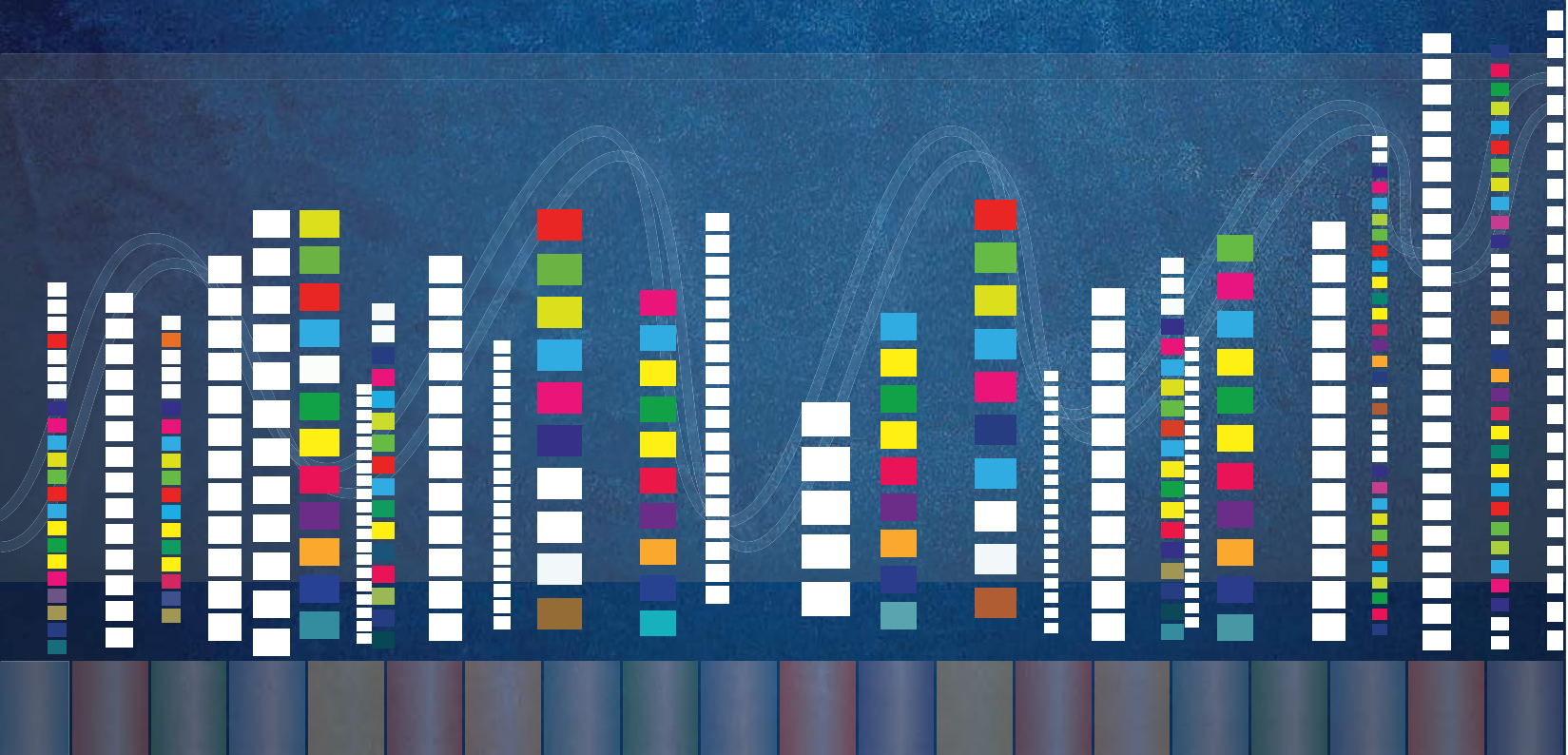




SHARING BEST PRACTICES

Addressing RH, Population and Development Challenges



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Addressing RH, Population and Development Challenges

By

Partners in Population and Development (PPD)

PPD Secretariat Office Complex, Block-F,
Plots-F/17 B&C
Agargaon Administrative Zone,
Sher-E-Bangla Nagar
Dhaka-1207, Bangladesh
<http://www.partners-popdev.org>
Phone : +88029117842, 9117845

United Nations Population Fund

(UNFPA)
605 3rd Ave, New York,
NY 10158, USA
<https://www.unfpa.org>

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turtlebangladesh@gmail.com

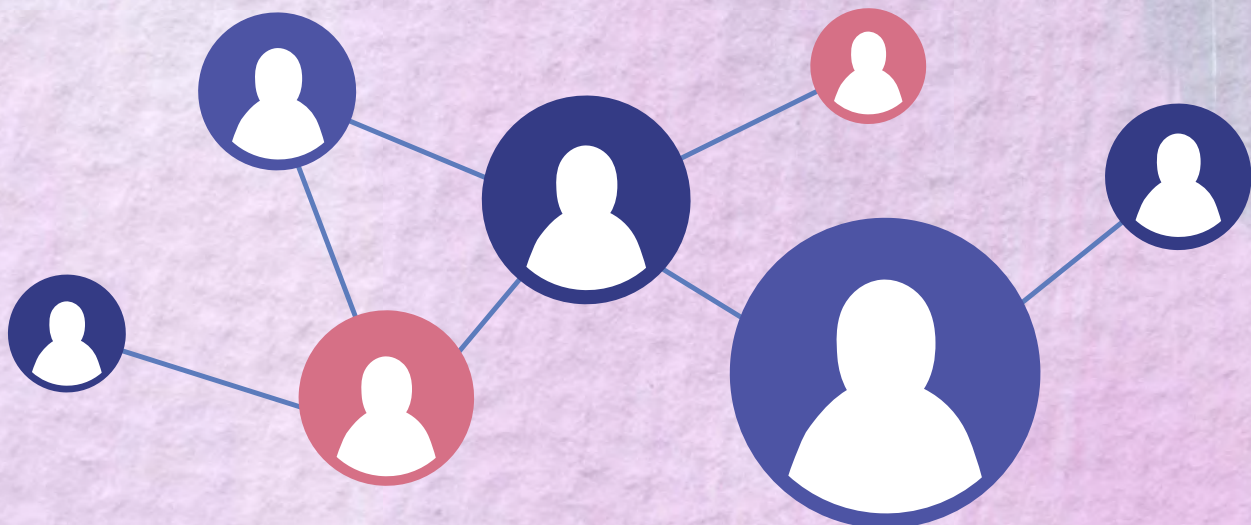


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ACRONYMS

ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
ANMOL	ANM Online
AR	Ashanti Region
ASHA	Accredited Social Health Activist
ASRH	Adolescent Sexual and Reproductive Health
BAR	Brong Ahafo Region
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CDRI	Central Drug Research Institute
CEO	Chief Executive Officer
CHCP	Community Health Care Provider
China CDC	Chinese Center for Disease Control and Prevention
CHSE	Comprehensive Health and Sexual Education
CIT	Center for International Training
COVID-19	Corona Virus Disease 2019
CPC	Senior Population Council
CPS	Contraception Prevalence Survey
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
CT	Computed Tomography
DA	District Assembly
DBCI	Digital Behaviour Change Interventions
DFID	Department for International Development
DGFP	Directorate General of Family Planning
DHIMS	District Health Information Management System
DP	Development Partner
EASIS	Expanding Access to IUCD Services in India
EDD	Estimated Date of Delivery
EDHS	Demographic and Health Survey, Egypt
EMU	Estimate Method Use
ENFPF	Enquête Nationale sur la Fécondité et la Planification Familiale au Maroc
ENPS	Enquête Nationale sur la Population et la Santé

ENPSF	Enquête Nationale sur la Population et la Santé Familiale
ENSME	Enquête Nationale sur la Santé de la Mère et l'Enfant
EOM	Enquête à Objectifs Multiples
EPSF	Enquête sur la Population et la Santé Familiale
ESSP	Etablissement de Soins de Santé Primaires
FGE	Futures Group Europe
FGMS	Finance and Grant Management Specialist
FOGSI	Federation of Obstetric and Gynecological Societies of India
FP	Family Planning
FPD	Family Planning Department
FPI	Family Planning Inspector
FP-LMIS	Family Planning - Logistics Management Information System
FUB	Free University of Brussels
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GDHS	Ghana Demographic and Health Survey
GES	Ghana Education Service
GHARH	Ghana Adolescent Reproductive Health Project
GHS	Ghana Health Service
GIS	Geographic Information System
GoG	Government of Ghana
HA	Health Assistant
HFFG	Hope for Future Generation
HMIS	Health Management Information System
HP	Health Professional
HPNSP	Health, Population and Nutrition Sector Program
HTSP	Healthy Timing and Spacing of Pregnancies
ICU	Intensive Care Unit
IEC	Information, Education and Communication
IP	Implementing Partner
IPA	Innovation for Poverty Action
IPPF	International Planned Parenthood Federation
ISRAD	Institute of Social Research and Development
IUD	Intrauterine Device

JHS	Junior High School
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LARC	Long Acting Reversible Contraceptive
MT	Mobile Team
MU	Mobile Unit
M&E	Monitoring and Evaluation
MCID	Maternal and Child Identity Number
MC	Mobile Clinic
MCH	Maternal and Child Health
MCH-FP	Maternal and Child Health - Family Planning
MCWC	Maternal and Child Welfare Center
MDG	Millennium Development Goal
MEC	Medical Eligibility Criteria
MGSP	Ministry of Gender and Social Protection
mHealth	Mobile health
MICS	Multiple Indicator Cluster Survey
MLGRD	Ministry of Local Government and Rural Development
MMHC	Multidisciplinary Mobile Health Caravan
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MO	Medical Officer
MOE	Ministry of Education
MOH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
MOHP	Ministry of Health and Population, Egypt
MP	Member of the Parliament
MPA	Medroxy Progesterone Acetate
NFPP	National Family Planning Program
NGO	Non-Governmental Organisation
NHP	National Health Policy
NPC	National Population Council
NSC	National Steering Committee
NTSU	National Technical Support Unit
NU	New User

NUTW	Union National Union of Tunisian Women
NYA	National Youth Authority
OC	Officer in Charge (Police)
OCA	Organisational Capacity Assessment
ONFP	Office National de la Famille et de la Population
ONPFP	ONPF and Population
OR	Operations Research
PAIUCD	Post-abortion Intra Uterine Contraceptive Device
PCC	Partner Country Coordinator
PD	Project Director
PHC	Primary Health Care
PHCD	Primary Health Care Directorate
PHI	Public Health Institute
PIP	Program Implementation Plan
PNC	Postnatal Care
PPAG	Planned Parenthood Association of Ghana
PPD	Partners in Population and Development
PPFP	Postpartum Family Planning
PPIUCD	Postpartum Intra Uterine Contraceptive Device
PSC	Personnel Status Code
PTA	Parent Teacher Association
QPR	Quarterly Project Report
RCC	Regional Coordination Council
RCEFP	Regional Center for Education and Family Planning
RCH	Reproductive and Child Health
RH	Reproductive Health
RHD	Regional Health Directorate
RHRC	Reproductive Health Referral Center
RMNCAH+N	Reproductive, Maternal, Newborn and Child, Adolescent Health and Nutrition
SM	Supervisory Midwife
SBCC	Social Behavioural Change Communication
SDG	Sustainable Development Goal
SFP	Sector for Family Planning
SHEP/MoE	School Health Education Programme/Ministry of Education
SHS	Senior High School

SMC	School Management Committee
SMS	Short Message Service
SRH	Sexual and Reproductive Health
SRS	Sample Registration Survey
SS	Survey and Statistics
SSC	South-South Cooperation
TFR	Total Fertility Rate
TL	Tubal Litigations
TOG	Tunisian Official Gazette
TV	Television
UEO	Upazila Education Officer
UFPO	Upazila Family Planning Officer
UHC	University Hospital Center
UHC	Upazila Health Complex
UHFWC	Union Health and Family Welfare Center
UHO	Upazila Health Officer
UNFPA	United Nations Population Fund
UNO	Upazila Nirbahi Officer
USAID	United States Agency for International Development
UT	Union Territory
VTP	Voluntary Termination of Pregnancy
WAHO	West African Health Organisation
WB	World Bank
WHO	World Health Organisation
WILDAF	Women in Law and Development in Africa
WSF	World Survey on Fertility
YMK	You Must Know
YOLO	You Live Only Once (A television serial)

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Adnene Ben Haj Aissa

Executive Director

CHAPTER 1

INTRODUCTION

Prof Joshua Kembo, Adnene Ben Haj Aissa**, Md. Nazrul Islam***, Tahrira Khan*****

The mandate of Partners in Population and Development (PPD) is promoting South-South Cooperation (SSC) through exchange of knowledge, experiences and best practices among its member countries (MCs) and other developing countries in reproductive health population and development field. PPD is involved in monitoring the progress of the ICPD and SDGs through SSC. It has realised robust achievements in addressing various critical challenges in its member countries and has achieved significant results.

The political commitments of PPD member countries are stronger towards promoting SSC than any similar inter-governmental organisation members who run through the financial and in kind contribution from the memberships. During this global COVID-19 pandemic when the developed world is in crisis, PPD member countries continued to access to its financial and in kind support to this organisation. Recent survey data revealed that the countries that pay regular contributions to PPD, paid their annual contribution from an amount of USD20,000 to USD 80,000, during this crisis period caused by the COVID-19 pandemic. This goes a long way to show the great political commitment for SSC in RH and population and development. In addition to that, these countries further contributed to SSC for PPD through various initiatives such as donating to projects, medical teams for COVID-19, medicines and commodities of FP.

The survey further revealed that more than 90% of the countries had specific political commitments to institutionalise and sustain the international inter-ministerial forum for political peer review on policy dialogue and exchange of knowledge to promote SSC. About 80% of the countries are engaged in SSC through technical cooperation and training programs for other countries. The available data revealed that following the commitment of ICPD and ICPD25, countries have sound population policies to address emerging issues and integrated population dynamics into their national plans. There were some countries that had already reviewed their policies and further modified them with emerging issues like ageing and the Nairobi commitments.

A number of countries were found to have benefited from technical and financial assistance in improving universal access to Sexual Reproductive Health and Family Planning during COVID-19 and in the context of the Nairobi Summit Commitments. The technical or financial assistance was provided for the review of policies, capacity building, results-based financing for maternal and child health, distribution of COVID-19 supplies, construction of community clinics, and scholarships for capacity building and provision of drugs, Personal Protective Equipment (PPE), and Ambulances, among others.

- * Prof Joshua Kembo is an Epidemiologist & Demographer with 28 years' experience in the design and analysis of population censuses and surveys
- ** Adnene Ben Haj Aissa, Executive Director, PPD
- *** Dr. Nazrul Islam, Program Director, PPD
- **** Tahrira Khan, Senior Program Officer, PPD

SSC has capitalised on the wealth of intellectual and programmatic capacity of its member countries through the documentation, dissemination and replication of best practices in population and sexual and reproductive health and rights (SRHR). About 26 best practices documents with 3 series have been published jointly with UNFPA, UNDP, the UN special Unit for South-South Cooperation, Population Communication and member countries. A series of international events, forums and seminars including China-Africa Forum on Population and Development have been established in recent years to exchange and disseminate success experiences of developing countries in the field of population and reproductive health.

SSC enhances the multiplier effect of technical cooperation among the countries. Technology transfer and commodity exchange in reproductive health is another area where SSC has made remarkable progress. For example, the Government of China has donated over USD 1 million worth of contraceptives and USD 600,000 worth of reproductive health medical equipment to some PPD member states. The Government of India contributed USD 1.2 million to construct 36 community clinics in rural Bangladesh to facilitate health care services to the hard to reach population. The Government of China created the South-South Cooperation Assistance Fund for promoting SSC in developing countries. It has contributed a grant USD 672,767 to PPD to implement a project to prevent postpartum hemorrhage to reduce maternal mortality in Bangladesh. With the technical support from the UN Population Division and UNFPA, the China Population and Development Research Center (CPDRC) developed a web-based population projection software in six UN working languages in 2010, which has been utilized in more than 10 developing countries. Countries collaborated with each other to establish Centers of Excellence for SSC in Population and Development. Recently a Centers of Excellence for SSC on population and development was established in China (China CPDRC). Tunisia, Mexico, Morocco, Kenya, Indonesia, Bangladesh, India, South Africa and Egypt have experienced the CPDRC Centers of Excellence for SSC on population and development in exchanging training and research programs in RH, population and development. A network of 23 research and training institutes were established whose role is to review capacity and strengthen the capacity of training programs through curriculum development and exchange of expertise. Evidently, these centers have been engaged in facilitating several exchange programmes for capacity building among the developing countries.

The scholarships and exchange of expertise programme is a unique SSC bridge established by PPD member countries which contribute to the advancement of knowledge and professional skills development and international understanding in the areas of RH, population and development. This scholarship programme is facilitated by a contributory grant from PPD member countries-India, Egypt and South Africa are the fund givers and overseers of this programme. The 3 countries facilitate more than 40 scholarships annually for young professionals of PPD member countries. As of today, PPD has provided training to over 4040 professionals working in developing countries to improve their technical skills and leadership abilities in the population and reproductive health field.

Apart from this unique program, China alone provided training programmes for over 50,000 people from other developing countries in China and sent over 7,000 young volunteers to other developing countries for skills transfer. Further, China announced that it would provide training

to 20,000 people and 150,000 scholarships for citizens of other developing countries to receive training in China. It will also help to nurture 500,000 professional technicians for the rest of the developing world. China has set up a South-South Cooperation and Development Academy to facilitate studies and exchanges by countries on theories and practices of development suited to their respective national conditions. PPD China Programme Office, with the government of China funding has trained more than 1,300 senior government officials, programme managers and health service providers for other developing countries over the past 10 years, and become the largest training provider in the PPD family.

PPD countries have fared far better in comparison with other developing countries in terms of achieving and implementing the global agreements of the ICPD, MDGs and SDGs. In the last fifteen years, there have been improvements in PPD member countries in many areas. For example, the number of the extreme poor declined by more than half; contraceptive prevalence increased from 55% to 64%; the proportion of births assisted by skilled health personnel increased from 59% to 71%; and the Maternal Mortality Ratio (MMR) declined by a magnitude of 44% Vietnam has reached the target of a 75% reduction in the MMR while some countries such as Bangladesh, China, Egypt, Mexico and Tunisia have achieved the Under-5 Mortality (U5M) target of the MDG targets. Some of the MCs' contraceptive prevalence rates reached 65%, skilled birth attendance 70% and adolescent birth rate 189 per 1,000 women. There are however, deficits in some other areas. Income inequality has widened; reducing the maternal mortality target by 75% was not met, and child marriage and adolescent pregnancy remain high.

SSC is further underscored with the adoption of the 2030 Agenda for Sustainable Development in September 2015 and the commemoration of the 40th anniversary of the adoption of the Buenos Aires Plan of Action (BAPA + 40). The Third International Conference on Financing for Development (FfD) also encouraged “developing countries to voluntarily step up their efforts to strengthen SSC, and to further improve its development effectiveness”. SSC has increasingly demonstrated its contribution to development results through knowledge exchanges, technology transfers, financing, peer support, and neighborhood initiatives, as well as countries forming common development agendas and seeking collective solutions. The United Nations Office for South-South Cooperation (UNOSSC) established the SSC Galaxy that publishes best practices from the southern and developed countries for facilitating knowledge transfer among the stakeholders and countries. Two of the best practices from Kenya and Tunisia are published in the SSC Galaxy that mostly recognizes the demand and importance of the best practices within the UN community.

The Islamic Development Bank established a mechanism on “Reverse Linkages for SSC” to promote the exchange of knowledge and technical cooperation among recipient and provider’s countries to address COVID-19 or any other Global Pandemic crisis in developing countries.

During the COVID-19 crisis, the Chinese donations of PPEs to many of the African countries is a good example of solidarity between developing countries when there were huge constraints on production systems and harsh competition among countries to get those protective and life-saving resources.

South-South cooperation is not a substitute for, but rather a complement to, North-South cooperation. There is indeed an opportunity for using Southern solutions as a complement to traditional assistance modalities. The Indian support to many developing countries on PPEs, tools

and COVID-19 vaccines are another globally recognized contribution to SSC that are an example of a complement to North-South cooperation.

All the southern and northern Governments and development experts stressed institutionalizing South-South and triangular partnerships as mechanisms for sharing of innovative ideas and practices through contextualized to local situations, global policy dialogue and technical cooperation. There was a call from countries of the Global South to increase financial resources to scale up such mechanisms.

In Nairobi, the session on South-South and Triangular Cooperation organized jointly by PPD and UNFPA, highlighted South-South Cooperation as an alternative political and financing tool in developing countries for achieving the unfinished ICPD and SDGs 2030 agenda. If countries are to accelerate progress after Nairobi in the framework of COVID-19, we, therefore, need to accelerate commitments and intensify South-South cooperation financing mechanisms.

The youth leaders have made South-South Cooperation a recognized approach to complement other forms of partnership and engagement to address challenges of population diversity and demographic dividend for economic growth during the 17th International Inter-Ministerial Conference hosted by NHC, PPD and UNFPA. Those forms of youth engagement and cooperation can be strengthened through exchange of knowledge and best practices together.

It was acknowledged that such documentation efforts have, many times, been successful, and several innovative, promising, good or best practices have been part of those intervention efforts by countries or communities. Unfortunately, those interventions are often not documented or shared widely. Documented information may be available, but not easily accessible to program managers and others as they design and implement programs. Program managers need resources that they can access quickly and easily, and they should be able to have confidence in the credibility of the information available. This exercise by PPD is aimed at addressing that gap.

Considering the fact, PPD and UNFPA jointly committed to work for the documentation of best practices, dissemination and replication of practices with specific needs of the PPD member countries. The selection process of best practices was started with providing a comprehensive questionnaire administered by the National SSC Focal Persons of PPD countries. The data was analysed and reviewed and validated through the SSC Focal Persons for the identification of the final list of best practices from the countries. An expert with experience on documentation and publication was hired from the individual countries to document practices which were later reviewed and edited culminating in a consolidated series of best practices from 11 countries.

PPD is convinced that sharing lessons learned from these country experiences with other countries would be beneficial not only to rapidly promoting the population and reproductive health agenda in general but also to achieving the ICPD25 and SDGs in developing countries. Experience has shown that many developing countries have indeed succeeded in strengthening access to quality family planning services, reducing unmet needs for family planning, reducing MMR, slowing the population growth rate, improving women's status and integrating population factors into development planning. It would thus be very timely and useful to document these successful approaches for wider dissemination and adaptation by other developing countries, given that many developing countries are still facing a myriad of population challenges.

PPD has adopted the broad definition of a “Best Practice” or “innovative practice” used by UNFPA: “planning or operational practices that have proven successful in particular circumstances and which are used to demonstrate what works and what does not and to accumulate and apply knowledge about how and why they work in different situations and contexts”.

Under this process, the specific topics of the case studies pertain to either family planning, reproductive health, maternal health, adolescent health, gender or population and development and advocacy communication. With respect to the topic of “family planning”, the case studies focus on expanding or extending access to family planning services through different approaches such as the use of improving the quality of care, access of Post-Partum Intra Uterine Contraceptive Device, reposition long-term methods in the national family planning system, strengthening community participation or promoting the greater use of a specific contraceptive method. Under maternal health platform, COVID-19 situation is highlighted together with the services for safe delivery and postnatal care and Safe Abortion Policy and Arranging Unsafe Abortion Prevention Service Under Universal Health Coverage (UHC) Scheme. “Reproductive health” focuses on Adolescent RH healthcare services and accessing RH services to adolescent through different youth-friendly facilities or satellites.

