiary or above……. 5 DK…….. 99	HED108	
109	What is your husband's occupation?	Labour ……..…… 1 Agriculture……..……. 2 Private office employee.……...…… 3 Govt. office employee ……..… 4 Small business – sewing, carpentry 5 Shopkeeper …… 6 Unemployed …….. 7 Student …… 8 Incapacitated …… 9 Others (Specify) _____ 19	HOC109	
110	Do you have own Mobile Phone?	1. Yes 2. No	MOB110	

Section 2: Access to LARC service sites

SN	Questions	Coding categories	CODE	Skip
201	What form of transport do you normally use to go to the health facility / clinics/ private hospital / outlets / health provider where you go for most of your health care needs?	Walking ……1 Bus ……2 Rickshaw ……..3 Other (specify) _____ 9	TRA201	
202	How many hours or minutes does it take you to reach this outlet using this transportation?	Hours: …… ___ ___ Minutes: …… ___ ___ ___ Don't know ……..99	TIM202	
203	How much does it cost to use this transportation to go from your home to the facility and then return home?	Rupees …….…… ___ ___ ___ No cost (walking) ……..2 Don't know……. 99	NRS203	
204	In the past 12 months, have you ever been unable to access FP services because outlet was out of staff?	Yes……...……...…… …. 1 No……..……..…….…… . 2 Don't know ……..…..….. 99	FAC204	
205	In the past 12 months, have you ever been unable to access because travel between home and outlet was unsafe?	Yes……...……...…… …. 1 No……..……..…….…… . 2 Don't know ……..…..….. 99	SAF205	

Section 2: Measuring client satisfaction

	Questions	Coding categories	CODE	Skip
301	Were you attended to quickly for health services in terms of emergency?	Public……...……...……. 1 Private……..……..…….…… . 2 Other… ……..…..….. 99	FAC301	
302	Was it easy to get to the clinic/site?	Yes……...……...…… …. 1	DIS302	

		No……..……..……..…. ….. 2 Don't know ……..…..….. 99		
303	Was the cost for your service appropriate?	Yes……...……....…… …. 1 No……..……..……..…. ….. 2 Don't know ……..…..….. 99	SAT 303	
304	Are the outlet hours convenient?	Yes……...……....…… …. 1 No……..……..……..…. ….. 2 Don't know ……..…..….. 99	OHR304	
305	Were you informed about other contraceptive methods?	Yes……...……....…… …. 1 No……..……..……..…. ….. 2 Don't know ……..…..….. 99	INF 305	
306	Was the time spent in consultation sufficient to discuss your needs?	Yes……...……....…… …. 1 No……..……..……..…. ….. 2 Don't know ……..…..….. 99	CTM 306	
307	Did you feel you had the opportunity to ask questions and clarify doubts?	Yes……...……....…… …. 1 No……..……..……..…. ….. 2 Don't know ……..…..….. 99	Res 307	
308	Was the use of the method(s) explained clearly to you?	Yes……...……....…… …. 1	INF308	

		No……..……..……..…. ….. 2 Don't know ……..…..….. 99		
309	Did you have sufficient privacy (during your consultation)?	Yes……...……....…… …. 1 No……..……..……..…. ….. 2 Don't know ……..…..….. 99	PRV309	
310	Did you find the clinic area to be clean?	Yes……...……....…… …. 1 No……..……..……..…. ….. 2 Don't know ……..…..….. 99	CLN310	
311	Were you treated in a friendly and respectful way?	Yes……...……....…… …. 1 No……..……..……..…. ….. 2 Don't know ……..…..….. 99	RESP 311	

Would like to add any other information to this?

Annex IIIb: Topic guide for in-depth interview with service provider from PFP outlet

The objective of the interview with service provide will be to get the answer for the research objectives. Perspective of provider in terms access and quality of LARC service provider through PF outlet. Specifically on choice of methods, information given to clients, technical competence of providers, interpersonal relations, and mechanisms to encourage continuity and appropriate constellation of services, cost of the service, catchment area of the outlet etc.

Access and quality of long acting family planning services from PFP in Nepal

Date: ..... Facility Name:……..

VDC/Municipality..... Ward No..... District:

Socio-demographic information

Ethnicity

Age

Education (highest level completed)

years as an ANM/Staff Nurse

Work experience in LARC

A. Role as a service provider

As an ANM/staff nurse, what is your roles specific to LARC?

Probe: Counseling, Clinic manage, Infection Prevention, Providing LARC services etc.

B. Management of Supply and equipment required for LARC

Ask: Mechanism of FP commodities for outlet?