This book is the first of its kind about best practices in sexual and reproductive health among the 11 participating countries in Partners in Population and Development (PPD). PPD is an Inter-Governmental organization of 27 developing countries presenting 60% of the global population with a mandate to promote South-South Cooperation (SSC) in reproductive health, population and development. Through SSC, countries show case successful practices that are shared with other countries in PPD, as to exchange experiences, share lessons and technical expertise. All case studies have a focus on reproductive health, population and development. The case studies highlight country achievements towards the International Conference on Population and Development (ICPD) Programme of Action (PoA), which is supported by the SDGs. Focus on reproductive health pertains mainly to Sustainable Development Goal (SDG) 3. The United Nations Population Fund (UNFPA), a key partner to PPD, also has a campaign on 3 Zeros: Zero unmet need for family planning information and services; Zero preventable maternal deaths; and Zero sexual and gender-based violence and harmful practices against women and girls.

We start off with chapter 2 where Rahim et al examine the Maternal Death Free Kapasia (MDFK) model in a sub-district of Bangladesh. The model was developed around destitute pregnant women as the priority. The authors indicate that the goal of this model is to achieve the SDG 3.1 and 3.2 in Kapasia. The model will create an environment where the goal can be achieved effectively. The focus of this model is to ensure information availability to pregnant women so that they can access proper services. The model reduces the gap between the beneficiary and service provider and make available the services required. The pre-requisites for replication in other developing countries include that Bangladesh has widespread field activities to address the health issues. In other developing countries if they want to replicate this model, they should have the field level force to introduce the model. The social engagement or community participation needs to be ensured for the purpose of the pregnant women.

In chapter 3, Li et al presents the Maternal Care Service during COVID-19 Epidemic in China. The initiator of this programme is the National Health Committee (NHC) of the People's Republic of China. The implementing institutions are Health Committees and related Health facilities in the whole country. The goal of the project is to effectively protect pregnant women and newborns during the COVID-19 epidemic to ensure mothers and their newborn infants' safety. The achievements of this project include that the management of maternal care services has been established from the township level to the national level. Health facilities and health care staff have been guided and supervised to provide maternal care for pregnant women and their newborn babies. Pregnant women and their newborn babies have access to antenatal care, safe hospital delivery, postpartum care as the same as that before the epidemic outbreak. In addition, the authors indicate that pregnant women with fever, suspected or confirmed infection have been managed and treated. Pre-requisites for replication in other developing countries include a system for fast communication of policies and a comprehensive network of maternal and child health services as well as a well-run community organisation.

In chapter 4, Nabhan et al provide a description of the Ayamna Ahla Initiative (AAI), as a best practice model with, respect to Reproductive Health, in Egypt. The initiative has three cross-cutting themes, that is, the right to reproductive health (RH), Youth and knowledge utilisation. The activities included the focused message seminars either as standalone, as part of campaigns or as part of the convoys. The initiative contributed to a significant years of protection achieved relative to the total years of protection achieved nationwide during the 12 months' duration of the initiative. This best practice is an excellent example of replicating what works in other countries through SSC. This can be achieved by collaborating with and working through national organisations and partners who are familiar with the preferences and values of the target groups as well as the local conditions.

In chapter 5, Nyabally and Jawara describe the Kaabilo Baama and Male Action Group (KBMAG) as a Best Practice for Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) in The Gambia. The project started in 2012 and is being implemented in the Kiang West and East Districts respectively, which are two of the four Districts in the Lower Region of the Gambia. The main implementing institution of the practice is RMNCAH of the Ministry of Health (MoH) and the Women's Bureau of the Ministry of Women, Children and Social Welfares, Department of Community Development and the Village Development Committees in the communities. Where a structured Village Development Committee (VDC) is absent, a village traditional structure is used as an entry point to the village/community. The Goal of the project is to contribute to improvement in the status of women and girls through improved RMNAH services and livelihood in the selected communities. The steps for replication in other countries include identification of a stable and peaceful country; identification of stable districts in a region; with the use of statistics, identify communities with low utilization of RMNCAH services and conducting a Community Profiling in which Baseline data is collected using quantitative and qualitative methods.

In chapter 6, Erasmus and Vikpeh-Lartey examine the Ghana Adolescent Reproductive Health Project (GHARH) located in the Brong Ahafo Region. The project had the ultimate goal of ensuring that more girls and women were empowered to achieve their full potential. The ultimate goal of the Project was to improve Maternal and Adolescent Reproductive Health (ARH) outcomes in order

to enhance progress towards the achievement of MDG 5. The implementation of the Project in the Brong Ahafo region led to the reduction in teenage pregnancy and abortion rates partly due to the high family planning uptake among adolescents; the effective management of adolescent sexual and reproductive health issues due to the creation of Adolescent Health Corners and School Health Clubs; and improved relations between health service providers and adolescents which has boosted the adolescent's confidence and trust in health care facilities. The planning and design of the GHARH project was based on the adolescent reproductive health situation in the country and ongoing efforts at improving ARH. The most remarkable lesson of the GHARH project is the benefit of multi-sectoral collaborations. The GHARH project did not develop an explicit sustainability plan; however, sustainability was embedded in its design. To ensure sustainability of the project, most of the programmatic components were built on existing structures. In order for the programme to be successful in other developing countries it would require strong institutional collaboration and sustainability planning.

In chapter 7, the National Council for Population and Development (NCPD) describes the ENGAGE project in Kenya. The project was implemented by The National Council for Population and Development (NCPD) with support from Population Reference Bureau (PRB) under the Policy, Advocacy, and Communication Enhanced for Population and Reproductive Health (PACE) project. The ENGAGE presentation toolkit offers the best available knowledge and information dissemination platform that can act as catalyst to trigger or stimulate policy dialogues to promote, and advocate for PHE programs and policies in Kenya. The main goal of the project was to promote policy dialogue among various stakeholders by enhancing the understanding of how PHE addresses the complex and interrelated challenges in the areas of family planning, access to health services, management of natural resources, and livelihoods faced by families and communities. The main activities of the project are the organisation, implementation and monitoring of policy and advocacy engagements for dialogue. Because of its simplicity, the presentation has enabled a number of users to engage non-technical people and change views about issues on family planning. The policy engagements and dialogue have resulted in the development of PHE strategy paper 2018-2022 which is expected to guide future intervention packages and projects.

In chapter 8, Lakssir describes the Introduction of the contraceptive implant, an innovative initiative to reposition long-term methods in the national family planning program in Morocco. The programme success is mainly explained by the adoption of innovative and pragmatic initiatives that include the provision of FP services through several channels including the primary healthcare centers (PHCs), among others. From the beginning, monitoring and evaluation was put as essential part of the implementation process of the initiative. The FPD ensured that monitoring and evaluation mechanisms were in place to ensure appropriate documentation of the initiative. Access to the method has started increasing in line with the extension of the method at the national level. In addition to the two pilot centers, the method is being available in other regions. The model of the pilot initiative has been replicated, so far, in three regions of Morocco. The Moroccan experience in integrating the implant into the service package offered by the NFPP can be transferred and reproduced in other contexts. Political support for the MOH as is the case in Morocco is required for the replication of the experience.

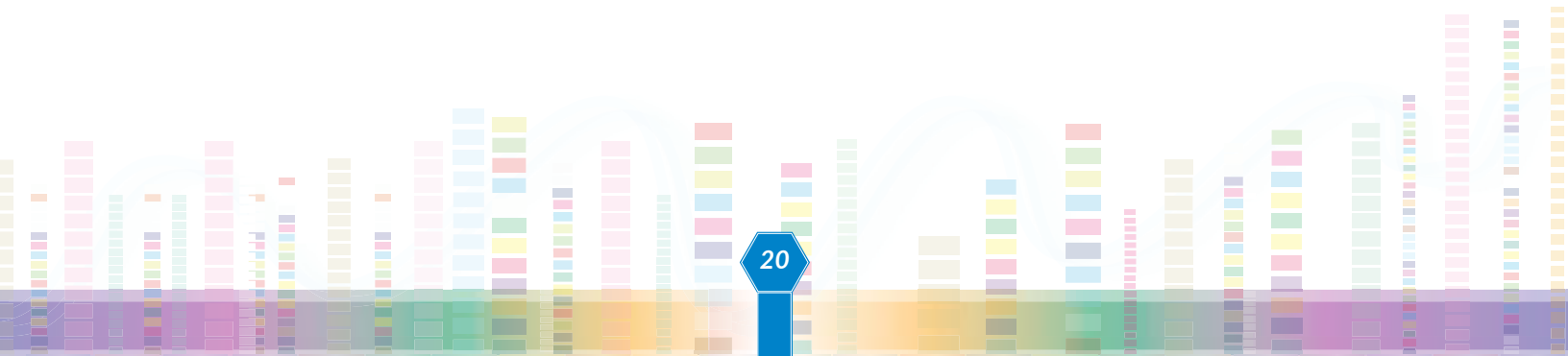
In chapter 9, Dr. Bancha Kakhong and Dr. Peerayoot Sanugul describes Thailand's best practice highlighting the success story on 'Safe Abortion Policy and Arranging Unsafe Abortion Prevention Service under Universal Health Coverage (UHC) Scheme.' Unsafe abortion is a major public health problem in many countries all over the world. The goal of the project is to support broader access to safe abortion among female teenagers and to reduce the number of unintended pregnancies among women of reproductive age with the aim of reducing post-abortion complications and mortality caused by unsafe abortions. In cooperation with the Concept Foundation, the Department of Health conducted a pilot study on medical abortion in the healthcare service system in Thailand in 2012 – 2014. There had been impacts from the cost of treatment for complications of unsafe abortion. The lessons learned include that Recipients' knowledge and attitudes towards safe abortion have a great impact on the service and continuation of the safe abortion services and that Family is also another crucial factor. If a recipient's family is optimistic about safe abortion, the recipient will be pleased to get a safe abortion service. Among plans for the future is expanding service units to cover a total of 77 provinces of Thailand.

In chapter 10, Mansour describes the Mobile Services Strategy for Family Planning and Maternal Health in Tunisia. The overall objective of the programme is to decrease population growth and keeping it under control. Right at the outset, the education program was preceded or accompanied by the modules of FP services. Hence, the education staff members were either integrated with the mobile teams or operated through independent units that are specifically dedicated to education. Lessons learned include: the management of the mobile units is carried out in conformity with clear and written organizational rules and steps to ensure more cost-effectiveness and setting up a coherent team of service providers. Monitoring of activities and evaluation of impact include use of a standard medical record is made available to FP/SRH service providers, along with an archiving system that facilitates data collection and analysis. Among the main obstacles that could impede the proper running of the mobile strategy, relevant to the FP/RH programme are aspects with respect to absence of mobile staff due to leave or illness and inability to ensure the takeover, unavailability of vehicles, for maintenance or repairing reasons, and for an unpredictable period of time and contraception stock-outs that might jeopardize the program performance and would often cause unmet demands and exacerbate people's distrust in the program performance.

In chapter 11, Dang et al describe the Population and Family Planning Programme of Vietnam. Viet Nam is one of the first countries in Asia that launched the population and family planning (PFP) programme. The objective of the programme is to ensure that to ensure small size family with healthy children to achieve happy and well-off life. The main activities include implementing the birth control movement to reduce fertility and communicating and advocacy program for FP implementation. The declining fertility and mortality rate has made Viet Nam's population enter a dividend period since 2007 with the number of population at working age is increasing. The success of the PFP program has had ripple effects in reducing poverty program, enhancing the education and health care for the people, improving gender issues as well as women empowerment, promoting migration and urbanization, increasing the GDP per capital in Viet Nam. The successes of the PFP program over the past decades have helped Viet Nam to issued new policies for the phase towards in which improving health population quality, life quality, taking advantage of the dividend period and strongly integrate population dynamic into development program to achieve

the SDGs by 2030. The authors suggest that one of the most important success lessons of the PFP programme in Viet Nam is the development of population collaborators and motivators at all villages, hamlets and streets in the whole country.

In chapter 12, Sikder and Bhatt examines the introduction and scale-up of Postpartum Intra Uterine Contraceptive Device (PPIUCD) services in India. Family Planning program in India has a rich history of more than seven decades (first country in the world to have a national program for family planning). The program since then has witnessed an evolution from population control to improving maternal and child health outcomes. One of the major reasons behind this inclusion is the considerable influence that contraception has on the maternal and child health outcomes. Periodic interventions, revisions of guidelines and program monitoring are entrenched in quality improvement process of all contraceptive services under National Family Planning Program. Within the decade of introduction as a pilot project PPIUCD has been accepted as a reliable Postpartum option by service providers and community which helped in securing a special place for IUCD as 'Long acting reversible contraceptive' (LARC) in the contraceptive basket. For replicability it is important to note that Ministry of Health and Family Welfare, Government of India together with development partners working in the area of family planning made collective efforts to ensure maximum learnings from other country programs and invited delegations from other countries of the region for exploring possibility of scale up of good programmatic interventions.



CHAPTER 2

MATERNAL DEATH FREE KAPASIA MODEL, BANGLADESH

Mohammad Abdur Rahim, *Nitish Chandra Sarkar, Dr. Mohammed Sharif, AKM Ahsanul Aziz and Mohammad Shariar Nafees*

1. Overview

This report focuses on the 'Maternal Death Free Kapasia Model' which is considered as 'Best Practice' in reducing maternal, newborn and child mortality in a sub-district of Bangladesh.

According to Oxford Advanced Learner's Dictionary, best practice is 'a way of doing something that is seen as a very good example of how it should be done and can be copied by other companies or organizations. Activities, disciplines and methods that are available to identify, implement and monitor the available evidence in health care are called 'best practice'.

The 'Maternal Death Free Kapasia Model' is termed as best practice. The model was initiated on 4th December, 2017. It was introduced by Mohammad Abdur Rahim, Upazila Family Planning Officer, Kapasia, Gazipur under the patronage and leadership of Simeen Hussain Rimi, a social worker, writer, a politician of Bangladesh Awami League and the Honorable Member of Parliament from Gazipur-4 (Kapasia), Bangladesh. Gazipur-4 constituency encompasses Kapasia Upazila (BEC, 2013). Rahim developed the model taking help from Honorable MP of Kapasia, officials of upazila family planning department, upazila health complex, upazila administration, local representatives and student associations. He placed all the components favorable for the pregnant woman and newborn babies. He sketched out all the problems a woman faces in her pregnancy time and incorporated the solutions in the model. In this report, the model's effectiveness to eradicate the problem and to find the sustainable solution has been discussed in detail.



Picture-1: Inaugural Ceremony of Maternal Death Free Kapasia Model by Honorable MP, DGFP and other notable personalities.

The model was developed with the destitute pregnant women as the priority. In Kapasia region, a good number of pregnant women are not aware of their health. Sometime they face life threatening situations due to lack of information/ knowledge. They often face problems in accessing better medical assistance. There remains a gap between service seeker and service provider. This model focuses on this segment of pregnant women in general. This model also found that if the proper information can be delivered at right time and at the right place, the maternal mortality can be reduced significantly. The model integrates human resources and digital technology.

It is essential to mention here that the software itself is not working as the model actor. Rather, it is working as the supportive means to the full operational activities of Upazila Family Planning Department. The software includes all information of the pregnant women and newborn babies, and at the same time it creates reports to officials when they will provide services. For making the model beneficial to the target beneficiaries, the Upazila Family Planning Department did not need to change its organogram. It provides the service to the target beneficiaries by making the information available and creating the environment where accountability is practiced. The attitudes of the service providers have changed as the model is pro-active towards beneficiary groups.

All the components of the model are working towards the awareness of the pregnant women and the larger context of the community. Every personnel and stakeholders working with the same motto: to eradicate the maternal death in Kapasia. The model has proved that if society is engaged in solving its problems, success thereof can become 'best practice'. 'Maternal Death Free Kapasia Model' is an epitome of that best practice.

2. Implementing Institutions/development actors:

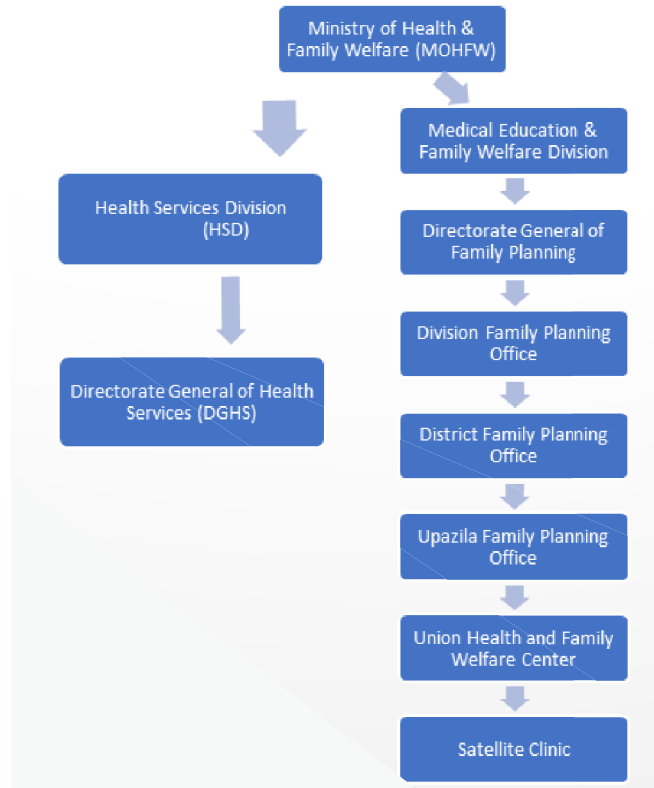
The Upazila Family Planning Office works under District Family Planning Office. The supreme authority is the Ministry of Health and Family Welfare (MOHFW).

Upazila Family Planning Office monitors the Union Health and Family Welfare Center and Satellite clinics. The total chain of command is working for the betterment of the community.

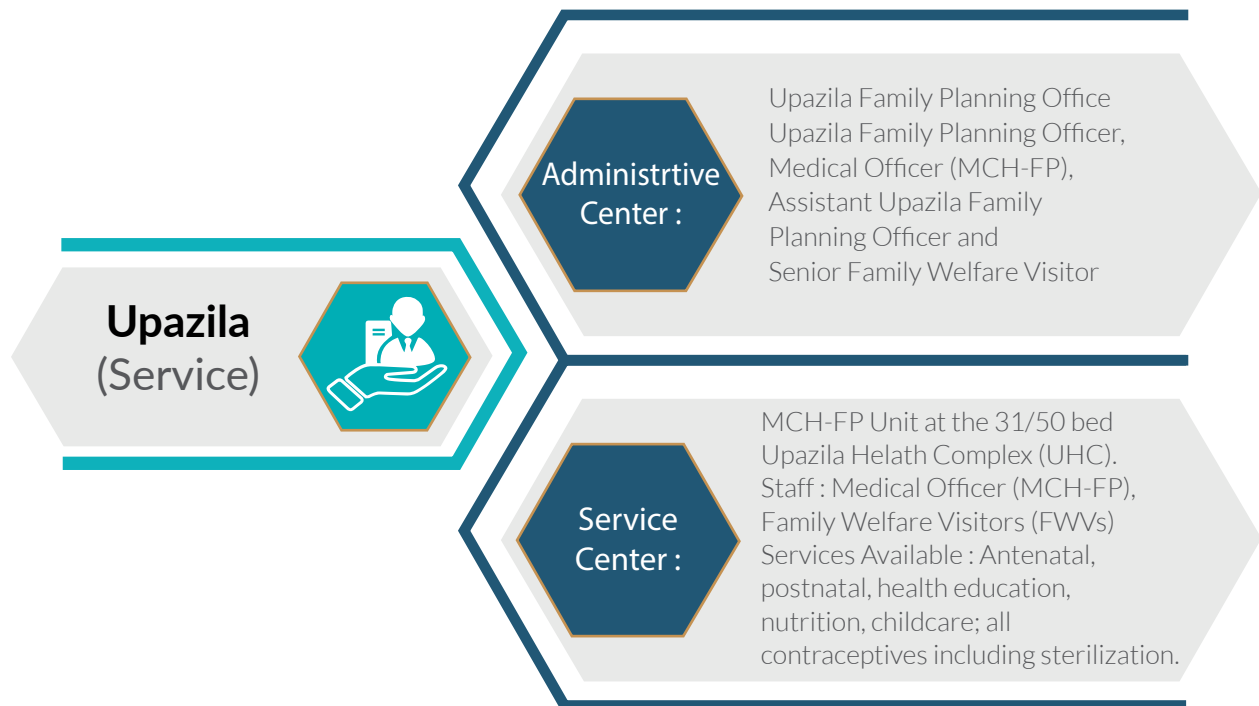
According to Upazila Family Planning Department (Kapasia, Gazipur), the Kapasia Upazila Health and Family Planning System includes the following health service facilities:

Sl.	Health Facility	No
1.	Satellite Clinic	68
2.	Community Clinic	52
3.	Union Health and Family Welfare Center	10
4.	Sub- Health Center	2
5.	10 seated Mother and Child Welfare Center	3
6.	Upazila Health Complex	1

Services are provided to the beneficiary groups through the combined effort of these existing facilities in Kapasia.



Picture 2: Hierarchy Pyramid from MOHFW to Satellite Clinic



Source: DGFP Website

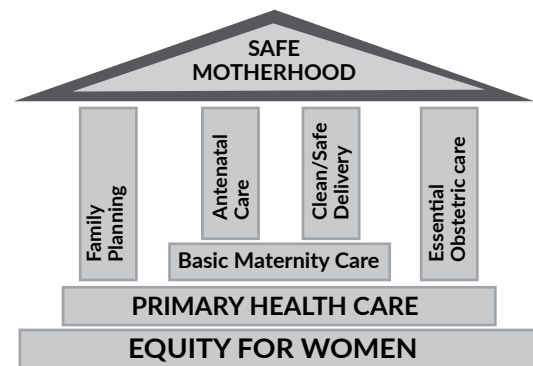
3. Summary: brief overview of the practice and overview of objectives and results

The major complications for nearly 75% of all maternal deaths are as follows (WHO, 2019):

- severe bleeding (mostly bleeding after childbirth)
- infections (usually after childbirth)
- high blood pressure during pregnancy (pre-eclampsia and eclampsia)
- complications from delivery
- unsafe abortion.

In Bangladesh, the scenario for maternal death relate to eclampsia and after-childbirth bleeding. According to the report (disclosed on November 22, 2017 by Ministry of Health) jointly done by the health ministry, the National Institute of Population Research and Training, the International Centre for Diarrheal Disease Research, Bangladesh, the USAID and the UKAID with support from a few foreign universities, the survey found that 55 per cent of the maternal deaths occur in Bangladesh due to hemorrhage and eclampsia (Maswood, 2019).

The scenario was not different in Kapasia. The death of two pregnant women due to severe bleeding shocked Mohammad Abdur Rahim, who took initiative to conduct base line survey with a view to finding out the actual causes of maternal death in Kapasia Upazila. The report from the base line survey and all other available case studies originated the ‘Maternal Death Free Kapasia Model’. Honorable Member of the Parliament Simeen Hossain Rimi’s direction and guidance led the model to be effective under the coordination of local administration, family planning and health officials.