Probe: how long to supplies last

- What do they tell people when commodities is out of stuck

C. Motivation and attitude toward work

Probe: How would you describe how you feel about your work? Why? What do you do when you encounter problems that are difficult for you to handle alone?

Further Probe: Support from other facility staff

- Support from referral facilities
- Support from leaders
- Support from community

D. Benefits for staff from the facility?

- Probe: Living (housing, allowances)
- Private practice
- Additional income

E. Important personal supports you have at this facility? Why are they important?

- Probe: From this community
- Family

F. Recording reporting

- Ask: Please share what information you record for LARC service
- Friends
- Colleagues

G. WRAP-UP

If you were able to improve the LARC as service provider in the next five years, what would you like to do?

Annex IIIc: Topic guide for semi structure questionnaire for program manager of supporting INGOs/ Family health division and district family planning focal person

Semi structure questionnaire will be administrated to program managers to get the answer for research objectives Interview questionnaire will be focused on logical module especially about policies, training, supplies, linkages, coverage, quality, and reporting, monitoring sustainability.

1. Personal data (to be completed for each participant on a separate sheet)	
Interview code	
Age in years	
Respondent category: FHD focal person/ District focal person/ Program manager from supportive I/NGOs	
Duration in the position 0 – 1 year, >1 – 5years, > 5 years	

1. Program background: About PFP outlet background	Probe; Program name, Started year, outlet provision
2. Program capacity – (in regards to training, quality assurance, monitoring, reporting, mentoring)	
3. quality of the LARC program	How is measured
4. Outlet recruitment	What are the basic criteria? How these outlet recruit the trained human resources?
5. Provider training	Cost. Frequency, training organizer
6. Monitoring and supervision of outlets	Who does? How frequently?
7. Contribution	Reporting, coverage, access, cost share, effectiveness
8. recommendation	
9. Cost	
10. Is it possible to expansion of service to the remote hard to reach communities?	
11. Closing of the interview	

Annex IV Curriculum Vita

CURRICULAM VITAE

Personal Data:

Name: Geeta Sharma
Date of birth: October 22, 1970
Place of birth: Shyangja, Nepal
Nationality: Nepalese
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Academic Qualification:

Year	Degree	University	Discipline
Sept 2016 to till date	MSc PH	Royal Tropical Institute (KIT)	MPH
2001 to 2004	Master in Sociology	Trichandra Multiple Campus, Tribhuvan University, Kathmandu, Nepal	Sociology, anthropology
1995 to 1996	Bachelor in Nursing (BN)	Tribhuvan University, Nursing Campus, Kathmandu, Nepal.	Majoring in hospital nursing
1992 to 1994	Bachelor in Commerce (B. Com.), Business management	Tribhuvan University Sankar Dev Campus Kathmandu, Nepal.	Majoring in accounting
1988 to 1990	Staff Nurse (Proficiency Certificate Level in Nursing)	Tribhuvan University, Nursing Campus, Kathmandu, Nepal.	
1987	School Leaving Certificate	SLC Board of examination, Nepal	

Summary of Professional Careers:

Organisation: Population Services International

Period: 2 July 2014 to till date

Position: Health Specialist

Key Responsibility

PSI most recently implements its women health project focusing on long acting family planning through local implementing partners in 30 program districts. As a lead of the program I am responsible to:

- Ensure adequate orientation to new Local implementing partners on WHP phase 4 implementation
- Coordinate with different partner organization for the finalization of detail implementation plan at different level
- Provide technical support to the LIP for the start-up of WHP Phase 4 at the districts as per SOW and allocated budget for the partners
- Work in close coordination with Regional Hub and Program coordinators at Head Office for monitoring contractual compliance of LIP
- Update information from all the LIP on periodic basis
- support in ensuring cross-departmental communication and coordination as required (share progresses and facilitate between Regional Hub and the Departments for timely support to LIP)
- Program monitoring field visits at the project districts/areas
- Ensure the quality of service provided to the clients

During the phase of emergency, I was assigned to implement emergency relief by engaging private sector for management of childhood illness in 14 earthquake affected districts. During this tenure I was responsible for:

- lead 5 month emergency project,
- Activate private sectors in 14 earthquake affected districts
- Support all FCHVs from district based on decision of MNCH subcommittee under FHD
- Supervise 15 district program officers and 1 program coordinator
- Coordinate with district health offices, child health division and other stake holders

Organisation: United Mission to Nepal

Date: 6 May 2013 to till date

Position: Health Advisor

Responsibility:

- Provide technical support for the field level activity in MNCHN
- Coordinate, organise and facilitate SBA, Implant and IUCD trainings to relevant staffs from government facility and ensure post trainings services in the working districts.