Picture 3: Four pillars of safe motherhood

According to WHO (2014) report, the safe motherhood is dependent on four pillars. They are family planning, ANC, Clean / Safe delivery and essential obstetric care. In this “Maternal Death Free Kapasia Model”, we find the reflection of these elements. This model aims to facilitate safe pregnancy and childbirth for women in Kapasia Upazila and to ensure effective childcare guidelines.

According to IPA (2019), this program has three broad categories. The categories with some description are provided in the following paragraph:

a) Category 1:

Targeting and monitoring: These activities are designed around a database that includes identifying pregnant women, filling out their forms, entering the data from the particular form to the database, recording blood donors, sending out reminder messages and voice calls to pregnant women regarding various health components etc. High risk pregnant women are automatically identified. In this software, one can easily have various information by colors. This database can be used to monitor the performance of the health workers.

b) Category 2:

Information and awareness: These activities include sharing knowledge regarding safe pregnancy, childcare, nutrition, keeping records during pregnancy and so on. This model gives a 44-page 'MCH Hand book' with a unique ID to each pregnant woman identified. Organizing 'pregnant women gathering' in each union, installing display boards, establishing 'safe maternity wall' in each Union Parishad, distributing leaflets, etc. are also included under the information and awareness category.

c) Category 3:

Better service delivery: It includes the following components for service delivery simplifications.

- Hotline for pregnant mothers,
- Phone numbers sharing of the nearby service providers/ health workers,
- Maternal and child health care one-stop service corner in the Family Planning Unit of Upazila Health Complex,
- Training to 198 local birth attendants,
- Facility of blood donor for emergency cases. Motivated riders are engaged for carrying donors from different corners of the Upazila. A total 33 volunteers of 11 Unions (3x11) are ready to bring a blood donor to Upazila Health Complex. Regular Bangla SMS and voice calls are sent to pregnant women, etc.

In a broader sense, the objectives of the program areas as follows:

- a) Reducing maternal and child mortality.
- b) Raising awareness of pregnant mothers on issues pertaining to nutrition, prenatal and postnatal care, childcare, and family planning methods.
- c) Availability of information and service simplification.

The results from this novel program are extensive and looming in large context. Kapasia Upazila has achieved almost zero maternal death after approximately two years since the launch of this program.

4. Background and justification, including origin of the project

Maternal mortality rate in Bangladesh has declined by 66% over last few decades, estimated at a rate of 5.5% every year. The latest Bangladesh Maternal Mortality Rate is 170 per 100,000 live births as per UN and WHO estimates (2014). The MMR was 600 per 100,000 live births in 1975 and 574 in 1990 (The Daily Star, 2015).

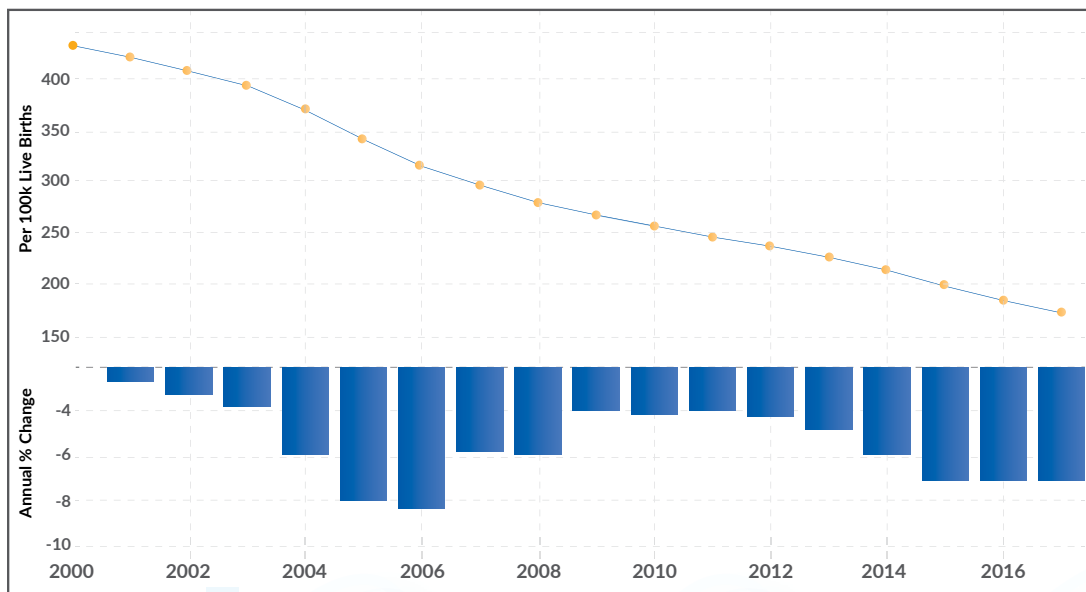
Remarkable progress has been achieved in the development of the HPN sector in Bangladesh. Honorable Prime Minister of Bangladesh received the MDG award for being on track for reducing infant and child mortality (MDG 4) in the 65th UN General Assembly Session. The government efforts and successes in the use of information and communication technology for health, recognized by the South-South ICT Award on health of women and children, which was received by the Honorable Prime Minister on September 19, 2011 during the United Nations General Assembly in New York. (HPNSDP Booklet, 2011-16).

The MDG 5 highlighted maternal health as a global public health priority. Reduction of maternal mortality ratio (MMR) by three quarters between 1990 and 2015 and achieving universal access to reproductive health by 2015 were two indicators to assess countries' progress in the MDG 5. Out of 186 countries only 19 have achieved the goal. Bangladesh is one of the successful countries in achieving the MDGs. The country is also on track in developing strategies and action taking for attaining targets of the Sustainable Development Goals (SDGs). Considering importance of the topic, a 'SDG Co-ordination Cell' has been established at the Prime Minister's Office (PMO) to guide the national SDG agenda. The 2030 agenda of SDGs are reflected in the current 7th five-year plan (2017-2021) as well as the current (4th) Health, Population and Nutrition Sector Program (HPNSP) (2016-2020).

Every year more than 200 million women become pregnant. Most pregnancies of healthy mother's end with the birth of a live baby. But, in many cases, childbirth is not the joyous event as it should be but a time of pain, fear, suffering and even death. Globally, it has been estimated that about half a million women die each year due to pregnancy related causes, 99 percent of them in developing countries. At least 9 percent of the pregnancies are complicated by a disease which is aggravated by pregnancy, such as malaria, iron-deficiency anemia, hepatitis, tuberculosis (TB); and heart disease.

As we know, maternal mortality ratio is the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births. The data are estimated with a regression model using information on the proportion of maternal deaths among non-AIDS deaths in women ages 15-49, fertility, birth attendants, and GDP. (World Bank, 2019)

- Bangladesh maternal mortality rate for 2017 was 173.00, a 6.99% decline from 2016.
- Bangladesh maternal mortality rate for 2016 was 186.00, a 7% decline from 2015.
- Bangladesh maternal mortality rate for 2015 was 200.00, a 6.54% decline from 2014.
- Bangladesh maternal mortality rate for 2014 was 214.00, a 5.73% decline from 2013.



Graph-1: Maternal mortality ratio (modeled estimate, per 100,000 live births)

The graph shows that Bangladesh in 2000, the maternal mortality ratio was high at above 400. Every year the maternal mortality ratio is showing the declining trend. For achieving the success, the government needs to work till the grassroots level of the country. As we know, the healthcare infrastructure under the DGHS comprises six tiers: national, divisional, district, upazila (sub district), union, and ward. If at each level the awareness is created, the SDG goal can be achieved easily.

'Maternal Death Free Kapasia Model' can be a means to fight against the high level of maternal deaths in Bangladesh. The model, through its technological and on-site logistic support, created a platform where pregnant women and newborn children can feel safe. With the innovative ideas of 'MCH hand book', mobile messaging and voice calls in the local language, awareness level of pregnant mothers has improved. In this model, high risk mothers are automatically identified and brought under intensive care. This process provides easy access to information, ensures transparency, accountability and service simplification and improved quality of the service. Thus, this unique model has significantly reduced maternal mortality that turned 'Kapasia' into a Maternal Death Free Upazila.

5. Goals and Principles

The goal of this model is to achieve the SDG 3.1 & 3.2 in Kapasia. The model will create an environment where the goal can be achieved effectively. As we know, the goal of the SDG 3 is as follows:

SDG 3.1	SDG 3.2
By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.

The principle of the model is to create awareness among pregnant women and accountability in the working force of Family Planning Department and Health Department. Before commencement of the model, the officials identified that the community could not avail the service they desire due to lack of information. The awareness level is raised through the proper use of communication. The officials are also providing timely services as the accountability system is raised through this model. If this process continues, the SDG will be achieved through the effective implementation of this model.

6. Methodology

For purposes of the report, the consultant surveyed in the field level of Kapasia. The pregnant and recently delivered women, family members, blood donors, schoolteacher, rider, journalist, community health workers, UNO, Member from Union Parisad and officials from Upazila Family Planning Department and Upazila Health Complex – all were interviewed through the means of FGD, IDI and KII.

The two-consecutive visits on 22nd October and 1st November, 2020 were done in Kapasia for collecting data from the field. The consultant even visited the pregnant women in their home and asked about the ANC and PNC services they receive from Satellite Clinic, Community Clinic, UHFWC, MCWC and UHC. Respective FWA were present at the pregnant women's houses while doing the visit.



Picture 4: From Left to right, interview session with UNO, Upazila Vice Chairman (Female), UFPO, Union Parishad Chairman, FGD with pregnant women, FPI; FGD with mother with newborn baby and community people, interview

The consultant visited the UHFWC and observed the process through which the pregnant women receive the service. On random basis two pregnant women were interviewed, and they were asked to show their SMS in mobile. They showed the consultant the SMS from the Upazila Family Planning Office. The MCH hand book was even found with the pregnant woman.

The consultant also interviewed Simeen Hussain Rimi, Honorable MP, at her residence in Banani DOHS, Dhaka. She discussed how the model was inaugurated with the assistance of Abdur Rahim, UFPO. She also shared the views on sustainability of the model.

7. Description including Activities, Achievements, Outcomes and Impact

- a. Main activities of the project
 - i. Activities / Achievements to date in respect to outcomes

To bring all pregnant women and newborn babies of Kapasia Upazila under digital service,

'Smart MCH Service Management Software' [www.mch-kapasias.com/presentation] been inaugurated. This software is named in Bengali as “গর্ভবতীর আয়না” or “Mirror of Pregnant Woman”.



Picture 5: The First Appearance of the Software.

This database includes 37 types of data from the pregnant women. Information of pregnant women is collected in a particular form and then it is included in the database.

In the following pictures, the data inclusion process of the software is discussed in the following paragraph.



Picture 7: Dashboard of the Software



Picture 10: ANC Service to Pregnant Woman in UHFWC

The information is sent through SMS and voice call to the pregnant woman of when, where and whom (with the contact number of the service provider) they will contact for ANC service. To include all pregnant women under ANC service, Bangla SMS is sent to each pregnant woman mentioning the information of service centers, service provider's name and phone number. Pregnant woman receives NC provider's address, time and corporate number three days earlier at her mobile number through SMS and Voice Call. When the pregnant woman's information is included in the Smart MCH Service Management Software, the four times of ANC and EDD are shown in the system automatically.

As soon as the pregnant woman gets her delivery done successfully, the data is then transferred to newborn babies list. The data entry operator gets all information by calling the new-born baby mother and the system updates the entry from pregnant woman database to newborn baby's data. It is important thing to mention that Honorable MP has given her voice for this voice call message from the software. The recorded voice is enclosed with this report Annexure 2.2.

Every month, union lists of pregnant women are printed and sent to each Union Health and Family Welfare Center. Service provider calls each pregnant woman from this list and inform them regarding ANC, during delivery and PNC services. They motivate people to get their baby delivered in institutional arrangement. The UHFWC and MCWC has all the facility for normal delivery if they feel the pregnant woman have complications then they transfer her to Upazila Health Complex.

পর্ভকালীন পরিদর্শনের তথ্য যোগ করুন

পর্ভকালী নাম: দম্পতি নং:

EDD: পরিদর্শনের তারিখ:

ওজন (কেজি): রক্তচাপ:

হিমোগ্লবিন: সুগার:

এম্বেলিন: ইউনিট:

Picture 11: Data Entry Field in Software

The above picture shows the type of the pregnant woman information is included in the software. This information is always updated, as soon as the pregnant woman gets ANC service from the health complex/ nearest UHFWC / satellite clinic. The authorized data entry operator includes the data accordingly.

শিশুর পরিদর্শন তারিখের জন্য এসএমএস পাঠানো সিস্টেম

ইউনিট: ইউনিট:

পরিদর্শন নির্বাচন করুন: এস এম এম প্রকৃতি নির্বাচন করুন:

এস এম এম এর বিবরণ:

*সর্বমোট 160 শব্দ

**দিন দিন পর বে সকল শিশুর পরিদর্শন তারিখ আছে
তথ্যের তহবল দেখা হলে নতুন এসএমএম যাবে।*

Picture 12: Data Entry Field in Software

The above picture shows how the software generates the blood donor information and send to the pregnant woman. The nearest blood donor's information is sent to the pregnant woman through SMS.

গর্ভবতীর ২য় পরিদর্শনের তারিখে নিকটবর্তী রক্তদাতার তথ্য সহ এস এম এস পাঠানোর প্রক্রিয়া

ইউনিয়ন: - নির্বাচন করুন - এসএমএস পাঠান

নিকটবর্তী গর্ভবতীর তথ্য সহ এস এম এস রক্তদাতার মোবাইল এ পাঠানোর প্রক্রিয়া

ইউনিয়ন: - নির্বাচন করুন - এসএমএস পাঠান

Picture 13: Data Entry Field in Software

In the same process, the blood donors receive the SMS from the system generated process about his or her nearest pregnant woman information. The software can categorize the pregnant woman and blood donor according to Union based. The pregnant woman who is in a certain union will get the blood donor information of that union. The same process is maintained for the blood donor. The nearest pregnant woman information will be shared to him or her. The PNC service follows similar process. The SMS is sent to the parents three days earlier from consultation dates.

Most important thing is all the communication on SMS & Voice Call is done in Bengali so that beneficiaries can understand the information properly.

To remind the date of ANC service visit date, a pregnant woman and her husband receive the voice call individually. The system has such coding it can easily detect the pregnant woman from 11 unions and send the notification message to respective woman / husband mobile number instantly.



Pregnant Woman

Mrs. X came to know about Satellite Clinic/ UHFWC from FWA. Iron pill, calcium, vitamin B complex and other medicines are provided from that center. Regular check up is also provided from that place. If she fails to visit on schedule date, Data Entry Operator of MCH Corner calls her to meet the service provider immediately. MCH Corner also communicate with the service provider to contact with the pregnant woman for follow up. Satellite clinic is near to her house and she prefers to visit it for check up and medicine. FWA also visits her home and provide necessary guidelines. The most important thing for a pregnant mother is that she gets every service free of cost. She does not prefer private clinic as they do not provide home service and the service is also costly. She informed during this pandemic situation, UHFWC is maintaining social distance and wearing mask issues strictly. She can call to service provider any time round the clock that is very helpful for her.



Mother with a soon month old baby

Mrs. Yeasmin Akter had normal delivery from UHFWC Kapasia Union. She came to know about UHFWC service quality from her relative. Her husband cross-checked the information and came to know that the center is well equipped with the necessary logistics and equipment. They also came to know about the reputation and skills of the FWV of this center. They did not face any problem there. Currently they are taking PNC service from that UHFWC.

Gorvobotir Goyna (Pregnant Mother's Ornaments)/ গর্ভবতীর গয়না has been titled to Mother and Child Health Care Hand Book. It is a 44-page guideline for children and mother. Every pregnant woman gets this book with a unique ID as soon as she gets enlisted in the software. The process is very simple for the pregnant woman to get this book. FWA/HA/CHCP/FWV and others collect information of a pregnant mother in a prescribed form. FPI of respective union collects and checks those forms. These are then submitted to MCH Corner every Thursday. When the Data Entry Operator receives the forms, they are captured in the software. Then MCH Hand Book is issued for each Pregnant mother with individual MC ID. After getting the ANC dates from the software, data entry operator writes the four visiting dates and other necessary information by hand in the book. Additionally, corporate number for emergency, the nearest FWV names, community clinic name and community health providers are provided.

The union wise health and family planning facilitators' and service centers' numbers are different, so it needs to be written in the book separately. After writing all relevant information, the book becomes ready to be delivered to a pregnant woman. At next visit of FPI in a week, the book is given to the pregnant woman under his/her territory coverage.

When the mother visits the Upazila Health Complex and shows this book, she gets a discount or subsidy for her necessary diagnostic tests. The mother becomes entitled to get this opportunity once in her pregnancy period. The cost for those diagnostic tests is met from 'Humanitarian Assistance Fund'.



Picture 14: Gorvobotir Goyna (Pregnant Mother's Ornaments) or Mother and Child Health Care Hand Book

"I want Maternal Death Free Kapasia Model be sustainable for longer period of time. I do not want this model be closed after my death. I wish everyone should come forward to make this model sustainable" Simeen Hussain Rimi, Honorable MP, Kapasia

When the new-born babies birth date is captured in the software, the four PNC dates are shown in the system. Mothers get the notification message before the visit time in Bengali. The nearest health service provider's name and phone number are given through Mothers can call the service provider and take necessary information as required. This book includes all the emergency phone numbers required for the pregnant woman or child bearing mother.

Perception of community people regarding MCH Services under Upazila Family Planning Office, Kapasia:

- The service providers under UFPO inform the community people regarding the service going door to door.
- FWA/ FWV and other service providers inform the people about number of services on Family Planning, ANC & PNC to the community people.
- Some of the medicines are provided free-of-cost.
- Counselling and medical service provided to adolescents.
- Medical test in UHC is cheaper than private clinics.
- Community people think this model is important for them as it is improving the health issue.
- Doctor fees not required.
- Utmost care and important is given to pregnant women in this upazila.
- During COVID-19, the UHC is maintaining the social distance and mask issue regularly.
- The service quality definitely improved from the earlier time in Kapasia Upazila. High school headmaster informed that the regular follow up is also ensured throughout the network.

Apart from the software support, UHC has commenced some facilities for pregnant women. They are discussed in the following points:

Mother and Child Health Corner: Pregnant woman and newborn children get one stop service from this corner. Medical Officer serves them. Upazila Health Complex is termed as Mother and Child Friendly Hospital.



Picture -15: (Left to Right) from very entrance of the health complex there is arrow mark to guide the pregnant woman to reach mother and children one stop service health corner.

Display board in public places: All unions and wards under the upazila are covered by establishing a display board containing the information of health and family planning services, service providers' name, service center address and all necessary phone numbers etc. The pictures below show the display board:.



Picture -16: Display Board in Public Place



Picture -17: Name Plate of service provider: The name plate is placed at every service provider's home door so that people can know the type of services s/he offers.

Birth Attendant

Emily is working for three to four years as birth attendant. She gets training regularly from the Upazila Health Complex. If she encounters complications with pregnant women, receives support from the monitor from UHFWC. If they cannot give any remedies, the patient is referred to UHC for proper medications. She does not face any



problem doing her duties. The patients who are near to her house can communicate easily. If any patient stays at distance, they communicate through her mobile number. The community accepts her service whole heartedly. She reports to her supervisor right after the delivery is done. During pregnancy, she suggests the pregnant woman husband and family members to take precautions for taking food and to be regular in ANC service. The family members accept the suggestions for the betterment of the pregnant woman. However, she admitted that there are some family members who do not provide better environment for the pregnant woman. In the meantime, it is even true that due to information gap some family members do not know how to keep the pregnant woman safe in the pregnancy period. In her coverage areas, about 70 to 80 percent family members are literate. Most of the family members are not well off. There are some family members who cannot afford to day-to-day livings cost. It becomes hard for them to available the special foods necessary for pregnant woman. She visits to pregnant woman house during morning time as husbands and other family members are available. She informs the family members to ensure the good nutrient food for the pregnant woman.

Blood Donor

Mahmudul Hasn Tushar donated blood three times till October, 2020. He has been inspired by MP to donate blood for good cause. He suggested that social media can be useful to inspire others to donate blood to community. He always posts in social media after donating blood. He hopes more blood donor can be enlisted if the activities are promoted in greater extent. Government assistance will make this program more effective, Tushar informed.



Rider

Md. Zahidur Rahman is volunteering as rider for donor in Kapasia. It takes him 10 to 30 minutes' time to bring the donor from his place (union). He informed that road facility sometimes become barrier to bring the blood donors to UHC. He is also donating blood for the last two years. He has donated blood seven times. He said more motorcycle rider can be included as rider. He has been selected by "Kapasia Blood Donor Service Association" and he is the member of that

association. He owns his motorcycle and this is why he has been included in rider list. He does not take any monetary assistance for motor repair and maintenance. He is voluntarily doing the service for the community.

Pregnant Mother Assembly Organizer

Abul Kaiyum Bhuiyan, a leader of students' association, says that with the full patronage and assistance of Simeen Hussain Rimi MP, Upazila Family Planning Office organize union wise 'pregnant mother assembly'. Local Students association, especially Bangladesh Chhatra League assists to organize this program. Health workers, family planning workers, trained birth attendants, students etc. enlist the pregnant women filling up the form provided by Upazila Family Planning Office. The campaign is organized by publicizing through making, banner, sticker in village level etc. People appreciate their effort. Everyone participates in the campaign spontaneously. He also stated that they arrange drinking water and tiffin for the participating people in campaign. Local leaders and teachers are very supportive to organize this type of campaign, he said.

Safe Pregnancy Wall: Pregnancy planning, duties during pregnancy, danger signs of pregnant and newborn children, emergency ambulance contact information are marked in every union parishad wall so that people can be inspired for safe pregnancy.



Picture -18: Safe Pregnancy Wall

Pregnant Women Assembly: In each union, pregnant woman assembly is organized every three months to aware them about safe pregnancy, free health checkup by doctors, medicine and blood grouping test etc.



Picture -19: The Pregnant mother's assembly

Student association attachment: Student association “Bangladesh Chhatra League” is attached with organizing pregnant woman assembly in every union. There are more than 1100 blood donors in Kapasia Upazila. In every union there are three volunteer riders who are ready to carry blood donors to UHC in emergency situation. All about 33 volunteer riders from 11 unions are ready to carry donors to UHC.

Fund generation for humanity sake: The ‘Humanitarian Assistance Fund’ is being formed to provide subsidy and donation to the poor people. The slogan of this fund generation is “Donate 1 Taka per day in health service, can save life of poor people’. The fund is collected from the Government official’s salary account. The account is opened under the joint signatory of UNO, UHO, UFPO in Sonali Bank Limited, Kapasia Branch. The account number is 0210503000100. There are about 1700 Government officials working in Kapasia Upazila. They are donating Tk. 1 per day or Tk. 30 per month for this model success. In this process, at least Tk. 51000 (USD 650) are generated from these officials each month. This fund is audited accordingly, and no fund can be withdrawn without the joint signature. Most importantly, the account is opened against three positions of the Govt. authorities. If the official even is transferred to other district for professional reason, the next new official will be able to operate the account. This is how the account maintenance has been confirmed by the Govt. officials.

This fund is used in a number of sectors. The SMS and Voice call to pregnant woman and her husband cost is borne from this fund. It is found that per pregnant woman only BDT 5 (USD 0.05) is required to communicate with SMS and Voice Call (4 times each) during her whole pregnancy period. For example, if the MCH Corner needs to send per month 5000 SMS & Voice call to pregnant woman, it is easily bearable cost from the humanity fund.

There are about 16 staff outsourced (lab technician, cleaner, gardener, ticket clerk, data entry operator etc.) for contributing in Health Complex. The salary of these people is allotted from this fund. Local funds are used for employing people in this model activities. Government do not need to allot funds for these people at all.

This fund is also used to subsidy the lab cost for the pregnant women when they come to UHC during their pregnancy period (8th month) in 3rd checkup. All about BDT 540 is subsidized for each mother from this humanitarian fund. This is how the pregnant women are relieved to spend money for their pregnancy.

মানবিক সহায়তা তহবিল গঠন

“স্বাস্থ্য সেবায় প্রতিদিন আপনার ১ টাকা দান
বাঁচাতে পারে অসহায় মানুষের প্রাণ”

আপনার ১ টাকায়:

- পরিচ্ছন্ন স্বাস্থ্য কমপ্লেক্স
- চিকিৎসা সেবার আধুনিকায়ন
- গর্ভবতী/ প্রসূতি মায়েদের জন্য বিনামূল্যে জরুরী এ্যাম্বুলেন্স সেবা
- দরিদ্র গর্ভবতীর প্রয়োজনীয় ঔষধসহ চিকিৎসা ব্যয়



ব্যাংক হিসাব নম্বর

0210503000100

সোনালী ব্যাংক লিমিটেড, কাপাসিয়া শাখা গাজীপুর

ii. Summary of strengths and weaknesses

The strengths of the model are as follows:

- Leadership is the strength of this model. The Honorable MP, UNO, UHO and UFPO have shown support for this model and are inspiring people to work towards the common goal of reducing maternal and infant deaths.
- The donation from the government officials to a Humanitarian Assistance Fund helps to subsidize health services for the poor people of the community.
- The innovative software and its implementation in addressing the service has improved the quality of service delivery and accountability.
- Involvement of maximum stakeholders in the program such as field service providers, student associations, local community, blood donors has proved to be very beneficial to the sustainability of the program.
- The mobile messages and voice call in the local language serve as timely reminders of ANC check-ups, date of delivery and PNC visits.



Picture -20: (Left to Right) Data Entry operator is inputting information of pregnant woman and sending the mother SMS.

- The 44-page booklet given to each pregnant woman contains comprehensive information about maternal and child health and nutrition; safe pregnancy, childcare; family planning methods; as well the names, addresses and mobile numbers of service providers in the vicinity.

The weakness of the model is as follows:

- Although the health providers make every effort to register all the pregnant women in the area, yet some people may remain out of this model. So, it is important to raise mass awareness in the community and include all the pregnant women into the program.
- If mobile phone availability for every pregnant woman or her husband is not ensured, the regular follow up call (through SMS and Voice call) will be impossible.
- Ensuring regular fund is a challenge for this model.

a. Achievements

The model has remarkable achievements by this time. They are as follows:

- Bringing the pregnant mothers under digital service system.
- Simplification of services and ensuring accountability.
- Raising awareness at community level.
- Ensuring maximum ANC and PNC.
- Availability of all necessary information.
- Consuming time, cost and visit of service seekers and service providers.

b. Outcomes:

To measure the outcome, we must therefore consider different timeframes (long and short-term), whether outcomes are direct or indirect (proximal and distal), and the consequences of initiatives. These factors make outcome measurement complex and require that outcomes be measured at

various stages throughout an initiative so that progress can be monitored. In the case of Kapasia Model, we have to assess the outcome on how the initiatives have reduced the maternal death and child death in the upazila. The outcome was not sudden, rather it happened took the direct involvement of local leaders, the presence of hard labor of the officials, and the full functional body of that place. The model could not have been able to become successful, if all the initiatives failed to address the issue.

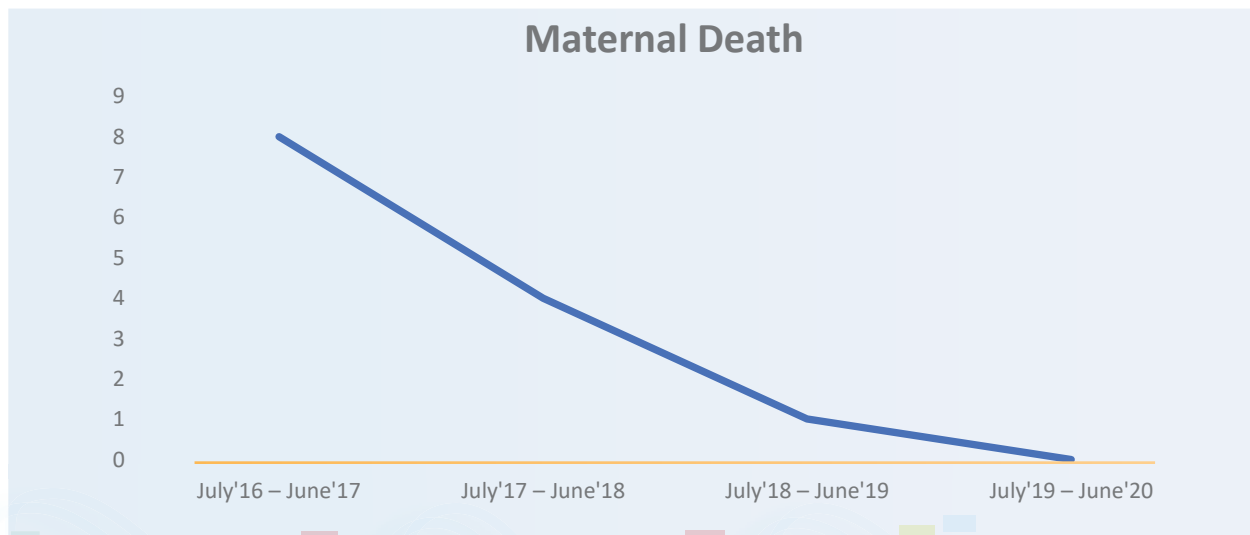
Analyzing the data from Upazila Family Planning Office, the outcomes of this model are as follows:

- a) Almost zero maternal death
- b) Newborn deaths significantly reduced from 12 (2016) to 3 (2020).
- c) Ensuring safe pregnancy and childbirth, raising awareness of pregnant mothers on issues pertaining to nutrition, prenatal and postnatal care, childcare, and family planning methods.

From the data received from Upazila Family Planning Office, the outcome is exemplary. UFPO provided the following data on maternal death, newborn death, infant and child death from July 2016 to June 2020. The has been remarkable progress been achieved over the last four years on the maternal death. Gradually, the maternal death numbers have been reduced, and it is now almost zero in Kapasia.

There were eight (08) maternal deaths in the year July 2016 – June 2017. This number was halved to 4 maternal deaths in the next year, followed by further reduction to only one maternal death in the year July 2018 – June 2019. Finally, there is zero maternal deaths for the year July 2019 – June 2020.

Year	Maternal deaths
July'16 – June'17	8
July'17 – June'18	4
July'18 – June'19	1
July'19 – June'20	0

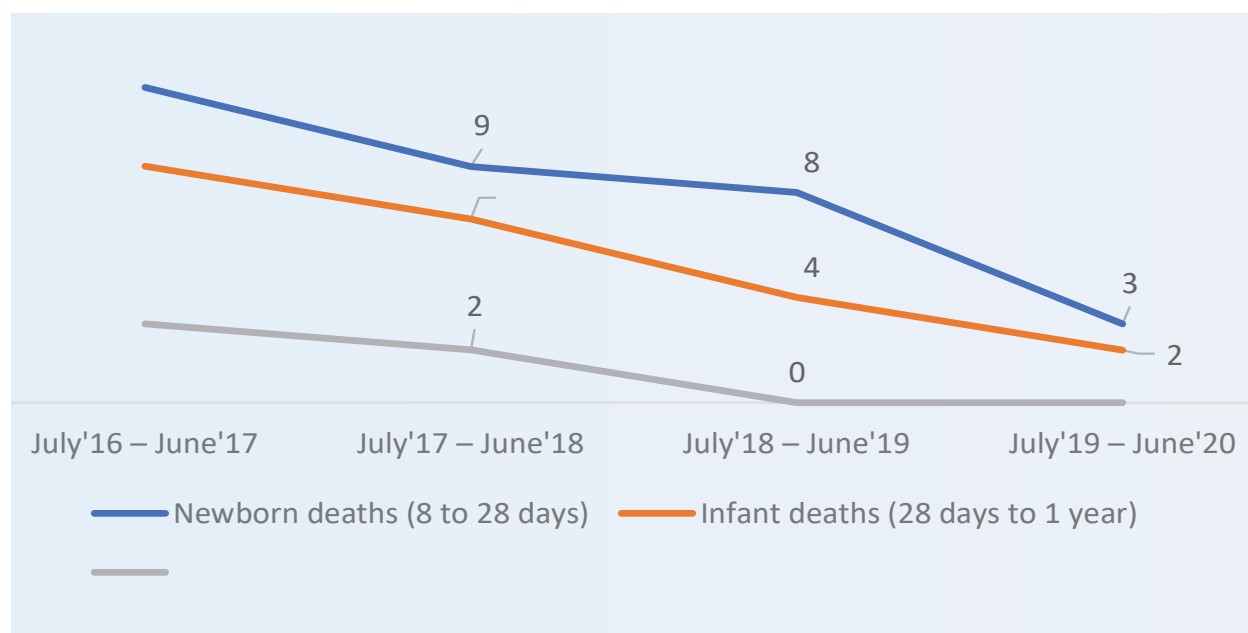


Graph 2: Maternal Death in Kapasia

The graph shows the gradual decline of the maternal deaths in Kapasia. The success comes as a result of the beneficiaries and the service providers working hand on hand.

In the case of newborn, infant and child deaths, there also has been some improvement. The graph and data above show the exact picture of the Kapasia model. Newborn deaths (8 to 28 days) and infant deaths (28 days to 1 year) have drastically reduced from 12 and 9 deaths to 3 and 2 deaths respectively since the Kapasia model was introduced in December 2017 till to date. There have been no child deaths over the last two years.

Year	Newborn deaths (8 to 28 days)	Infant deaths (28 days to 1 year)	Child deaths (1 to 5 years)
July 2016 - June 2017	12	9	3
July 2017 - June 2018	9	7	2
July 2018 - June 2019	8	4	0
July 2019 - June 2020	3	2	0

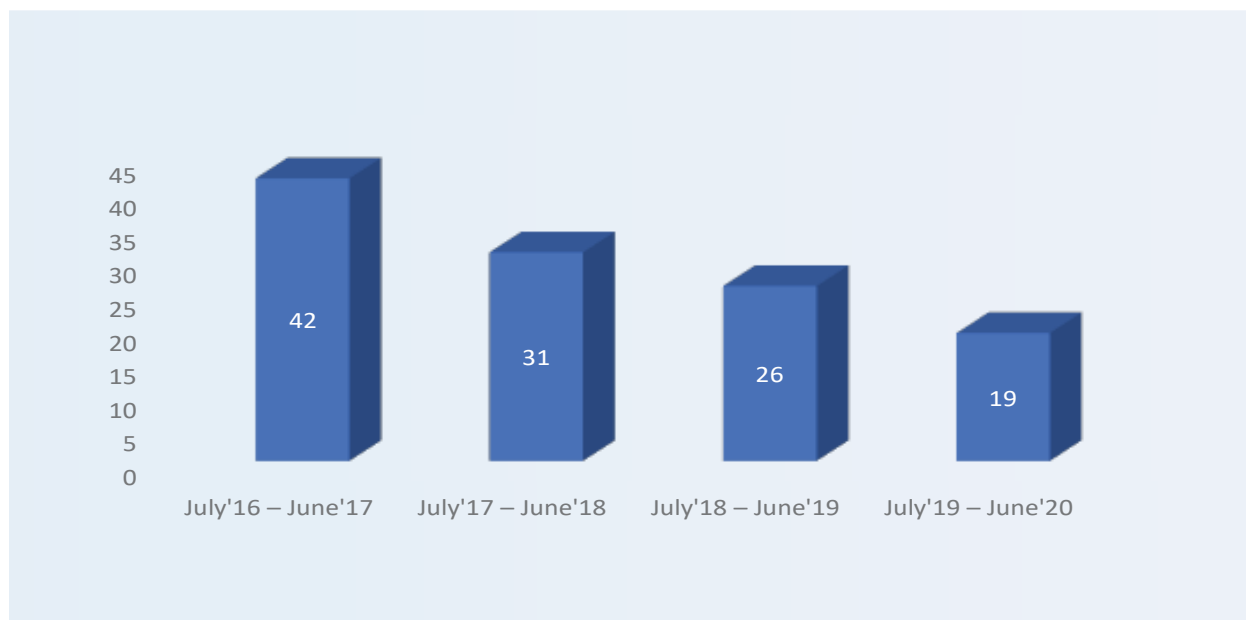


Graph 3: Newborn, child and infant deaths

The situation improved as the parents of the babies are now referred for PNC service. The people are more aware of the healthcare of newborn babies.

Similarly, stillbirths were significantly reduced from 42 in the year July 2016 - June 2017 to 19 deaths in the year July 2019 - June 2020. The data show a gradual decline of in stillbirths in Kapasia.

Duration	Stillbirths
July'16 – June'17	42
July'17 – June'18	31
July'18 – June'19	26
July'19 – June'20	19



Graph 4: Still Births in Kapasia

d. Impact

The Kapasia Model has already proven to be remarkably successful in reducing maternal deaths to zero over the span of two years; along with significant reductions in infant and child mortality. If this model is replicated in other regions of the country, it can contribute substantially to achieving the SDGs.

8. Planning and Design: Experience

a) Process of planning

As mentioned earlier, the process of model formation started from 2016. The synergy and the cooperation between Honorable MP and UFPO directed the way to form this model. Honorable MP Simeen Hussain Rimi informed us that she was very anxious about the health facilities and adverse situation in her constituency. She was looking forward to working with local UFPO and to make available the effective and efficient medical facilities in Kapasia.

On other side, Mohammad Abdur Rahim had similar vision to implement in Kapasia. He took initiative to have base line survey first in all unions of Kapasia. Through this survey he found out the gaps remaining with the medical facilities and community engagement.



Picture -21: Discussion with Honorable MP Simeen Hussain Rimi

Rahim took this survey report and discussed with Honorable MP to eradicate the problem in Kapasia. The most important thing they identified was that the information gap is creating the vast gap between beneficiary and service provider. Regarding safe maternity, people do not know when and what should be done. They do not know the functions and services provided from the government health service centers. They even do not keep medical records, emergency phone numbers etc.



Picture -22: Discussion with Mohammad Abdur Rahim, UFPO

UFPO, with assistance from Honorable MP developed the model in such a way that community engagement occurs in greater extent. They are using the tools which are readily available to the poor or vulnerable people. Government Administration with the support of the Local leadership helped the model to work effectively. Both the parties are helping each other to provide services to the beneficiary groups. Without local leadership and motivation of people engagement, the initiative could not reach at higher level.

b) Representativeness:

The administration of the initiative is carried out by the following officials in Kapasia.

- MP
- UNO
- Upazila Health Officials
- Upazila Family Planning Officials
- NGOs
- Local student associations
- Political leaders
- Teachers and Religious leaders

The integrated effort from all authorities are working behind the success of the model. The theme of the model is well accepted by the authorities.

c) Community engagement

- Local political leaders
- Elected Member and Chairman of Union Council
- Students
- Volunteers
- Scouts

d) Local institution building (including through informal networks)

The model is working with the assistance of informal network.

- Local leaders
- Volunteers (Blood donors, riders and others etc.)

e) Sustainability plans (including through links to other projects)

The 4th Health, Population and Nutrition Sector Program 2017–2022 has set the target of reaching an MMR of 105 per 100,000 live births in 2022. At present, the rate of total maternal deaths in Bangladesh is 169 per 100,000 live births. As a signatory of the Sustainable Development Goals (SDGs), the country will have to reduce the number to less than 70 per 100,000 live births by 2030. (Tawsia, 2020).

The Kapasia model is working remarkably in the region to reduce the rate of maternal death. The drastic activities are required to achieve this goal. In this regard, the sustainability of this project can be ensured if the project funding and the level of eagerness remain high. This model received a lump sum amount BDT 6,51,000 (USD 7683) [assuming 1 USD equal BDT 84.73] for 'Innovation and Service Simplification' under 4th Health, Population and Nutrition Sector Program from Ministry of Health and Family Welfare one time (supporting document is attached in Annexure 1.4). This amount they used for the purpose of the model sustainability i.e. upgrading of software, purchasing bulk SMS and voice call etc. They have used this amount for raising awareness in an innovative way. Safe Maternity Wall has been installed in each Union Council. This type of Government fund is highly required to keep this model active.

The project funding is dependent on the 'Humanitarian Assistance Fund' generated from the government official's salary account. If this account remains active and the passionate people work on the project, there is possibility of sustainability of the project progress.

And last not the least, the overall motivation came from Honorable MP of Kapasia. Her contribution to engage community with full responsibility cannot be ignored. Leadership like hers will be required for the sustainability of the project. People are working voluntarily for the benefit of the community. This model has become ideal as the full engagements of all stakeholders are working in same scale.

f) Description of evaluation activities taken to date

There is no evaluation formula Upazila family Planning Office practice now. But the report which comes from the field level is monitored and evaluated. Through the weekly meeting, if any gap is found, the officials are asked to address the issue properly. If any pregnant woman does not come for the schedule visit, the respective FPI, FWA or FWV contacts with her to ensure the visit.

At the same time, the data entry operator who is taking feedback every day from the pregnant women, (who were schedule to have consultation dates earlier) also play vital part. If any woman is found not consulted in the satellite clinic/ UHFWC, her number is reported to the nearest center/ service provider immediately.

The field level officers are working every day and interacting with the pregnant woman. The status of the working process is also updated from the Upazila Family Planning Office. As the data entry operator calling for data upgradation to pregnant woman, the overall situation can easily be observed. There is little scope for the field level officers not to contact with the pregnant woman within due time. The process is designed such a way that it can be evaluated regularly.

g) How this model suitable to address any emerging issues like COVID19 in order to maintain effective health care services?

This model is working properly integrating information of pregnant women and newborn children in MCH Software. Whenever the beneficiary groups are scheduled to receive ANC and PNC, the software sends them message 3 days earlier. The pregnant women and husbands get the SMS and VOICE CALL in their mobile phone. The service is using the local language so that the beneficiary

gets to understand easily and properly. So, there is no hassle to queue in hospital or satellite clinic to get the ANC and PNC service on consultation dates. As beneficiaries get the information well ahead through digital means, people can well prepare and visit the nearest doctor/ service provider.

If pregnant women fail to go to hospital/UHFWC for delivery, the skilled birth attendant goes to their home for assistance. For any emergency issues, the pregnant woman is referred to nearest hospital for safe delivery.

The model is focusing on eradicating the communication barrier between Service provider and service seeker (especially pregnant woman). It is true that the family members of pregnant mother sometimes need to consult the doctor. But they are scared to visit the hospital due to financial shortage. Through this model, people are becoming aware to have the necessary medical assistance almost free of cost. They are always under guidance of SMCH software to get their consultation dates. There is no scope for them to forget the dates of visit. In any case, if they fail to visit, they can easily consult with the doctors through their corporate numbers round the clock 24/7. This model is a combination of digital software and human resources. Software is creating awareness of the consultation dates and human resources are making those dates effective with effective solution. Through this software mechanism, people are getting the information well ahead. No field worker needs to go to their homes reminding them of dates. The SMS and voice call service is saving time and creating touchless communication. And if the pregnant woman visits the hospital or health complex, the sound hygienic steps are taken from the hospital end.

This is reason why, in the pandemic situation, the service delivery for the pregnant woman did not get hampered at all.

h) Is there any remarkable progress that have been made during pandemic time of COVID19?

Due to COVID-19 pandemic situation, pregnant women and family members are unable to move further from their home. Many family members are getting the birth attendant service at their homes. During the COVID-19, the rate of maternal death raised as most of the deliveries were done at home around the country. Upazila Family Planning Department of Kapasia addressed this problem and took rapid action to solve it.

Under the direction of Simeen Hussain Rimi, MP of Kapasia, 198 birth attendants of Kapasia Upazila were trained so that they can provide services to pregnant women. Family Planning Department of Upazila organized six-day long training program for the birth attendants. Upazila Health Officials and Gynecologist of UHC conducted the training program. Birth attendants were given “Penguin Sucker” along with other instruments to ensure safe delivery.

Additionally, two more pages (page 41 & 42. attached in Annexure 1.9) have been added to the MCH Hand Book with a view to make the pregnant mothers and her husband aware of the Covid-19 situation. These two pages include all information about how to keep the pregnant woman safe. The hand washing process is also shown in the instruction pages. The pregnant woman can easily use this material and practice at home for saving themselves in this pandemic situation.

9. Partnerships

a) Overview of implementing institutions

Upazila Family Planning Department, Kapasia is working under collaboration and cooperation mode with relevant Ministry and all authorities for the implementation of the model. The Upazila Family Planning Office, Kapasia is responsible to implement this model.

b) Role of government

The Ministry of Health and Family Welfare and other departments support this model to act properly. The Health Education and Family Welfare Division has already taken an initiative to replicate this model in 100 Upazila of Bangladesh.

c) Civil society partnerships

Local political leaders and influential personalities are the prime factor for collaborating with this model.

d) Role of multilateral agencies

The model engages the collaboration and cooperation from all the agencies working in Kapasia. The law and order agencies, and relevant stakeholders are cooperating for the success for this model.

10. Monitoring and Evaluation

The focus of this model is to ensure information availability to pregnant woman so that they can get the proper service from their point. This model reduces the gap between the beneficiary and service provider and make available the service at their door step.

The model is not working alone. The officers and the institutions are working as supportive component to make this model fruitful. The book also provides pregnant mothers all the necessary phone numbers from grassroots levels to higher officials like MP, Upazila Chairman, UNO, UHO, UFPO, OC etc. If any doctor or service provider fails or shows reluctance to provide service, the pregnant woman has the scope to report to higher officials. They will be able to get their rights established. Due to that reason, accountability is ensured.

Of critical importance is that the higher officials along with MP motivated the service providers and all stakeholders such a way that they work not for money but for the sake of humanity. This gesture has been observed in different times talking with them. They are highly motivated to provide the higher service to the beneficiary groups.

However, the MIS unit under Directorate General of Family Planning, Directorate General of Health Services and District level monitoring is also practiced for this model.

11. Successes and Lessons Learned

The maternal and child death rates have significantly reduced over the time and it is now almost zero in Kapasia. The success came due to make available the services to the community people and to make the officials accountable for their services.

The lesson from this model so far can be assumed that if the information becomes available to right person at the right time the remarkable progress can be achieved.

12. Future Plans: extensions that are currently being implemented.

The software includes all information about the pregnant woman. The family members' information is also included. The financial status of the pregnant woman can easily be detected through the software information. The innovation of this model is that the same software can be used for the

13. Replicability and Scalability to promote South-South Cooperation

a) Pre-requisites for replication in other developing countries:

Bangladesh has widespread field activities to address the health issues. In other developing countries if they want to replicate this model, they should have the field level force to introduce the model. The social engagement or community participation needs to be ensured for the purpose of the pregnant women. If government and local leaders both can work hand to hand, the model can be replicated easily.