- Manage health service unit program budget under UMMN health team leader
- Provide support to health team at central and cluster level to integrate health agendas in development work
- Participate in meetings related to MNCH and emergency preparedness
- Coordinates and communicates with clusters to organise for field visits of the experts from donor community

Organisation: Jhpiego Nepal

Date: Feb. 2006 to May 2012

Position: Health Program Manager

During the long tenure with GIZ, I got extensive involvement for MNCHN momentum of the country. My involvement was beyond the scope of work assigned to me. I got involved in policy dialogue at different divisions specially to family health division, national health training centre, CTEVT, skill birth training sites and sometimes to ministry of health and population. I worked on progressive carrier with jhpiego. In my initial phase **(2006-2009)** I was responsible to lead development of Skill Birth Learning Resource Package (SBA-LRP) under USAID/ACCESS program. After 6 month of endorsement of SBA policy we were able to provide extensive learning package along with training curricula for different cadre of human resources existed in the country (curricula for MRT trained HR, Curricula for BEOC trained HR and curricula for the HR who do not have any additional training. Additionally, I was involved for strengthening the SBA training sites, testing of QI tools in different training site and during this period my involvement was also for ongoing NMMM study from Jhpiego site. During this position I was responsible for:

- lead SBA LRP development process consistent with SBA policy
- Coordinate with different level (FHD, CTEVT, CHD and NHTC, IOM and MOHP) for advocacy and ownership in the LRP
- Coordinate with national and international experts for development
- Manage the program budget for LRP development and finalization
- Represents Jhpiego in different forums including USAID/Nepal briefings and presentations
- Produce program reports and financial reports for Jhpiego and USAID/ACCESS program
- Coordinate manage and participate in regular meetings in jhpiego office, SBA technical Advisory Meetings and other MNCH related meetings in government
- Development and testing of quality improvement tools (QI tools) consistent with SBA LRP and other national standards for standardized services from each level.

In later period of my time in Jhpiego **(2009 -2012)** i was responsible for MCHIP funded projects , mainly research focused interventions to generate the evidence for managing 2nd second leading cause of maternal morbidity and mortality during pregnency in Nepal. I was responsible for both managerial aspect of the research i.e. coordinating to research body in Nepal as well as in US to managing field research team and technical aspect of the research i.e. research findings and impact at field level. Manly in two research projects; acceptablity of calcium sactch vs. Tablets by pregnant women and major for early detection preeclempsia at community level.

Organisation: German Technical Cooperation (GTZ), Health Sector Support Program, Dhading

Date: Sept. 1999 to Feb.2006

Position: Training officer, District Coordinator

During the tenure with German Technical Cooperation (GTZ), Health Sector Support Program I manage all component of the program. Specially,

- Manage MNCH related activities at district level.
- Participate in Meetings in DHO, DDC and HFOMC
- Implement Client Oriented Providers Efficiency /Participatory Learning and Action (COPE-PLA) program to activate HFOMC in working district
- Support DHO to implement program to strengthen infection prevention practices in health facilities
- Manage the initiatives to increase the institutional delivery focusing to fill the gaps of trained HR, Equipment and supplies, awareness raising activities in the community and local initiatives
- Provide inputs to GIZ head office in Kathmandu for development, implementation and expansion various GO/NGOs and for the use of HIV/AIDS tool kits developed by GTZ-HSSP and UNAIDS.
- Take leadership for planning and implementation of all four components of HSSP at district level.
- Provide technical leadership and representing as a technical resource person in the organization and in district and lead, support the design and maintenance of Health Information System (District Health Profile) and analysis of the information for management decision.

Organisation: Mental Health Project,

Date: 1998-1999

Position: Training Officer

- Support to develop training materials for different groups
- Organize training to school teachers and community youth on mental health
- Manage to operate hotline services for people with mental disorder.

Date: 1999

Position: Technical Trainer

Organisation: peace Corps

Work as Health Technical Trainer for training 27 American Volunteers in pre-service training.

Organisation: Family Planning Association of Nepal,

Vision 2000 Project **Date:** July 1997 to Oct. 1998

Position: Women & Youth Development Officer

- In FPAN I was responsible for formation of women and youth groups, assessments, planning, organize and facilitate reproductive health program for MNCH and family planning and sexual health for women & youth groups, schoolteachers and political and religious leaders organize and facilitate group meeting of community leaders, youth and women groups and supervise RH health clinics.