The 'Maternal Death Free Kapasia Model' is supported by the Government fund and logistic support. Though there are subsidy arranged by the humanitarian fund, the logistics support and others are coming from the Government. It was easy to create influence in community as the officials are Government appointed. People have tremendous reliability on the government officials. This is the positivity the model enjoyed at the implementation stage in Kapasia. The replication can be done easily if the officials are equally trusted in other countries. If the awareness can be created in the community level about the model, the higher result will come automatically.

b) Experiences in replicating in other countries through South-South Cooperation:

This model is not practiced yet in other countries through South-South Cooperation.

c) Suggested steps for replication in other countries:

The Kapasia 'Maternal Death Free Model' is currently practiced in the specific location. The holistic use around the country has not yet been practiced. The result is not known on how the model would perform if implemented around the country. If the model can be implemented in the certain area or district or zone level of developing country at first, that would be beneficial. The advantage and disadvantage of the model will be identified from that region and taking the result into consideration the model can be implemented in greater context.

Still the model can be replicated if the following steps can be followed in other countries:

- Identify the problem (maternal or child death in the country / specific area)
- Decision on how to address the issue from administrative side (hospital and local government can work together)
- Engage the effective local leaders.
- Engage the community
- Ensure quality service
- Introduce the Model (Software and human assistance integration)
- Promote the benefits of hospital
- Prepare sustainability plan
- Generate funds for the subsidy and other operations

- Continuous fund collection
 - Build root level hospital or Community Clinic/ Satellite Clinic
 - Available the resources pregnant woman can get at doorstep (Trained birth attendants)
 - Ensure data transparency
 - Create accountability towards officials
 - Get the benefit of the model.
- d) Potential partnerships (what would be provided, willingly, upon request) The partnership can be extended learning the scenario of the county who become interest to adopt the '*Maternal Death Free Kapasia Model*'.

14. Contacts

a) Details of implementing institutions

i. Head, Address, E-mail, website:

Mohammad Abdur Rahim, UFPO,
Email: ufpokapasias@gmail.com

ii. Project team and individuals in leading roles:

Mohammad Abdur Rahim is leading the team for implementing the model activities.

b) Practice documentation team

Usually, the best practice documentation has no specific team at this moment. But as Head of the supervising activities, Mohammad Abdur Rahim preserving the notes and report through the assistance of his colleagues / sub-ordinates of his office in Kapasia.

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CONTRIBUTORS

Mohammad Abdur Rahim

Upazila Family Planning Officer
DGFP, Kapasia, Gazipu

Nitish Chandra Sarkar

Additional Secretary, Population, Family Welfare and Law
Medical Education and Family Welfare (MEFW) Division
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh
Bangladesh Secretariat

Dr. Mohammed Sharif

Director, (MCH- Services) & Line
Director- MCRAH, Directorate General of Family Planning, Dhaka.

S. M. Ahsanul Aziz

Deputy Secretary (Population 1)
Medical Education and Family Welfare (ME&FW) Division
Ministry of Health and Family Welfare (MoHFW)
Government of the People's Republic of Bangladesh
Bangladesh Secretariat

Mohammad Shariar Nafees

Program Development and Implementation Specialist
Bangladesh Training and Research Foundation (BTRF), Dhaka

CHAPTER 3

MATERNAL CARE SERVICE RESPONSE DURING THE COVID-19 EPIDEMIC IN CHINA, 2020

Dr. Song Li, Dr. Wang Ai-Ling, Dr. Qiao Ya-Ping and Dr. Jin Xi

Overview

An outbreak of 2019 novel coronavirus diseases (COVID-19) in Wuhan, Hubei Province, China has spread quickly nationwide. By the end of July 9, 2020, there are 85,399 report cases COVID-19 in China. As a result of the epidemic, many human activities have been affected. However, women's pregnancies and deliveries will not be interrupted by the epidemic. How to maintain maternal health in the COVID-19 epidemic is a crucial challenge for the health systems. China's health service system is constantly exploring and summarizing some experiences to cope with the dual pressure of the epidemic and maternal health.

The first is to focus on pregnant women and children's unique characteristics at the beginning of the epidemic and clarify stakeholders' responsibilities through a government notification. Moreover, according to the situation, adjust the service way, guide the pregnant and lying-in women to change the cycle and way of medical treatment. In its implementation, the Government pays attention to supervision and evaluation.

So far, the results from studies and routine surveillance have shown that no maternal infections are higher than in the same age group, and no maternal deaths are higher than in the same period last year.

Implementing Institutions/development actors

The initiator of this program is the National Health Committee of the People's Republic of China.

The implementing institutions are Health Committees and related Health facilities in the whole country. The Health Committees include committees at the provincial, prefectural, and county levels in the country. Related Health facilities are defined by health facilities that provide antenatal and delivery care services at national, provincial, county, and township levels in the country.

Objective

Effectively protect pregnant women and newborns during the COVID-19 epidemic to ensure mothers and their newborn infants' safety.

Practice

1. Clarified the requirement of maternal care services provision during the COVID-19 epidemic.

On February 8, the National health committee (NHC) had issued a "Notice on strengthening the treatment of maternal diseases and safe delivery during the prevention and control of the new

coronavirus pneumonia epidemic”¹ and clarified the requirements for maternal health work. Health committees at the provincial level, prefectural level, and county levels in the county have to be responsible for developing a work plan to guide implementation at the local level, coordinating medical resources, and monitoring the implementation.

2. Capacity building to ensure maternal care services in the context of the COVID-19 epidemic.

National Center for Women and Children’s health, China CDC has developed technical guidelines, training materials, and online training courses to help remote professional learning promptly. The relevant associations and academic societies had conducted online training toward health providers to update related knowledge and information on how to respond to COVID-19. Each hospital also organized its staff to conduct various training in different ways.

Besides, universities and research institutions have conducted various studies to understand the virus and the disease better. These results were also being updated in the guidelines and would be passed on to clinical service guidance.

3. Consistently provided maternal care services to guarantee the health of pregnant women and their newborn babies.

According to the Notice issued by NHC and work plans issued by local health committees, health facilities providing maternal care services at national, provincial, county, and township levels have provided qualified maternal care services to pregnant women from Feb 2020 to currently. There are four parts of the services to emphasize: 1) Actively instruct pregnant women protection and accept antenatal care; 2) Strictly manage pregnant women with fever; 3) Effectively guarantee antenatal care and safe delivery services for suspected and confirmed pregnant women; 4) Strengthen the management of pregnant and lying-in women with suspected infection and the treatment of newborns.

Results

The management of maternal care services has been established from the township level to the national level. Health facilities and health care staff have been guided and supervised to provide maternal care for pregnant women and their newborn babies. Pregnant women and their newborn babies have access to antenatal care, safe hospital delivery, postpartum care as the same as that before the epidemic outbreak. Pregnant women with fever, suspected or confirmed infection have been managed and treated.

So far, from the result of the China Maternal Mortality Rate Report System, no maternal deaths are higher than in the same period last year. However, a more systematic and scientific evaluation of how COVID-19 influences the safe of maternal health needs further data and research.

Monitoring and Evaluation

Health administration departments of the national Government and local governments in China have monitored the work.

There are two ways to evaluate. One is to monitor and assess surveillance data to examine the change of situation. The data about birth, death, and central processes indicate maternal health can be found in the surveillance report system. Another way is to learn about the implementation through field visits. Nation Health Commission sent several expert teams to the provinces to supervise and evaluate the implementation.

Successes and Lessons Learned

- 1) The government of China prioritizes maternal and child health and the lives of the population.
- 2) Set up designated hospitals for pregnant women and ensured service provided during the epidemic.
- 3) Well-planned treatment and management plans for suspected and confirmed pregnant women and their newborns.
- 4) Various measures to provide health education, counseling, supports and direct antenatal care services.

Future Plans

- 1) A scientific summary of the advantages and disadvantages of current activities is needed, includes an in-depth analysis of available data and associated impacts.
- 2) According to scientific analysis results, adjust the existing measures scientifically, and formulate the response plan.
- 3) Conduct scientific stockpiling of material and personnel capabilities in case of a possible disaster. Moreover, rehearse on the routine obstetrics department training. The rehearse may be organized by one hospital or by the local health administration section.
- 4) A large-scale health education campaign was conducted to raise the awareness among general population on how to protect pregnant women and how pregnant women to protect themselves and their children when disaster strikes.

Replicability and Scalability to promote South-South Cooperation

- e) Pre-requisites for replication in other developing countries
 - A system for fast communication of policies and a comprehensive network of maternal and child health services.
 - A well-run community organization.
- f) Experiences in replicating in other countries through South-South Cooperation
 - According to the epidemic and the advice of experts, the response measures were to be formulated quickly.
 - The activities can be implemented very quickly.
 - According to the situation's progress and changes in the epidemic situation, the measures could be adjusted.
- g) Suggested steps for replication in other countries
 - The establishment of designated hospitals can make infected pregnant women get effective treatment and are effectively reduce other pregnant women's infections.

- Develop appropriate strategies based on the country's health system and resources.
- Mothers and children should be protected first by society and government, no matter what disaster strikes.

h) Potential partnerships (what would be provided, willingly, upon request)

1. Background and Justification

In December 2019, Wuhan, Hubei province, China, became the center of an outbreak of pneumonia of unknown cause, which raised intense attention within China and internationally. Cases of COVID-19 are no longer limited to Wuhan, Hubei province. As of January 23, 2020, confirmed cases were consecutively reported in 32 provinces, municipalities, and special administrative regions in China, including Hong Kong, Macau, and Taiwan.

As a result of the epidemic, many human activities have been affected. However, women's pregnancies and deliveries will continue and will not stop because of the epidemic. How to do maternal health in the COVID-19 epidemic is a crucial challenge for the health systems.

There is little knowledge about the risks of COVID-19 infection during pregnancy—no evidence of vertical transmission of COVID-19 from mother to infant during pregnancy and breastfeeding. However, changes in hormonal levels and immune system function generated by pregnancy may increase women's vulnerability to infections. Pregnant women show higher mortality rates and complications associated with viral infections compared to the general population. Moreover, health facilities and medical resources have been reallocated to respond to COVID-19 control and treatment.

Hence, Efforts need to guarantee pregnant women access to consistent maternal care as the same as before the COVID-19 outbreak and specific health care services for pregnant women suspected or confirmed COVID-19 infection.

2. Goals and Principles

2.1 Goals

Provide maternal care and COVID-19 protection services to pregnant women and their newborn infants to ensure mothers and children's safety.

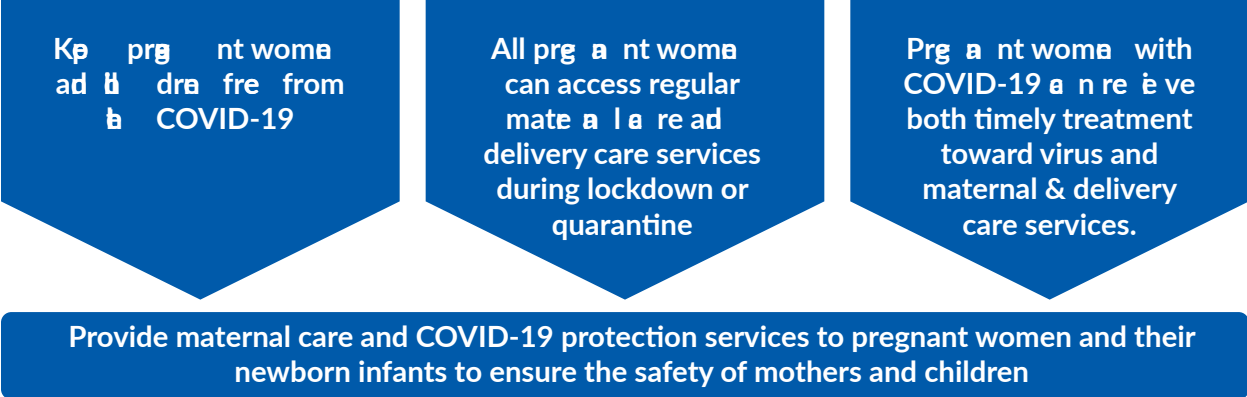
2.2 Principles:

2.2.1 Keep pregnant women and children free from the COVID-19.

2.2.2 All pregnant women can access to regular maternal care and delivery care services during lockdown or quarantine.

2.2.3 Pregnant women infected with COVID-19 can receive both timely treatments toward virus and maternal & delivery care services.

Figure 1. the goal and principles of maternal health response COVID-19 in China



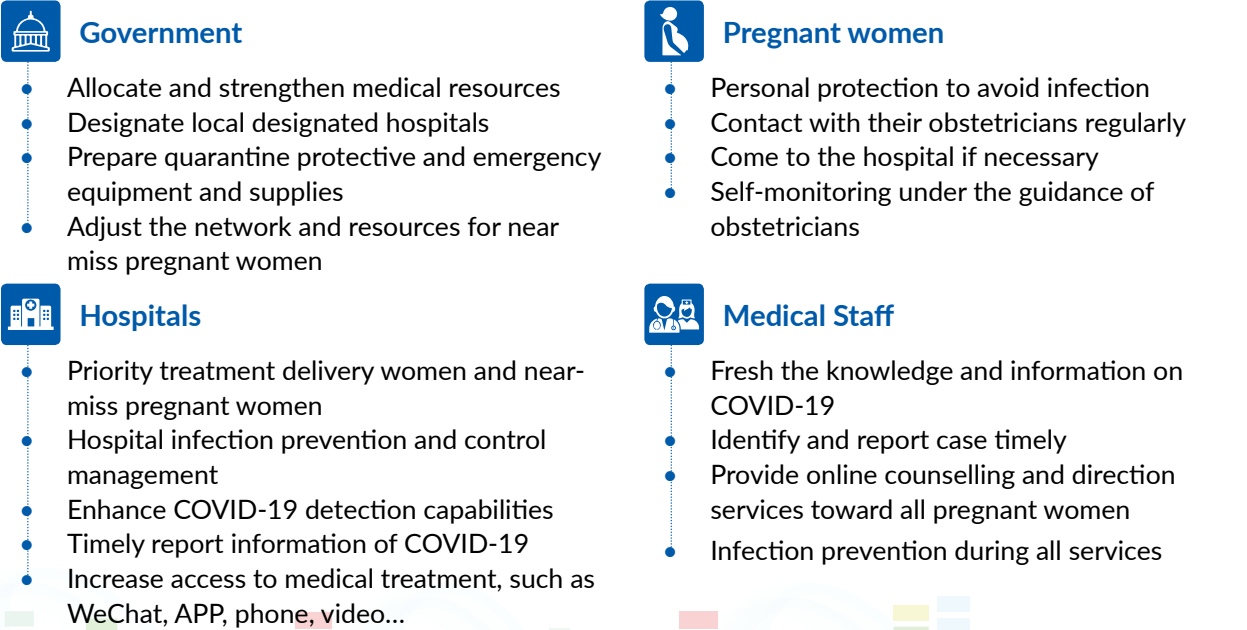
3. Descriptions

3.1 Requirement and work plans issued by health authorities

National Health Committee (NHC) has issued “Notice on strengthening the treatment of maternal diseases and safe delivery during the prevention and control of the new coronavirus pneumonia epidemic” and clarified the maternal health work requirements. Health committees at the provincial level, prefectural level, and county levels in the county have to be responsible for developing work plans to guide implementation at the local level, coordinating medical resources, and monitoring the implementation.

The responsibilities of different perspectives were identified by this Notice. The main details can be found in Figure 2.

Figure 2. The responsibilities of different perspective among COVID-19



There were 1,774 hospitals that pointed as designated hospitals overall the county. The list of the designated hospitals was posted online, making it accessible to everyone on the Internet. Local Government also designated and opened their own designated hospitals to the public.

3.2 Classify health institutions and adjust procedures

In China, under normal situation, most hospitals can provide pregnancy care and delivery services. During the COVID-19 period, hospitals were divided into general hospitals and designated hospitals.

Medical institutions at all levels strengthened their hospital infection control management, guide health workers to follow standard prevention principles strictly, and ensure sound implementation of the principles such as personal protection, hand hygiene, environmental disinfection, and waste management based on the risks of transmission through medical operations, to strictly prevent infection among the health workers.

3.2.1 General hospitals that provide antenatal and delivery care toward uninfected pregnant women

For general hospitals, their responsibilities are providing antenatal and delivery care toward uninfected pregnant women,

Hospitals transform the obstetric wards in response to of COVID-19 epidemic. For general obstetric wards, beds are at least one meter apart and separated by screens or curtains. Stop using central air conditioning and keep the rooms well ventilated and at a suitable temperature.

To detect infected people in time and avoid nosocomial infections, at the beginning of the COVID-19 outbreak, all medical institutions added COVID-19 related consultation and examination services following the policy requirements.

All registrations should be made through prior booking appointment to reduce the waiting time for pregnant women. If feasible, the hospital should set up special consultation rooms for pregnant women. Pregnant women must wear masks properly when visiting medical institutions. Before entering the consultation room, the pregnant women must have their body temperature checked; if the pregnant woman's body temperature is higher than 37.3?, she must be sent to a fever clinic. With a few exceptions having particular circumstances, only one pregnant woman can enter the consultation area.

In non-emergency treatment, pregnant women who need to be admitted to the hospital should complete the routine blood test and lung CT screening at the outpatient clinic if they are suspected with a COVID-19 infection.

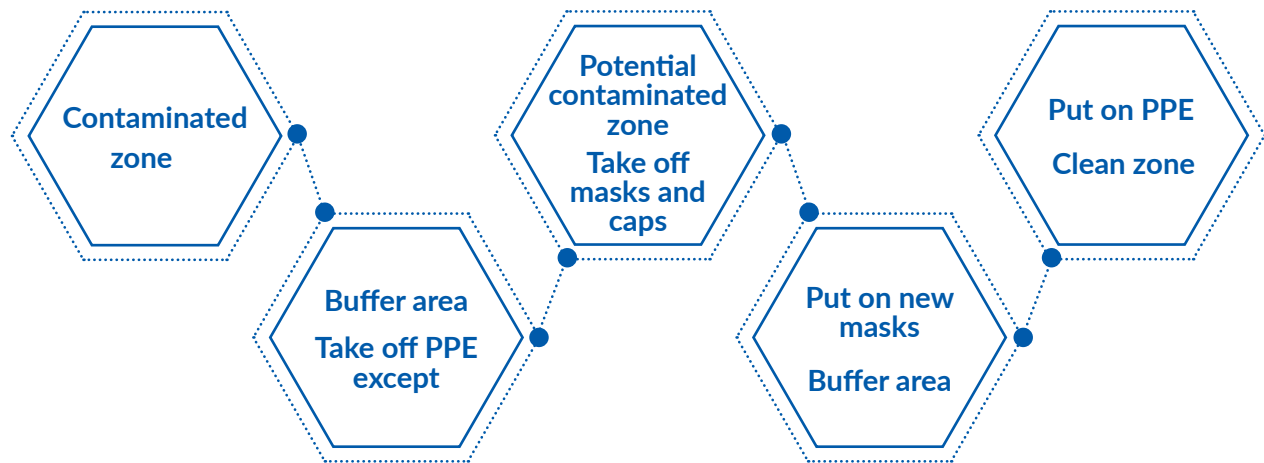
3.2.2 Designated hospitals that provide antenatal and delivery care

For designated hospitals, their responsibility is providing antenatal and delivery care toward infected pregnant women.

Isolation obstetric wards should be constructed with a clear division of various areas, including “two channels, three zones, and two buffer areas.” Two different access channels will be used for the access to health workers and patients. The three zones are clean areas, semi-contaminated areas, and contaminated areas. For the two buffer areas, the first is between the clean area and the semi-contaminated area, and the second buffer between the semi-contaminated area and the contaminated area.

The ward, delivery room, and operating room should be located in the negative- pressure isolation area. The clean area, semi-contaminated area, and contaminated area should be set up in the ward, corresponding to different levels of personal protection for health workers. When the patients are transferred, a specific transfer channel should be set up and equipped with sound disinfection and protection protocol.

Figure 3. Schematic diagram of the isolation obstetric ward setup



3.3 Training for health staff

3.3.1 Medical institutions at all levels strengthen their hospital infection control management, guide health workers to follow standard prevention principles strictly, and ensure sound implementation of the principles such as personal protection, hand hygiene, environmental disinfection, and waste management based on the risks of transmission through medical operations, to strictly prevent infection among the health workers.

3.3.2 The isolation and separate accessing between the COVID-19 infected patients and other non-infected patients should be strengthened, the management of key wards for the gynecology, obstetrics, and pediatrics departments be strengthened, family visits be minimized, and visits by companions in the neonatal ward were suspended, to effectively reduce the risk of infection among the hospitalized patients.

3.3.3 Medical institutions at all levels should carry out training for all health workers on the identification, reporting, and medical treatment of COVID-19 cases, hospital infection control, close contact management, and personal protection, to enhance their containment, diagnosis, and treatment capacity. Health workers from crucial posts such as the outpatient

clinic, emergency room, and the laboratory should be evaluated for the impacts of training to ensure they have acquired the knowledge and skills.

3.4 Maternal care services during the COVID-19 epidemic

3.4.1 The rate of ANC is above 99% in China. Almost all pregnant women visit the hospital for antenatal care when they know their pregnancy status.

To respond to the universal two-child policy, the National Health Commission issued and implemented a package of nationwide strategies in 2016. The package of strategies includes 1) pregnancy risk screening and assessment strategy, 2) case-by-case management strategy for high-risk pregnancies, (3) referral and treatment strategy for pregnant women and newborns with serious illness, (4) reporting strategy for maternal deaths, and (5) accountability strategy. Among the five strategies, screening for and assessing high-risk pregnancies is the basis for high-quality perinatal healthcare. All the pregnant women are screened and assessed by obstetrician using uniform standards and procedures, all of whom have undergone unified training. After risk assessment and classification, medical records of women are labeled with green (low risk), yellow (moderate risk), orange (high risk), red (highest risk), or purple (infectious disease) for tailored management. Pregnant women with different risk levels are transferred to designated medical institutions at different levels for further perinatal care and delivery. Case-by-case management is implemented on pregnancies at a higher risk level (labeled with orange, red, and purple). This was the main mode of management for pregnant women in China before the COVID-19 epidemic.



3.4.2 During the epidemic of COVID-19, the number of prenatal visits and contents decreased compared with previous times.

When it is time for pregnant women to go to the hospital for antenatal care, most of them contacted their doctors via phone (including Hotline, hospital calls), WeChat, or Internet first. After the remote consultation, they go to the hospital to see their obstetricians in person when necessary.

Hospitals have strengthened the prevention and control of hospital infections and provided pregnant women with health education and psychological counseling services on maternal care and COVID-19 prevention through video online, telephone, WeChat, and so on and instructed pregnant women to arrange the time for antenatal care and go to medical institutions for delivery in time.

The principles below should be followed for maternal safety management during the epidemic period. Pregnant women should seek medical attention as needed. That is, pregnant women need to see a doctor in time if there are emergencies such as vaginal fluid or bleeding.