Organisation: Gandaki Technical School, Tanahau **Date**: Jan. to July 1997

Position: Training Coordinator

- Coordinate and manage classes for CMA, ANM, LAB students group for all aspect of academic course
- Organize field visits and micro health project,
- Coordinate with other governmental and nongovernmental health organizations to facilitate students learning

Organisation: Nursing Campus, Birgunj

Date: Aug. 1992 to Sept. 1994

Position: Assistant Instructor

- At Birgunj Nursing campus I had guided nursing students on community health and midwifery, provide support to hospital management for human resources, infection prevention and improve the quality of services delivery, organize concurrent and residential community field trips and organize community field practice for students.

Organisation: Plan International

Date: June 1991 to July 1992

Position: Clinic In-charge

- At Plan clinic, as first part of my job I was responsible to manage MCH clinic and provide service to mother and children at the clinic, Conduct mobile immunization clinic and organize, organise mother group, TBAs and FCHVs trainings and meetings.

Research and documentation works

1. Field study of use of mesoprostral for prevention of PPH, WHO sponsored study by freelancer professor of university of Liverpool
2. Documentation of SBMR approach for health system strengthening including quality health services in Arghakhanchi and Kapilbastu districts, April 2013. A consultative work for HealthRight International.
3. Editing abstract book on first national health promotion conference, March 30- April 1, 2013
4. Documentation of peer education system and best practices on strengthening youth friendly services, Feb- April, 2013

Presentation (aboard):

14-17 Sept 2011 **Poster presentation** on improving quality of maternal and newborn training in Nepal using standard during 28th international ISQUa conference in Hong Kong

19-22 Nov 2009 **Paper presentation** in IX ICM regional Asia pacific midwives conference in Hyderabad India on Setting standard for safe childbirth: empowering women enabling midwives.

9-12 Oct. 03 **Paper presentation** on Bringing Cairo home: experiences of Nepal in Bangkok, Thailand.

Non-academic qualifications (Training/workshops/ key experience):

International level

Dates	Training /workshops/ key experience
29 Nov-4 dec 2015	Participated in Theory of Change applied in Sanitation in total market approach (TMA) training – South Africa organized by PSI.
14-17 Sept 2011	Participate in 28th international ISQUa conference in Hong Kong
2-6 May 2011	Participate in Global Workshop on Public Health Monitoring, Evaluation and Research organised by MCHIP/Jhpiego from 2-7 May in Kenya.
6-11March 2010	Participate in Reconvening Bangkok: 2007 to 2010 – progress made and lesson learned in scaling up FP/MNCH best practices in Asia and Middle East region Achieving MDGs in Asia and the Near East at Bangkok, jointly organised by ESD, USAID and WHO.
19-22 Nov 2009	Participate in IX ICM regional Asia pacific midwives conference in Hyderabad
3-8 Sept. 2007	Participate in Technical meeting on scaling-up FP/MNCH best practices in Asia and the near East at Bangkok, Thailand jointly organised by ESD, USAID and WHO.
18-22 Sept. 2006	Participate in ZUMA Simulation Workshop in Kublenz, Germany.
6-10 Oct. 2003	Participated in 2nd Asia Pacific Conference on Reproductive and Sexual Health in Bangkok,
1-10 June 1998	Observation visit to involvement of Muslim leaders in reproductive health in Bangladesh

National level

09-17 Nov 2014	Basic IUCD insertion and removal training, Maternity hospital Thapathali Kathmandu
20–24 June 2011	Participate and honoured the certificate in International training on "Update on the Clinical Training Skills Course" for the Asia Region conducted by NHTC
28-29 Apr. 2011	Participate and Contributed in workshop to review the implementation status of the National SBA program, organised by NHTC in Kathmandu
4-25 Apr. 2007	Received Clinical Skill Training (CTS) organized by National Health Training Centre, Department of Health Services in Kathmandu
19 - 22 Mar. 2004	Field exposure visit to community-based nutrition intervention in Bardiya district by GTZ-HSSP
26-28 Sept. 2001	Participate in workshop on Participatory Monitoring and Evaluation organized by GTZ-HSSP in Dhading
23-25 May 2000	Received Gender Communicated and Applied Training organized by Communication and Management Institute (COMAT) in Kathmandu.
18-24 Jan. 2000	Participatory Learning and Action (PLA) organized by NEPAN in Dhading
1996	Participated to support CTEVT curriculum revision for ANM, CMA and HA course