Pregnant women should follow the doctor's advice and visit the hospital based on the time slot booked through prior appointment to shorten the waiting time in the hospital for lower risks of infection. Especially for patients with pregnancy comorbidities and pregnancy complications, they should receive diagnosis and treatment according to the doctor's advice.

Efforts should be made to ensure medical observation, tracking and follow-ups, and rehabilitation during the recovery period for asymptomatic pregnant women. Once clinical manifestations appear during the period, their status should be corrected as confirmed cases, and treatment should be provided in time.

They should have thorough personal protection during hospital visits. In order to prevent cross-infection, pregnant women and their companions need to pay close attention to personal hygiene and protection throughout the way to the hospital and during the hospital visit, including wearing masks, washing hands, minimizing touching surfaces, avoiding crowds, reducing the time spent in the hospital, and so on.

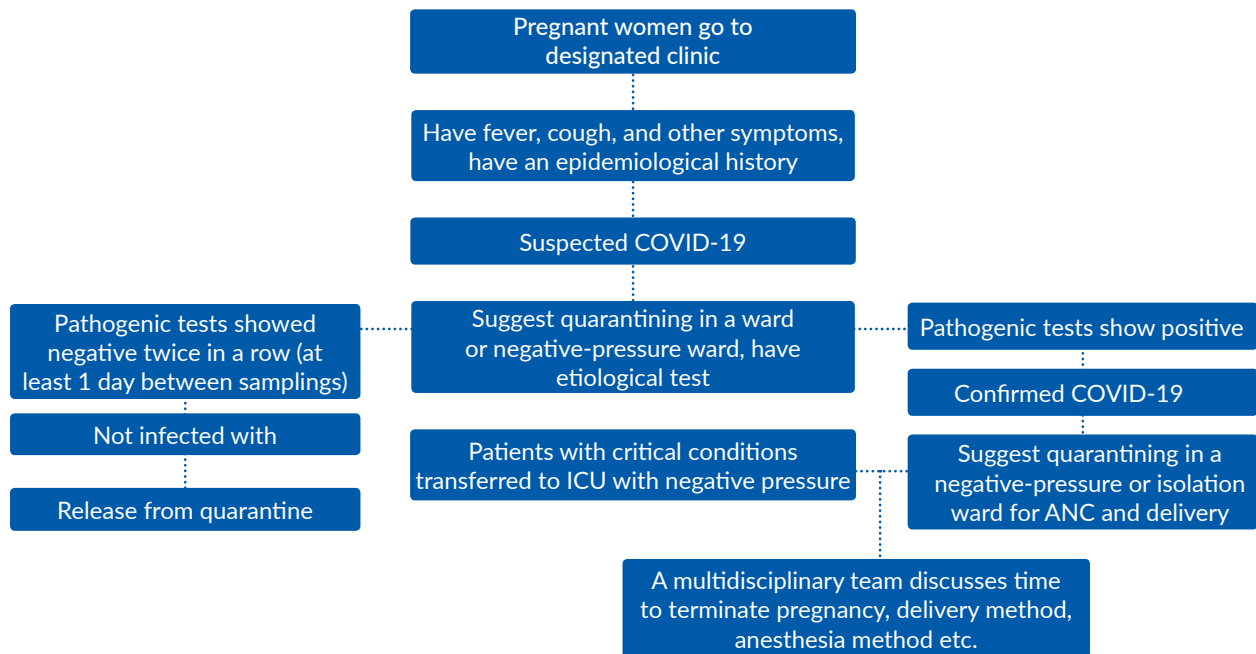
Manage pregnant women with fever. Fever clinics have been set up in qualified midwifery institutions at the local level. The midwifery institutions have established a pre-check and triage system. Pregnant women with fever are identified in fever clinics. For suspected or confirmed pregnant women, they are referred to designated hospitals as soon as possible, accompanied by medical staff following regulations. Midwifery agencies have continued to carry out project management for high-risk pregnant women and provide timely treatment and referrals based on high-risk pregnant women's conditions.

3.4.3 Guarantee antenatal care and safe delivery services for suspected and confirmed pregnant women. Based on the number of pregnant women and the technical service resources of midwifery, a batch of midwifery institutions with strong comprehensive treatment capabilities has been designated as designated hospitals for pregnant women to prioritize the admission and treatment of suspected and confirmed pregnant women. Designated hospitals for

pregnant and lying-in women provide maternity examinations and safe delivery services and treatment services for critically ill pregnant and lying-in women. The list of designated hospitals for pregnant and lying-in women was announced to the public to facilitate pregnant women’s treatment. Figure 4. shows the details for how to diagnose and treatment procedure for pregnant women with confirmed COVID-19.



Figure 4. Diagnosis and treatment procedure for pregnant women with confirmed COVID-19



3.4.4 Strengthen the management of pregnant and lying-in women with suspected infection and the treatment of newborns. Strengthen cooperation in obstetrics and pediatrics when providing delivery services for pregnant women with suspected or confirmed infections. Newborns who are suspected or confirmed to be infected by pregnant women should be classified and managed after assessing the neonatology department. For those with severe clinical manifestations, they should be transferred to designated hospitals with strong neonatal treatment capabilities in time.

5. Discharged and Postnatal care for women with COVID-19

Pregnant women discharged from the hospital after recovering from COVID-19 are advised to continue monitoring their health status for 14 days. After returning home, pregnant women should avoid close contact with their families and live in a single room with adequate ventilation if possible. They are encouraged to wear masks, practice hand hygiene, avoid outdoor activities, and have individually served meals. Those who have not delivered should also count fetal movements, monitor the fetuses closely, and seek immediate medical attention in case of symptoms such as fever, cough, decreased fetal movement, vaginal bleeding, or other abnormalities. Follow-up checks are recommended in the second and fourth weeks after being discharged.

Hu, 27, was 33 weeks pregnant when she was diagnosed with COVID-19 on March 6, 2020. She recovered and was discharged from the hospital on March 22. "I am grateful. You are thoughtful. Thank all of you so much." she said as she was discharged from Whhan Leishenshan Hospital.



6. How to provide psychological guidance for pregnant women?

6.1 Psychological problems of pregnant women prone to occur during the epidemic

Because of fear about COVID-19 as well as ANC delivery in hospital and their health conditions impacted by the epidemic, pregnant women might be set to worry, anxiety, fear, irritability, and other negative emotions; they may develop symptoms of anorexia, nausea, vomiting, insomnia, and dreaminess or make previous symptoms aggravated. Pregnant women suspected or confirmed with

COVID-19, in particular, may deny infection of the disease and avoid examinations or treatments, while some may become overcautious and request examinations and medications repeatedly. Such situations require the attention of medical personnel for psychological and emotional support.

6.2 Methods of psychological support

Medical personnel should attach importance to the early identification and management of psychological problems, including screening of depression and anxiety and recognition of intense physical and mental reactions in a crisis. Suggestions for pregnant women are as follows:

- 1) Accept the current situation of the epidemic, obtain information from official sources, reduce the possibility of exposure to COVID-19 related information, and stabilize their emotions.
- 2) Turn off electronic devices before bedtime and do some relaxation exercises, such as meditation, breathing, listening to music, and so on, to ensure a good sleep.
- 3) Ensure regular meals and a good diet with balanced nutrition; keep moderate exercise and a happy mood.
- 4) Devote their attention to an activity that they enjoy, such as reading, to enjoy the current moment, establish daily routines, and stabilize their states of mind.
- 5) Communicate and interact with their babies proactively, try to “talk” with their fetuses to enhance secure bonding as well as their emotional stability and cognitive adjustment.
- 6) Encourage pregnant women to establish connections with the outside world, communicate more with their husbands, families, friends, and colleagues to seek support or assistance.

6.3 Psychological counseling for pregnant women suspected or confirmed with COVID-19 infection

For pregnant women suspected or confirmed with COVID-19 infection, medical personnel need to establish an excellent doctor-patient relationship through listening and empathy and understand their concerns over the isolation environment and their health conditions; inform patients of the possible risks of the disease, the necessity, and benefits of isolation and treatment as well as the possibility of recovery; understanding and compliance of pregnant women, and work in collaboration, for the best outcome. It is equally vital to encourage pregnant women to be self-motivated by recalling their experience and strategies of success in coping with difficulties and challenges, mobilizing internal resources, promoting positive emotions, and enhancing mental resilience.

7. Implementing institutions and Partnerships

Health administration

The health administration component plays a vital role as a government agency in managing and treating pregnant women during COVID-19. From the national level to the provincial level to the prefecture prefecture-level to the county level, health authorities are the headquarters of local maternal treatment and management. Health administration departments of the national Government and local governments in China have led this work.

The national health committee (NHC) is responsible for maternal care and management at the national level.

- 1) Adjust the strategy of maternal health in time according to the epidemic situation. On February 8, 2020, the National Health and Health Commission issued the “Notice on Strengthening the Disease Treatment and Safe Delivery for Pregnant Women during the COVID-19 Period” and proposed a series of measures.
- 2) Concern about maternal and child infections. Organized experts to develop and adjust treatment strategies for infected pregnant women and children.
- 3) Collected designated hospitals that treat COVID-19 infected pregnant women and children from all provinces and publicized them to the public.
- 4) Monitor and evaluate the implementation of all provinces.

The provincial health committee is responsible for maternal care and management at the provincial level. In addition to implementing national strategies, provincial health authorities should also coordinate and arrange medical resources according to local conditions.

The roles of the health committee on the prefecture and county level are similar. They are lead at local on the management of maternal and children care during the COVID-19 epidemic. According to the strategies from the national and provincial committees, they direct local health institutes to improve services for pregnant women and children. Furthermore, to collect protective materials to protect the medical staff.

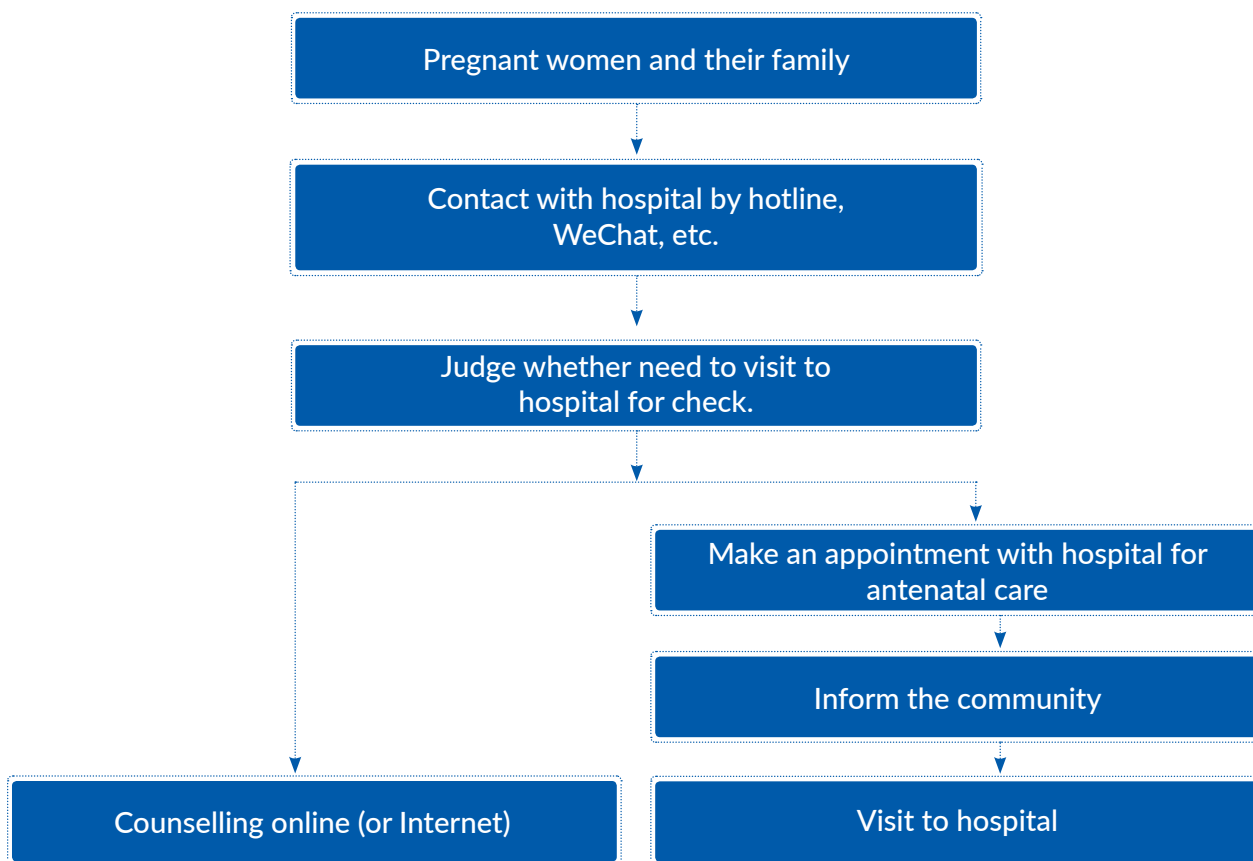
The agency of responsible responsibility for maternal health during the epidemic below the county level is community governments in Urban and township governments in rural areas. Their main functions are health education, notification, and transport of pregnant women for medical treatment.

Figure 5. Schematic diagram of health administration departments at all levels



Community plays a vitally role in COVID-19 epidemic prevention. They know how many pregnant women in their community and which apartment. When the time of lockdown, the hospital visit was allowed, especially for pregnant women and children.

Figure 6. The process of pregnant women seeking medical treatment during the lockdown.



Health institutes

During the COVID-19 period, health institutions were divided into two categories—designated hospitals and general hospitals.

As mentioned earlier, general health care facilities are responsible for maternal health services for women who do not have COVID-19. However, their service models and processes have changed because of the outbreak.

The hospitals' primary responsibility is to treat pregnant women who are infected or suspected of being infected. In addition to the treatment of COVID-19, they also provide maternal health care and midwifery services.

Civil society partnerships

Associations and academic organizations related to obstetrics, pediatrics, infectious disease and ICU developed technical guideline and treatment comments on pregnant women with COVID-19. They also organized many times training online for clinic health providers.

Health research institutes and hospitals are also involved in the research on mother-to-child transmission of COVID-19. This research focuses on the pregnancy outcomes of pregnant women with COVID-19. Whether the virus infection can cause miscarriage and whether mother-to-child transmission can occur are two research topics.

8. Achievements

The management of maternal care services has been established from the township level to the national level. Health facilities and health care staff have been guided and supervised to provide maternal care for pregnant women and their newborn babies. Pregnant women and their newborn babies have access to antenatal care, safe hospital delivery, postpartum care as the same as that before the epidemic outbreak. Pregnant women with fever, suspected or confirmed infection have been managed and treated.

There was no significant increase in maternal and neonatal deaths compared with the same period last year.

9. Outcomes

1. A prevention and treatment network for pregnant women and newborn babies has been established at all levels to cope with COVID-19.
2. Pregnant women have protected from COVID-19 infection.
3. Infected pregnant and lying-in women received timely treatment.

10. Planning and Design: Experience

The program was launched in beginning of February in response to the outbreak in Wuhan. The official closing date for Wuhan is 10 AM on January 23, 2020.

At that time the initial consideration has several points: one is the special characteristic of maternal, delivery and some necessary examinations are must come to the hospital, unlike other types of patients; Second, hospitals should try their best to avoid COVID-19 infection in hospitals. Third, pregnant women and children infected with COVID-19 can receive timely treatment and corresponding services.

Considering the above factors, the Department of Maternal and Child Health soon convened experts in related fields for discussion. After several times of expert workshop, “Notice on strengthening the treatment of maternal diseases and safe delivery during the prevention and control of the new coronavirus pneumonia epidemic” was published on 8 February,2020.

The Department of Maternal and Child Health also organizes experts to conduct various forms of training and requirements on this strategy to enable interventions to be implemented in health facilities throughout the whole country.

After repeated outbreaks in Beijing, Kashgar and other places this year, based on the original document, “Notice of the General Office of the National Health Commission on the Prevention

and control of COVID-19 in Autumn and winter in maternal and child health institutions” was promulgated on 4 November 2020. This document gives more detailed guidance on how MCH Hospital can protect and treat pregnant and lying-in women in the context of COVID-19.

11. Monitoring and Evaluation

Health administration departments of the national Government and local governments in China have monitored the project.

There are two ways to evaluate. One is to monitor and assess surveillance data to exam the change of situation. The data about birth, death, and main processes indicates on maternal health can be found in the surveillance report system. Government and experts are concerned about changes in indicators.

Another way is to learn about the implementation through field visits. Nation Health Commission sent several expert teams to the provinces to supervise and evaluate the implementation. They also gave technical support while field visits.

12. Successes and Lessons Learned

Judging by the results so far, a prevention and treatment network for pregnant women and newborn babies has been established at all levels to cope with COVID-19. The government of China prioritizes maternal and child health and the lives of the population. Set up designated hospitals for pregnant women and ensured service provided during the epidemic. During the COVID-19 epidemic, designated hospitals and non-designated hospitals have a clear division of responsibility in the provision of maternal health services.

In the specific service, the health providers provide Well-planned treatment and management plans for suspected and confirmed pregnant women and their newborns. This project also benefited from various forms of communication, especially during the lockdown. Various measures to provide health education, counseling, supports and direct antenatal care services. Therefore, in the document issued in November, the requirement of “MCH services on the cloud” was proposed.

13. Future Plans

This project is carried out nationwide, but it needs to be perfected and summarized. A scientific summary of the advantages and disadvantages of current activities is needed, includes an in-depth analysis of available data and associated impacts.

According to scientific analysis results, adjust the existing measures scientifically, and formulate the response plan.

Conduct scientific stockpiling of material and personnel capabilities in case of a possible disaster. Moreover, rehearse on the routine obstetrics department training. The rehearse may be organized by one hospital or by the local health administration section.

A large-scale health education campaign was conducted to raise the awareness among general

population on how to protect pregnant women and how pregnant women to protect themselves and their children when disaster strikes.

14. Replicability and Scalability to promote South-South

- 1) Pre-requisites for replication in other developing countries
 - A system for fast communication of policies and a comprehensive network of maternal and child health services.
 - A well-run community organization. As described above, much of the communication and implementation during the new Coronavirus was done in the community. Therefore, good functioning of community organizations, or grassroots organizations, is particularly important for maternal health.
- 2) Experiences in replicating in other countries through South-South Cooperation
 - According to the epidemic and the advice of experts, the response measures were to be formulated quickly.
 - The activities can be implemented very quickly.
 - According to the situation's progress and changes in the epidemic situation, the measures could be adjusted.
- 3) Suggested steps for replication in other countries
 - The establishment of designated hospitals can make infected pregnant women get effective treatment and are effectively reduce other pregnant women's infections.
 - Develop appropriate strategies based on the country's health system and resources.
 - Mothers and children should be protected first by society and government, no matter what disaster strikes.

15. Contacts

Details of implementing institutions:

- Department of Maternal and Child Health of National Health Commission of the People's Republic of China.

Head: Dr. Song Li

Address: No 1 Xizhimen Outer South Road, Xicheng District, Beijing, China

E-mail: songlimoh@126.com

Website: http://en.nhc.gov.cn/2014-05/22/c_74788.htm

- National Center for Women and Children's Health, China CDC
Dr. Wang Ai-Ling (ailing@chinawch.org.cn)

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CONTRIBUTORS

Dr. Song Li

Dr Song Li is the Director General in the Department of Women & Children's health, National health commission (NHC) of China. Since 2002, she started from a senior program officer to the current position as a DDG of NHC. During her career development, Dr. Song's responsibilities are to design, guide and coordinate the implementation of national and international health programs in China, and to participate in the development of legislation and policy on strengthening MCH health service system. Dr. Song Li has rapid response to public health emergency, such as SARS, bird flu outbreak and COVID-19.

Dr. Jin Xi

Jin Xin, China CDC's Chief Expert of Maternal and Child Health, had been working fifteen years as the Deputy Director of the National Center for Women and Children's Health (NCWCH), China CDC. She has been engaged in maternal and child health work for more than 30 years and dedicated to MCH for her entire career life with a persistent work attitude and a strong sense of professionalism and responsibility. She has won the United Arab Emirates Health Foundation Prize from the World Health Organization in her capacity as a representative of maternal and child health in China.

Dr. Wang Ai-Ling

Wang Ailing, Chief Physician, Director of the Maternal Health Department of the National Center for Women and Children's Health, China CDC. Mainly engaged in maternal health care, prevention of mother-to-child transmission of HIV, syphilis and hepatitis B. As the team leader, she are responsible for national maternal health management, PMTCT program planning, technical guidance, training, supervision and evaluation, and other technical support work.

Dr. Qiao Ya-Ping

Dr. Qiao Yaping majored in public health, health social science, and maternal and child health. She has served as associate professor of the Department of Maternal Health of National Center for Women and Children's Health, China CDC, since 2016. In this role, she participated in the national program and researched maternal health and prevention mother-to-child transmission of HIV, syphilis, hepatitis B.

CHAPTER 4

AYAMNA AHLA INITIATIVE, EGYPT

Professor Ashraf Nabhan, Dr. Farida Elshafeey, Dr. Rana Magdi and Dr. Farah Younis

Overview

Egypt's population growth is one of the country's greatest challenges. Egypt is the most populous country in the Middle East and the third most populous country in Africa. Fertility levels are the main determinant of population growth. Since 2006, fertility levels in Egypt were on an upward trend, reaching its highest level in 2014 at 3.5 [1].

According to the latest Demographic and Health Survey, Egypt (EDHS) in 2014, 16 percent of births in the five-year period prior to the survey were not wanted at the time of conception. This percentage is slightly higher than the percentage of women who reported an unwanted birth in the 2008 EDHS (14 percent) [2].

Egypt's government-led national family planning (FP) program has succeeded in raising the contraceptive prevalence Rate, from 48 percent in 1991 to 59 percent in 2014 [1]. However, the unmet need for family planning in Egypt remains at 12.6 percent [1]. Further, only 30 percent of women were counseled on postnatal birth control methods. Child spacing continues to be a challenge especially among young mothers, about 20% of births occur within 24 months of the previous one [1]. Another angle of the challenge is the overall level of adolescent pregnancy (aged 15-19) which shows a slow but steady upward trend, from 9 percent in 2005 to 10 percent in 2008 [2] and finally 11 percent in 2014 [1]. Seven percent of adolescents are already mothers, and 4 percent are pregnant with their first child, according to the EDHS 2014 [1].

In response to the observed alarming trends, policy makers in Egypt launched several initiatives to face these family planning challenges. One of these initiative started in 2019 and aimed at supporting the right of families to obtain sound and valid family planning information and to access safe affordable family planning services. This major initiative known as "Ayamna Ahla" has proved to be a success story and has been considered a model of a best practice in family planning in a developing country. A best practice entails a relevant policy or intervention implemented in real life settings and which has been assessed to be favorable in terms of adequacy and equity as well as effectiveness and efficiency related to process and outcomes [3].

The aim of this report is to document and share the aforementioned best practice. Documenting best practices, knowledge and experience sharing as well as replication of the best practices is one of the intervention areas of Partners in Population and Development (PPD). PPD continuously work to promote South-South Cooperation to improve reproductive health, population and development in its member countries.

Implementing Institutions

Ayamna Ahla initiative was developed and conducted by the Ministry of Health and Population. Collaborators and partners included the ministry of Social Solidarity, Religious Endowment, Youth, and Media, several civil society organizations and the United Nations Population Fund (UNFPA).

Summary

“Aymana Ahla” included three cross-cutting themes: knowledge utilization, the right to reproductive health, and youth. The work involved a bundle of proven high impact practices within two categories, namely social and behavior change (SBC) and service delivery. The project was developed by the Sector of family planning (SFP) at the MOHP and was conducted by teams of the SFP in collaboration with relevant stakeholders.

The **overall goal** was to support the right of families to gain sound health information and valid knowledge of family planning and to have access to safe and affordable family planning services. The initiative also aimed at creating a community movement, particularly among the youth, with the aim of advocating and lobbying to make a change in public behavior towards family planning. Creating a critical mass of future mothers can ensure a sustained behavioral change for decades.

The **specific objectives** of the initiative were to raise community awareness about the importance of family planning and its impact on maternal and child health and increase the total number of visits of current and new contraceptive methods users thus increasing the Years of Protection achieved particularly by long term methods.

The initiative was conducted over 12 months in areas of need and resulted in positive change in key indicators of the Population and Family planning sector, namely an 18% increase in total number of beneficiaries' visits, 11% in Total number of new users' visits, 19% in Total number of recipients of Contraceptive methods, 7% in Years of Protection achieved, and 4.9% in Years of Protection achieved by long term methods.

Ayamna Ahla Initiative showed that developing countries can utilize efficient practical approaches to SBC and service delivery programming. Experience from this best practice indicates that a carefully planned bundle of 2 high impact practices can exponentially improve knowledge, attitudes as well as practice. In the future, we need to probe additional way including digital health for SBC like mobile health (m-health) and social media platforms.

Background and justification

In recent years a challenge emerged in Egypt in the domain of family planning. Following a successful period of more than 25-year of declining fertility, the average number of children a woman has in her lifetime increased substantially from 3.0 births per woman in 2008 to 3.5 births per woman in 2014 [1]. This has been attributed to several factors including a tide of social, cultural, and religious norms that have re-stigmatized family planning.

Family planning captures the essence of a well-known fact that a health care system alone cannot make a society healthier, human behavior is a key driver. Therefore, it has been hypothesized that continuous and well-designed family planning campaigns and convoys to deliver services and raise awareness need to be accompanied by the activation of appropriate direct mass communication. This will achieve a greater impact in changing public behavior and improving family planning indicators. In other words, incorporating SBC activities into service delivery programming.

Stakeholders agree that it is necessary to expand the media approach horizontally so that a single topic is permeated in a unified message every month. The unified message needs to be delivered simultaneously through several outlets and using different ways. The topic needs to be addressed in a multifaceted way including health, social, economic, and religious aspects. This model has a direct impact in convincing the public with the message addressed, answering inquiries and questions. It also has a direct impact on explaining the concept and the consequences of family planning and means of modern family planning methods, how to use, advantages and disadvantages of each method. One of the dimensions that was carefully sought is to address and respond to rumors and myths regarding family planning. This would have a meaningful impact on increasing the demand for family planning services across all health provision facilities (fixed and mobile).

Goals and Principles

Overall goal

The overall goal was to support the right of families at different ages to gain sound health information and access safe family planning services and to create a community movement that advocates for a positive public behavior towards family planning.

Specific objectives

The specific objectives of the project were to

1. Raise community awareness about the importance of family planning and its impact on maternal and child health.
2. Increase the total number of beneficiaries' visits.
3. Increase the total number of new users visits.
4. Increase the total number of recipients of Contraceptive methods.
5. Increase in Years of Protection achieved.
6. Increase in Years of Protection achieved by long term methods.

Description

Vision

All Egyptians should have the best available knowledge and information in addition to the safest services for family planning and reproductive health. It is better knowledge, for better health, ultimately better days "Ayamna Ahla"

Message

The core message is "strengthening the ability of couples and individuals to exercise their fundamental right to freely and responsibly decide the number of their children, the intervals between each child and the child that follows". A truly well-informed, evidence-based, and shared decision-making in family planning.

Themes

The initiative has three cross-cutting themes:

1. The right to reproductive health (RH).
2. Youth.
3. Knowledge utilization.

Main activities of the project

The initiative was conceptualized on proved high impact practice pertaining to

1. SBC in the form of direct interpersonal communication and community group engagement, in addition to mass communication. SBC interventions is an effective component of a successful family planning program by Creating demand for services and methods, supporting correct utilization of contraceptive methods, supporting provider behavior change and enabling positive client-provider interactions, improving women's ability to articulate and advocate for their needs, and Shifting social norms that enable healthy behaviors [4]
2. Service delivery in the form of mobile outreach services, in addition to the fixed clinics, to expand access to a full range of modern contraceptives. Evidence demonstrates that mobile outreach services can successfully increase contraceptive use, particularly in areas of low contraceptive prevalence, high unmet need for family planning, and limited access to contraceptives, and where geographic, economic, or social barriers limit service uptake [4].

Achievements

The initiative included a series of campaigns and convoys.

Activity	Number of activities (in all governorates)	Total visits of recipients of Contraceptive methods	Visits of new Beneficiaries	Total Beneficiaries' visits	Years of protection achieved
Campaigns	4	885555	218615	1044952	549248
Convoys	42	24381	6670	44491	17227
Total	46	909936	225285	1089443	566475

The activities included the focused message seminars either as standalone, as part of campaigns or as part of the convoys.

The Activity	Number of activities carried out
Unified seminars at all Governorates	938 seminars
Seminars accompanying the Campaigns	572 seminars
Seminars accompanying the Convoys	42 seminars
Total No. seminars	1764 seminars

In terms of efficiency, the initiative showed that the ratio of average day of the initiative to normal working days was 4:1.

Outcomes

Indicator	March 2019 to February 2020	March 2018 to February 2019	Percentage of change
Total number of beneficiaries' visits	22625563	19149930	18%
Total number of new users' visits	2821640	2532171	11%
Total number of recipients of Contraceptive methods	22336051	18836704	19%
Years of Protection achieved	6454805	6012692	7%
Years of Protection achieved by long term methods	3929358	3744902	4.9%

Impact

The initiative contributed to a significant years of protection achieved relative to the total years of protection achieved nationwide during the 12 months' duration of the initiative.

The impact extends beyond to achieve major sustainable development goals, mainly goal 3 Ensure healthy lives and promote well-being for all at all ages, goal 5 Achieve gender equality and empower all women and girls and goal 8 Promote sustained, inclusive and sustainable economic growth.

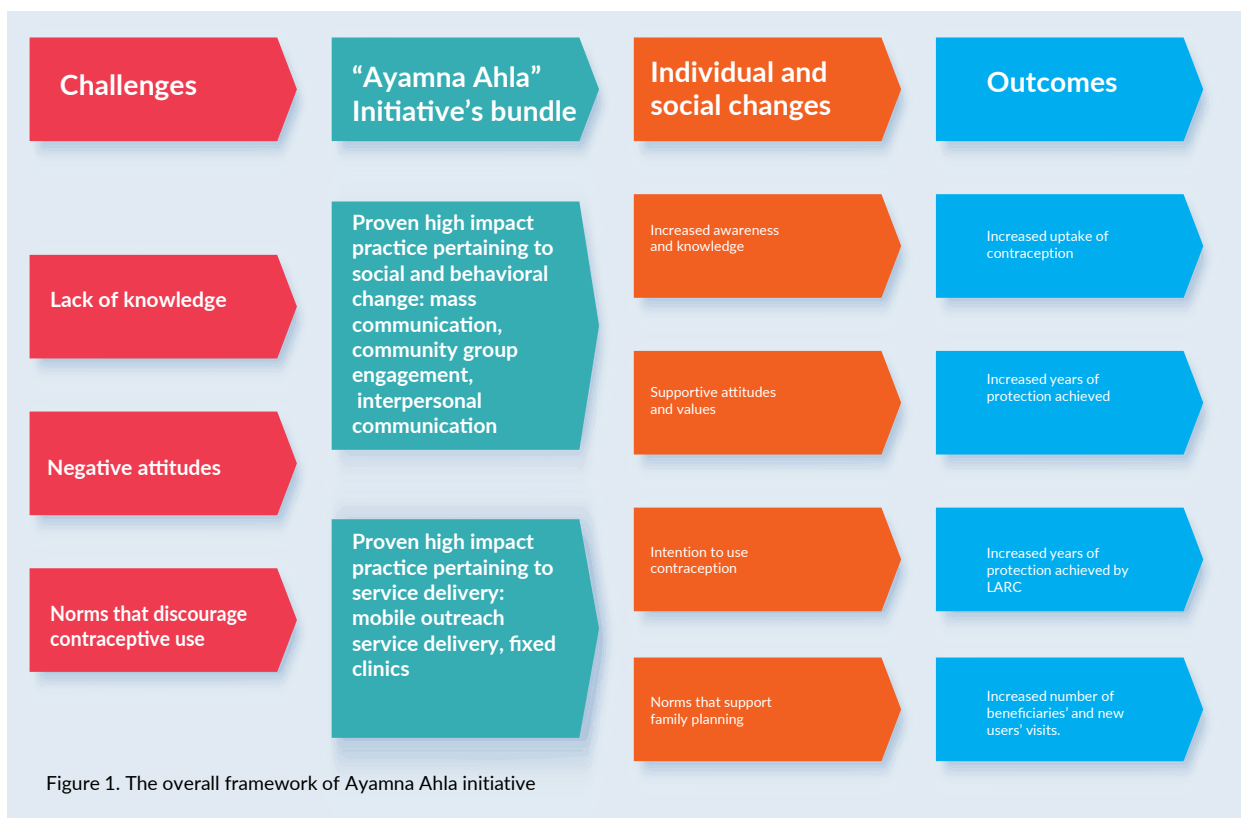
Planning and Design

Process of planning

- **Framework of "Ayamna Ahla" Initiative (Fig. 1)**

Using innovative methods to implement service convoys hand in hand with direct mass communication campaigns to

- spread the sound information regarding family planning and its implications for maternal and child health and for sustained economic development
- provide safe family planning services through fixed and mobile clinics in order to increase the demand for family planning services. Free of charge Campaigns and Convoys (under the name of "Your Right to Plan" or "Hakek Tnazamy") were implemented by fixed and mobile clinics, mobile medical teams to provide family planning services and methods especially long-acting methods particularly implants and IUD. The Campaigns and Convoys served the most deprived areas and villages including the poor of villages of the President's initiative (Hayah Karima), especially in districts with low population indicators.



The initiative addressed major drivers behind Egypt's fertility reversal documented in the 2014 EDHS: namely:

- Decreased exposure to FP and RH messages in the media
- Decreased FP and RH information and counseling
- Discontinuation of methods due to myths regarding side effects.
- Increased trends toward earlier marriage
- Increased trends to having the first child sooner and having shorter birth intervals; and
- Fewer young women using contraception.

- **Overview of Pre-implementation considerations**

The planning phase was carefully conducted to achieve the best results of the project. During the planning phase a wide range of stakeholders were involved. There were in-depth activities to conduct situation, audience and program analyses. The planning activities include gathering information on the nature and extent of the problem, potential audiences (characteristics, barriers and facilitators to change), available resources (financial, human), communication environment (availability and use of communication channels), and areas for programmatic improvement (if program already exists) or focus (if program is just beginning). This was followed by a careful development of selection of the audiences and development of the communication objectives.

1. Input about the initiative has been sought from a range of stakeholders. Individuals who implemented the initiative have been involved in the design
2. The initiative addressed known service delivery issues.
 - Given the financial and human resource requirements, the initiative is feasible in the local settings where it is to be implemented
 - The initiative is consistent with existing national health policies, plans, and priorities
3. The project has been designed according to agreed- upon stakeholder expectations for where and to what extent interventions are to be scaled up.
4. The initiative has identified and taken into consideration community, cultural and gender factors that might constrain or support implementation.
5. The initiative has been kept as simple as possible without jeopardizing outcomes.
6. The initiative has been tested in a variety of sociocultural and geographical settings where it will be scaled up. The initiative has been tested in the type of service delivery points and institutional settings in which it will be scaled up.
7. The human and financial resources can reasonably be expected to be available during scale up.
 - The financing of the initiative will be sustainable.
 - The health system currently has the capacity to implement the initiative.
8. Appropriate steps have been taken to assess and document health outcomes as well as the process of implementation.
9. The project design included mechanisms to review progress and incorporate new learning into the implementation process. The MOHP used findings and insights from the pilot project during implementation.
10. There has been a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the initiative before scaling up.
11. The team developed key message points for each audience. These are the points that were conveyed in all messages and activities, by all partners implementing the strategy. These key message points were delivered in different ways depending on the approach.

- **Situation Analysis**

The increasing population density in Egypt increases the need for family planning services. This is highlighted by the following Key points:

1. The total fertility rate for the three years prior to the 2014 EDHS is 3.5 births, thus reversing a more than 25-year pattern of declining fertility, the total fertility rate rose substantially during the six-year period between the 2008 and 2014 surveys, from a level of 3.0 births per woman to 3.5 births per woman.
2. Currently, 58.5% of married women in Egypt are using a family planning method, which represents a slight drop from 60.3% in 2008.

3. Approximately 61% of the population is young, under 29 years' old
4. Discontinuation rate from the use of family planning methods (30%), unmet needs (12.6%), and unwanted pregnancy (16%).
5. The illiteracy rate of 28% constitutes a major challenge and has a major impact on family planning practices.
6. The number of visits by new users in 2018 decreased by 2% in comparison to 2017.
7. The number of women using the IUD in 2018 decreased by 7.1% in comparison to 2017.
8. Years of protection achieved in 2018 decreased by 2% in comparison to 2017.

The SWOC matrix

Strength

1. Availability of expertise in the family planning sector to develop and implement programs.
2. The presence of a fleet of mobile clinics and fixed family planning clinics located in cities and villages.
3. The presence of a team of media officials within the family planning team at the level of each district and each governorate.
4. The presence of a large team of community health workers trained in family planning and reproductive health messages in all governorates.
5. Existence of a working guideline for media officials, and a developed multi-message curriculum for community health workers.

Weakness

1. Weak motivation for social marketing team.
2. Shortage of manpower among mobile clinics (doctors - drivers)

Opportunities

1. Presidential support to limit population growth and reduce the birth rate (Hayah Karima Initiative).
2. Donors support for media and service activities for family planning.
3. The existence of information, education and communication centers that can disseminate the concept of the small family and the importance of birth spacing and marketing of family planning services

Challenges

1. Unfavorable population beliefs and characteristics to foster development.
2. Large gap between the level of knowledge about family planning and modern methods, and the actual practice of family planning within the community.
3. Low social awareness of family planning and reproductive health services and their importance.
4. Myths and rumors that might reduce uptake and continuation of use by women.

- ***Timing of implementation of the initiative***

The initiative was launched in March 2019, then it was included in the Population and Family Planning Sector Action Plan for the years 2019 and 2020.

- ***The geographical scope of the initiative***

The geographical scope of the initiative included districts with low population indicators according to the indicators of the National Population Council. The initiative targeted at first the poor villages that are identified by the President's Initiative (Hayah Karima). It also targeted new areas with potentials of job opportunities and new urban communities in addition to industrial areas.

The choice was guided by the availability of one or some of the following criteria:

1. A village relatively deprived of medical services.
2. The frequency on family planning clinics is low.
3. The couple year of protection rate is low.
4. The birth rate is high.
5. Low utilization of family planning methods.
6. The illiteracy rate is high.

The Outreach Awareness Activity Executor: The Social Marketing Team

1. The Media Team: Through the monthly awareness campaign targeting various topics every 3 months, using on a unified message every month.
2. Community health workers: Through home visits especially for pregnant women starting from the 30th week of pregnancy, and for women in the post-partum period within 30 days of birth (the 30th initiative focusing on attracting new beneficiaries).

- ***The target audience for the initiative:***

1. Adolescents and young couples.
2. Women of childbearing age.
 - Girls who are about to get married
 - Newly married women wanting to postpone pregnancy.
 - Married women non-using family planning methods.
 - Married women who use family planning methods.
3. Women in post-childbearing age (mothers-in-law).
4. Men of different ages.
5. Official and natural leaders (clerics - natural leaders - community leaders - village heads of families).

- **Phases of Implementation**

First: Preparatory meetings are held (centrally and locally) to introduce the initiative.

Second: Carrying out awareness seminars through large scale and mini-meetings that highlight and disseminate a focused topic, through:

1. Unified seminars in all governorates every quarter with a monthly message
 - Family planning and its implications on family and community health:
 - The dangers of frequent, concomitant, early and late pregnancy.
 - The benefits of birth spacing.
 - Correct misconceptions about family planning and respond to rumors.
 - Various Population Characteristics:
- **Illiteracy**
 - The risks of early marriage and school dropout.
 - Women's Empowerment
 - Control population growth:
 - Responsibility and positive participation of men in family planning.
 - Family planning, family health and its role in economic and human development.
 - Population characteristics and their impact on society.
2. Implement (our family is perfect) (Asabee' Osretna Methaleya) to cover the governorates in conjunction with reproductive health campaigns and convoys through rural mini-seminars discussing and tackling the following topics:
 - Meetings for men under the slogan (Words of men) (Kalam Regalah).
 - Meetings for women (house-wives) under the slogan (whisper to your health) (Hamsah Le Sehetek).
 - Meetings for the mothers-in-law under the slogan (My Mother-in-law is My Life) (Hamaty Hayaty).
 - Meetings for working women of childbearing age (Are You Planning!!) (Nazamty).
 - Meetings for youth under the slogan (Our family is perfect) (Osretna Methaleya).
 3. Places to implement the seminars:
 - National Societies.
 - Mayor's House.
 - Camps for conscripts in the Ministries of Interior and the Armed Forces.
 - Governmental organizations.
 - Factories and companies.
 - Secondary schools (boys - girls).
 - Youth centers and sports clubs.
 - Institutes and universities.

Third: Implementing RH awareness and service campaigns and convoys:

1. Free of charge Campaigns and Convoys (under the name of “Your Right to Plan” or “Hakek Tnazamy”) are implemented by fixed and mobile clinics, mobile medical teams to provide family planning services and methods especially long-acting methods.
2. The Campaigns and Convoys served the most deprived areas and villages including the poor of villages of the President’s initiative (Hayah Karima), especially in districts with low population indicators.

Fourth: Publications

1. Designing and printing informational materials to promote
 - the concept and payoff of family planning
 - the positive responsibility and participation of men in family planning.
2. Designing and printing media materials to promote family planning methods and their proper use in a manner that guarantees the safety of beneficiaries.

Fifth: Media coverage

1. Issuing press releases to introduce the initiative and the sites of implementation.
2. Communicating with satellite channels to cover the initiative, informing the public and highlighting success stories.
3. Communicating with local media channels to cover the initiative’s activities and documenting success stories.

Representativeness

The development team made sure that a sufficient number of and types of people are included in the engagement activity to ensure that those engaged can speak on behalf of the target population.

The geographical scope of the initiative covered districts with low population indicators according to data from the National Population Council, poor villages according to another initiative, new urban communities, and industrial areas.

Community engagement

The development team explicitly aimed, from the outset, to maximize the involvement of community members and service users. This stems from a profound understanding that community participation is vital in expanding access to information and services and that the uptake of family planning methods and services is shaped by socially embedded values and preferences.

Local institution building including informal networks

- The project planned to build alliances and networks with other governmental and non-governmental organizations or local community leaders and youth committed to supporting the priority issues. The full-time female providers were the main catalyst in this process of building local informal networks.

- The project supported leadership which is critical for local institution-building, and consequently the sustainability in programs. This was executed through the training and capacity-building processes of the project.

Sustainability plans including links to other projects

The project builds on a leadership commitment in the “Hayah Karima” presidential initiative. It was linked to relevant projects to maximize impact and ensure sustainability. It was linked to the “Your Right to Plan” reproductive health project. “Our family is perfect” was also a co-project to cover the governorates in conjunction with reproductive health campaigns and convoys through rural miniature seminars discussing and tackling men engagement project, housewives project, mothers in law project, working women project, and the youth project.

Description of evaluation activities taken to date

The team developed a monitoring and evaluation plan before starting the implementation of the project. During the development of the strategy, the team create a draft plan that included communication indicators, methods for monitoring and evaluation, and tools to track progress and evaluate effects. A smaller taskforce finalized the plan after all partners agreed on the draft.

1. The team started from the project goals and objectives.
2. The team used the pre-specified indicators.
3. The team drafted a data collection form and decided on the timeframe.

Partnerships

Needless to emphasize that this project would not have been such a success if partners were committed and collaborative. The generous fund and professional advice provided by the UNFPA were pivotal to the realizing and sustaining the activities of the project. The collaboration of the Ministry of Social Solidarity were imperative to the efficiency of the project by identifying the areas of need. In a religious community, the involvement of religious figures to achieve the goals of the project cannot be overstated. Last but not least the involvement of local community NGOs and the youth helped in exponential dissemination and service utilization.

- Overview of implementing institutions: The initiative was implemented by dedicated teams lead by sector of Family planning of the MOHP.
- Role of government: governmental collaborators included the ministry of Social Solidarity, Religious Endowment, Youth, and Media.
- Civil society partnerships: several civil society organizations contributed to the activities of the initiative.
- Role of multilateral agencies: funding was provided by the UNFPA with close monitoring.

Monitoring and Evaluation

Selection of appropriate indicators for monitoring and evaluation of reproductive health programmes in the Region was guided by the WHO global reproductive health strategy

targets, the SDG framework, and the proposed framework of indicators reported in the national-level monitoring of the achievement of universal access to reproductive health [5]. The indicators included

1. Total number of beneficiaries' visits
2. Total number of new users' visits
3. Total number of recipients of Contraceptive methods
4. Years of Protection achieved
5. Years of Protection achieved by long term methods

Successes and Lessons Learned

- A carefully planned and rigorously implemented bundle of proven high impact practices are favorable in terms of adequacy and equity as well as effectiveness and efficiency related to process and outcomes. This success is evident in terms of raising awareness, increasing the total number of beneficiaries' and new users' visits, increasing the total number of recipients of contraceptive methods, and increasing in Years of Protection achieved. This worked well because of the careful planning and the spirit of goodwill of the dedicated teams in addition to the intelligent choice of the short focused unified message.
- By analogy from social media, the succinct, crystal clear and comprehensible message that is virally and continuously disseminated is far more effective than tedious TV shows or newspaper articles, etc.
- We speculate that the effect of this bundle of high impact practices would be maintained by continuing the viral spread of the focused messages. It is even more suitable than other approaches in certain circumstances as shown by an example of the current situation due to the unforeseen SARS-nCov pandemic.
- Focusing on adolescents, the future mothers, and creating a critical mass would ensure that the effects will linger on for years.
- Effective communication objectives focus on the key constraints to reaching the shared vision.
- To develop benefits that resonate with the audience requires a deep understanding of the audience.

Future Plans

- Enhance pre-service and on the job training and continuous professional development of providers.
- We need to probe additional ways to achieve SBC, including m-health and social media platforms
 - In many developing countries the penetration of mobile or cellular phone services became extremely high. The number of mobile connections in Egypt in January 2020 was equivalent to 91% of the total population [6]. There is moderate certainty evidence

that mobile phone message reminders might be an effective strategy for health system improvement targeting recipients of care in low-income countries [7]. The use of cellular phone applications has proved to be effective in the current pandemic in many aspects. We may speculate that the utilization of this approach will be even more successful in a less acute domain of health service.

- Social media platforms have been of a huge impact on our lives. Lately, there are ongoing research on how to benefit from social media in changing social behavior to the better. Facebook, Instagram, and twitter which are used by billions around the world have introduced a suicide hotline information to users who search suicidal terms, and this helped in reducing suicide rates. In addition, social media users share their experiences to help others in need, Donna Helm Regen lost her daughter who was a tanning bed user to melanoma now she is hosting a platform to raise awareness upon that matter [8].
- Digital behavior change interventions (DBCI) employ digital technologies to encourage and support behavior change that will promote and maintain health, through primary or secondary prevention and management of health problems [9].
- DBCI aims at modifiable behavioral risk factors. Studies have been focusing on including social media to DBCI; however, design principles are not complete to express the use of social media in behavioral interventions. A recent systematic review of 5264 articles showed that DBCI has an overall 70% positive outcome on behavior change and 2% negative effect. Results also showed that DBCI decreased the needed financial and human resources. Communication based social media were the most effective in behavioral intervention. Interactions among participants led to improvement in behavior [10]. A striking current example for the benefit has been shown by the positive effect of social media platforms on protection against the COVID-19 pandemic [11].
- There were 42.00 million social media users in Egypt in January 2020. The number of social media users in Egypt increased by 2.9 million (+7.3%) between April 2019 and January 2020. Social media penetration in Egypt stood at 41% in January 2020 [6]. Incorporating social media features into behavior change interventions has the potential to contribute positively to their success [10].
- Policy maker and program managers can actively utilize these platforms in the future to influence awareness of public health behavior improvement and to target specific issues throughout the spread of concise message to target populations. We need to gather information with respect to the effect of social media on outcomes and to have a clear guidance to inform the selection process based on the features' suitability for the behaviors relevant to family planning.

Replicability and Scalability to promote South-South Cooperation

- Pre-requisites for replication in other developing countries: the activities that explicitly attempt to reproduce this best practice in a different country will require national policies to enhance enabling environments.
- Replicating in other countries through South-South Cooperation: this best practice is an excellent example of replicating what works in other countries through SSC. This can be achieved by collaborating with and working through national organizations and partners who are familiar with the preferences and values of the target groups as well as the local conditions.
- Suggested steps for replication in other countries: Briefly, the viral dissemination of a unified message tailored for local context.
 - Involve key stakeholders from the beginning and ensure their meaningful participation.
 - Conduct situation, audience and program analyses. Include information on:
 - Nature and extent of the problem
 - Potential audiences (characteristics, barriers and facilitators to change)
 - Available resources (financial, human)
 - Communication environment (availability and use of communication channels)
 - Areas for programmatic improvement (if program already exists) or focus (if program is just beginning)
 - Select the audiences
 - Develop Communication Objectives:
 - determine each audience segment, their key constraints and the desired change
 - Next, determine how much change the program expects to see.
 - Last, set the time frame for the expected change.
 - Decide how the program will accomplish its communication objectives by selecting strategic approaches.
 - For each audience, outline the core information – key message points – that should be conveyed in all messages and activities, by all partners implementing the strategy.
 - Decide which communication channels will best reach the audience. It is effective to use a variety of channels, keeping in mind that there is no one perfect channel.
 - With the approaches and channels selected, the team can outline activities that will lead to achieving the objectives.
 - Develop an implementation plan that covers partner roles and responsibilities, activities, timeline and budget considerations.
 - Estimate the amount of funding needed for each main category and create a draft budget. The budget must be flexible as needs and activities change. Be sure to determine what resources partners will contribute.
 - Develop a Monitoring and Evaluation Plan

- Potential partnerships: The team can share practical experience to develop a well thought out and articulated strategy. A well-defined plan which involves key stakeholders from the outset will greatly increase the chances of successful implementation.

Contacts

Details of implementing institutions

Sector of Family planning, MOHP.

- Address: 3 Parliament street, Cairo, Egypt.
- Website: www.mohp.gov.eg

Project team and individuals in leading roles

1. Dr. Sahar El-Sonbaty, Secretary General of the National Council for Childhood and Motherhood
2. Dr. Hossam Eldin Abbass, Head of the Sector of Population and Family planning, MOHP
3. Dr. Duoaa Mohamed, Head of Central Department of Family Planning Services and Commodities, Sector of Population and Family planning, MOHP

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CONTRIBUTORS

Professor Ashraf Nabhan

“Ashraf Nabhan, Professor and consultant of Obstetrics and Gynecology, Ain Shams University, Egypt. He is the director of Egyptian Center for Evidence Based Medicine. Prof. Nabhan is a full editor at the Cochrane Pregnancy and Childbirth and a member of the Editorial Board of the International Journal of Gynecology and Obstetrics (The official Journal of the FIGO).”

Dr. Farah Younis

Dr Farah Younis, Intern at Ain Shams University Hospitals and Research fellow at Egyptian Center for Evidence Based Medicine.

Dr. Farida Elshafeey

Dr Farida Elshafeey, Intern at Ain Shams University Hospitals, Research fellow at Egyptian Center for Evidence Based Medicine, and Associate editor in Cochrane Clinical Answers.

Dr. Rana Magdi

Dr Rana Magdi, Intern at Ain Shams University Hospitals, Research fellow at Egyptian Center for Evidence Based Medicine, and Associate editor in Cochrane Clinical Answers.

KABABILO BAAMA AND FAAMA INITIATIVE THE GAMBIA

Lamin Nyabally and Ba Foday Jawara

1.0 Introduction

1.1 Population Dynamics

The Gambia's population is estimated at 2.4 million and growing at a rate of 34 percent per annum. This rapid growth rate is underpinned by high levels of fertility and declining mortality which the country continues to experience. The Total Fertility Rate according to the Demographic and Health Survey, 2013 was estimated at 5.9 (GBoS,2016). With regard to mortality, the DHS, 2013, has shown that Under-5 mortality has declined from 109 per 1000 livebirths to 54 per 1000 livebirths in 2013. Similarly, infant mortality has declined from 81 per 1000 to 34 per 10000 livebirths. Additionally, Maternal mortality has declined from 1050 per 100,000 live birth in 1990 to 433 per 100,000 livebirths in 2013.

Poverty levels remain quite high in The Gambia. It is estimated that 48% of the Gambian population live in poverty, that is the percentage of households living below the poverty line of \$US1.25 /day (WFP, 2018) and 40 per cent of the population are also considered 'working poor', meaning that their earning capacity and standard of living is inadequate even for meeting basic needs and the persons living with disabilities are more vulnerable to poverty. An important feature of poverty in The Gambia is the female face that it wears as women constitute the majority of the poor and extremely poor, exacerbated by the fact they occupy a low socio-economic status.

Against the backdrop of the foregoing, the Government of The Gambia first recognized and expressed the need to address population and development issues in a 1979 cabinet paper entitled "Framework for the Development of a Population Policy". This led to the formulation of the first National Population Policy in 1992. The Gambia joined the rest of the world to discuss and reach a consensus on the ICPD Conference in Cairo, 199. As a country that adopted the ICP Programme of Action, The Gambia revised the national population Policy in 1996 with a view to integrating the recommendations of the Conference. Despite the formulation and implementation of Population and other Policies such as the Sexual and Reproductive Health Policy, Family Planning Policy, Education Policy and many, The Gambia registered significant successes in the implementation of these policies but also faced challenges. which include high unmet needs for family Planning (25%), high fertility rates (5.9), high levels of Maternal Mortality (433 per 100,000 livebirths) and the high prevalence of harmful traditional practices such as FGM.

1.2 Overview of Reproductive, Maternal, Child and Adolescent health

The Gambia has a very high maternal mortality rate. Though is on decline but is still among the highest in the sub region ranging from 1050/100,000 live births in 1990 to 433/100,000 live births. It is against this back ground that maternal and child health programme unit was established in 1975 by Ministry of health and Social Welfare then for coordination and implementation all maternal and child health services in the country. However, in 1994, the unit was expanded in scope and functions after the Cairo conference to cater for in addition neonates, adolescents/ youths and all others within the reproductive age cohort including family planning.

The Gambia subscribed to 75% reduction of maternal mortality ratio (MMR). However, the reduction of MMR in the country has been very slow and remains the top priority of the country for the post -2015 SDG agenda. Majority of the maternal deaths in the country are as a result of avoidable direct obstetric complications, including hemorrhage (37%) hypertensive disorder of pregnancy (11%) and sepsis (11%) (WHO et al 2015). The main contributing factor include inadequate access to CEmONC and BEmONC services, lack of trained human resources, transportation and low socioeconomic status of the people. Addressing these challenges these and improving availability of and quality of CEmONC can contribute to at least 60% of maternal mortality reduction in the country.

In the country, 86% of pregnant women receive antenatal care services from a skilled provider with 78% receiving ANC4+ and 38% starting antenatal care during the first trimester. 63% of the births are attended at the health facility, with 57% being assisted by skilled birth attendant and 76% of mothers receive postnatal care in the first two days after delivery

Trends in infant and under-five mortality have shown a steady decrease in the Gambia. Under five mortality had declined from 109 per 1000 live births in 2010 (MICS2010) to 54 per 1000 live births in 2013. Similarly, infant mortality rate had declined from 81 per 1000 live births in 2010 (MICS 2010) to 34 deaths per 1000 live births in 2013. Neonatal mortality accounts for 41% of under-five mortality

Several efforts together with partners have been made to increase the contraceptive prevalence rate, reduce unmet need for modern contraceptives and thereby reduce the total fertility rate (TFR). The TFR of the country is 5,6 per woman. About 31% of women give birth by age 18 years and about half (49%) by the age 20 years. Almost one in five (18%) of adolescent women age 15-19 are already mothers or pregnant with their first child (GBOS. 2014)

2.0 Goal and Principles of Kaabilo Baama Faama

The Goal and Principles of the Kaabilo Baama Initiative are as follows;

2.1 Goal

The Goal of the project is to contribute to improvement in the status of women and girls through improved RMNAH services and livelihood in the selected communities

2.2 Guiding Principles

The Kaabilo Initiative is guided by the following principles in design, and implementation.

Good governance and country ownership: Good governance, national ownership, country leadership and leadership commitment for the provisions of comprehensive and high quality RMNCAH services.

Right based approach: Respect the rights of the individuals to information and education and emphasizes access to accurate information in order that they take full, free and informed decisions. People-centered provide RMNCAH services, which are people-centered, confidential and not to discriminate against any individual on account of gender, or social background.

Affordable, equitable and quality: RMNCAH services are provided in a manner that ensures affordability, equity in access and quality corresponding to the needs of each individual.

Gender responsive: equity and equality in access to national resources and services by all people regardless of their sex or social status;

Men involvement: Men and women to take responsibility for their own sexual behavior, fertility, health and wellbeing as well as that of their partners and families;

Privacy and confidentiality: RMNCAH services ensure privacy of the individual, and sensitive and responsive to the socio-cultural circumstances of the individual.

Evidence based: Evidence-based interventions, which lead to provision of good quality of RMNCAH services within a continuum of care along the life course.

Consistent: The RMNCAH service provisions will be consistent with other related national policies, legal provisions and relevant international agreements and conventions.

Sustainable and universal access: Health system strengthening based on PHC to ensure sustainability for achieving equity and universal access to comprehensive RMNCAH interventions.

Partnership: strong partnership with relevant programmes and sectors, development partners and stakeholders in RMNCAH to optimize coordination and collaboration that promotes transparency and accountability in achieving the RMNCAH goals and to ensure community participation.

Community engagement: active community participation and ownership of the RMNCAH programmes from planning to implementation and monitoring and evaluation

3.0 Background and Justification of Kaabilo Baama and Faama Initiative

In Kiang East District where the project started, there is low institutional delivery, late booking of pregnant women for antenatal care, low male involvement and participation in Reproductive Health (RH) (BAFROW, 2012). Women leaving their family planning cards at health facility for fear of divorce or domestic violence were also identified as a challenge. In addition, blood donation was not accepted by men particularly during obstetric emergencies. Low uptake of modern contraceptives, underutilization of RMNCAH services in the District and low participation of male folk in RMNCAH services were concern to RMNCAH program of the Ministry of Health and Social Welfare.

Data from health facility in 2012-indicated that at baseline, institutional deliveries were 38.4%, Family planning new acceptors- 21.6%, and Early antenatal care booking 14.8% which were lower than expected.

Against this backdrop, the Population Commission Secretariat and implementing Partners of the National Population Programme deemed it fit to implement a strategy coined as Kaabilo Baama and Faama with a view to increase access and utilization of RMNCAH services in the various Districts of the Lower River Region

3.1 Kaabilo Baama and Faama Initiative

Kaabilo is a Mandinka (one of the main local languages) word meaning a close-knit group of interrelated families and individuals who share common interest and values in a settlement. Baama on the other hand means Mother This is a community-based intervention strategy aimed at improving the utilization of RMNCAH services for better pregnancy outcome and empowering women with livelihood skills using traditional family structures in the villages/communities. The Initiative was referred to as Kaabilo Baama and Faama (otherwise referred to as Male Action Group given that the women and children were the target beneficiaries of the Initiative; it was deemed necessary to observe the gender dimension by giving equal space to men to increase their participation in the project by adding Male Action Group. The full name became Kaabilo Baama and Faama. This was crucial and added value given that the Gambia is a male-dominated society in which major decision on reproductive Health and other issues are normally dictated by men. For the modus operandi, each Kaabilo in the Settlement identifies women and a man to represent them in the project.

These Kaabilo representatives are then registered and trained using appropriate training manuals (pictorials) that can easily be applied. The training is two-folds RH training and Skills Development. For the RH training the theme includes: Early Booking for antenatal, Health Centre Delivery, Family Planning and Birth spacing, exclusive Breastfeeding, etc. At the end of their training, these representatives become the Focal Point for the various Kaabilos and are given their roles and responsibilities vis-avis the implementation of the initiative. In addition to serving as an advocate for access and utilization of RH services, these representatives, create awareness in their respective Kaabilos by making pictorial presentation of the thematic RH issues mentioned above. Given that most of the representatives are not literate, communicating messages pictorially has helped them understood the messages well. For Skills development, the Representatives were trained on appropriate skill that are easily marketable in the communities. These include Tie and Dye and soap making. UNFPA, provided seed money for the activity and all the representatives and a few Kaabilo members were trained, and provided initial capital as start-up. Most representatives embarked on soap making since the demand is high and is more affordable. To ensure financial sustainability, a regulation was established within themselves which every Kaabilo member, particularly women would be given soap on loan to be paid at an agreed timeframe. This has helped the Kaabilo in the mobilization of funds. The Regulation also allows members of the Kaabilo to borrow money from the Kaabilo Account and repay without interest. The initiative was considered a Best Practice and replicated in additional 10 villages in 2015, in 2018 it is extended to an additional 7 villages making a total of 24 villages. In 2015 this initiative was identified among others by West African Health

Organization (WAHO) as a best practice. In 2017 a WAHO team was in The Gambia to support in development of proposal for the scale up in the North Bank Region, which has started this year

3.2 Implementing institutions and Actors in the design and conduct of the Practice

The main implementing institution of the practice is RMNCAH of the Ministry of Health (MOH) and the Women's Bureau of the Ministry of Women, Children and Social Welfares, Department of Community Development and the Village Development Committees in the communities. Where a structured VDC is absent a village traditional structure is used as an entry point to the village/ community.

3.2.1 Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)

Responsibilities of The National RMNCAH Unit:

- Formulation of policy, development of strategic plan and guidelines for implementation of the RMNCAH activities,
- Overall coordination of Reproductive Maternal Newborn Child Adolescent Health (RMNCAH) partners and the implementation of RMNCAH policies and strategies
- Advocacy for the engagement of all partners and stakeholders in the resources mobilization and implementation of this policy.
- Facilitate the timely and regular meetings of the National RMNCAH Committee,
- Preparation of quarterly and annual RMNCAH work plans and follow the timely development of Regional RMNCAH work plans
- Quarterly and annual monitoring and evaluation of RMNCAH services delivery performance of the unit and all regions.
- Resource mobilization for the implementation of RMNCAH interventions.
- Facilitate the procurement and distribution of RMNCAH equipment, supplies, commodities, tools and other necessary logistics.
- Needs assessment & building the capacity of health mangers and services providers at all levels.
- Mentoring of lower-level facilities and health professionals
- Collect, collate and analyze RMNCAH service data and provide timely feedback
- Conducting and supervising research activities in collaboration with Research Institutions;
- Provide regular supportive supervision to the Regional Health Management Teams (RHMTs) and service providers;
- Provide and disseminate relevant information on RMNCAH.

3.2.2 National Population Commission Secretariat

The National Population Commission Secretariat is the technical arm of the National Population Commission which was established in 1992 following the formulation of the first explicit Population Policy for The Gambia. The Secretariat among other duties, is responsible for policy and programme planning, formulation, coordination, resource mobilization, monitoring and evaluation as well as South-South Cooperation on Population and Reproductive Health issues.

3.2.3 Women's Bureau

This is a programme unit under the Ministry of Women and Children affairs. It is responsible for women affairs and highly engaged in gender issues and empowerment activities of women and girls. Their mandate includes:

- Review national and sectoral policies, and development frameworks and reports to determine their gender sensitivity and make public the outcomes of the reviews accordingly
- Provide technical advisory services to the national and sectoral structures for gender mainstreaming while ensuring that such services are secured and accessible.
- Promote the collection of gender disaggregated data, management of information systems and disseminate the data for national development planning.
- Establish and maintain a Gender Data base
- Identify key areas of research on gender issues, and ensure that the results of research are incorporated into national and sectoral development programmes.
- Coordinate advocacy efforts on gender and development issues;
- Mobilize resources for overall coordination and policy implementation;
- Establish linkages, partnerships and networks both internally and externally on gender and development issues;
- Strengthen institutional capacity for systematically and consistently taking gender concerns into account in institutional policies, programmes, budgets and plans;
- Monitor and evaluate the Gender and Women Empowerment Policy implementation;
- Evaluate the achievements of the Policy goals and objectives;
- Attend gender-related meetings, seminars, workshops and conferences at national, sub-regional, regional and international levels for purposes of updating on current and emerging discourses, sharing knowledge, information and skills in gender, and share outcomes of such meetings with colleagues and gender focal points.

3.2.4 Village Development Committees

These committees serve as the government of the village and are responsible for coordination of their subcommittees and facilitation of all development activities in the village. They are the entry point to the village/community.

3.2.5 Donor Institutions

Under its current Country Programme, UNFPA is providing financial support to the Ministry of Health and Ministry of Women, Children and Social Welfare to implement the Gender component. Part of this support has been used to fund the livelihood component of the Kaabilo Baama Initiative. West African Health organization is also providing financial support for the expansion of the initiative.

3.2.6 Intended Objective of the Practice

- To increase the utilization of Reproductive health care services in the district.
- To promote male involvement and participation in Reproductive Health services.
- To increase the uptake of modern contraceptives.
- To empower women through livelihood skill development.

4.0 Key Activities, Achievements, Outcome and Impact of the Practice

It should be noted that there was no baseline data collected directly from the targeted communities. The Project used clinical records from the Management Information System domiciled with the various Health Centers in the targeted communities. Had there been such a baseline, the Results framework linking activities, outputs and outcome could have been much easier. Nevertheless, the activities, achievements, Outcome and Impact of the Initiative are detailed as follows

4.1 Activities

The activities undertaken for the implementation of the Project include:

- Main activities undertaken by the project
- Identification of the communities
- Selection of the communities
- Assessment of the selected communities
- Sensitizing the communities
- Selection of the kaabulo representatives by community members(committees)
- Development of the tools
- Training of committees
- Provision of tools (guidelines)
- Provision of posters
- Follow up supervision after training and during implementation
- Home visits for awareness creation by different committees using pictorial flip charts at household level
- Presentations for awareness creation by committee during social gatherings in the community

4.2 Achievements/Outcomes

- Increased awareness on reproductive and child health issues
- Increased early registration of pregnant women at antenatal clinic for antenatal services
- Increased skilled attendants at birth
- Availability of revolving fund which is used to support the needy for transportation of obstetric emergencies to the health center.
- Improved environmental sanitation in the community
- Improved Infrastructure for the Initiative at the community level
- Developed skills in soap making and TIE & DYE for income generation
- Increased male participation in RMNCAH, Men in the communities would accompany their wives to the clinic, a practice that was very rare before the introduction of the Initiative

- Increased knowledge on services and their importance at the clinic
- Increased skilled attendance at birth as a result of increased clinical visits
- Availability of a revolving fund for the support to needy members of the community for patient escort especially obstetric emergencies to the health center. This fund is paid back without interest
- Acceptor rate for family planning increased and consequently birth interval increased
- Increased knowledge on reproductive issues and compliance to advise offered increased.

4.3 Benefits/Achievements as reported by Beneficiary communities during visit of Consultants

A famous quote from a woman in a village called Sare Samba 'before the introduction of Kaabilo Baama and Faama the community was deaf, dumb and blind on health issues especially on reproductive health. Antenatal and infant welfare clinic attendances were not valued and antenatal women and infants are taken to the clinic only when they are ill but not for routine services. Now everything has changed since the introduction of the initiative. More knowledge on RMNCAH leading to tremendous attitudinal changes and consequently better pregnancy outcomes. Specifically, the benefits as reported include:

- Increased awareness on reproductive and child health issues
- Increased early registration of pregnant women at antenatal clinic for antenatal services
- Reduced deaths among women due to pregnancy and child birth
- Increased skilled attendants at birth
- Availability of revolving fund which is used to support the needy for transportation of obstetric emergencies to the health center.
- Improved environmental sanitation in the community
- Renovated a community structure for communal meetings
- Developed skills in soap making and TIE & DYE for income generation
- No maternal death registered in the beneficiary communities in the last couple of years
- Increased male participation in RMNCAH, Men in the communities would accompany their wives to the clinic, a practice that was very rare before the introduction of the Initiative
- Male folk support their wives in labour intensive activities like pounding, fetching water & firewood
- Increased knowledge on services and their importance at the clinic
- Increased skilled attendance at birth as a result of increased clinical visits
- Availability of a revolving fund for the support to needy members of the community for patient escort especially obstetric emergencies to the health center. This fund is paid back without interest
- Acceptor rate for family planning increased and consequently birth interval increased
- Increased knowledge on reproductive issues and compliance to advise offered increased.

4.4 Impact

- No maternal death registered in the beneficiary communities in the last couple of years
- Male folk support their wives in labour intensive activities like pounding, fetching water & firewood
- Well-being of the communities improved
- High desired attitudinal change registered.

5.0 Planning and Design: Experience

The initiative was undertaken as a result of undesirable RMNCAH indicators of Kiang East. Utilization of RMNCAH services including family planning. Attendances at RMNCAH service delivery points for antenatal, infant welfare, labour and delivery and postnatal services were poor. This included late booking of pregnant women for antenatal care 14.8%, low uptake of modern contraceptives 21.6%, high maternal deaths recorded, low participation of male folk in maternal and child health services to name a few. This necessitated the RMNCAH programme unit of the Ministry of Health to implement the initiative in the districts.

The planning and design of the intervention was facilitated by community profiling of the selected villages in the area and the assessment of their reproductive health needs which was conducted through semi structured interviews with a randomly selected sample of women in child bearing age (15 to 49 years). This segment of the population constitutes about 24% of the total population of the area.

5.1 Criteria for Village Selection

The villages were selected using the following criteria:

5.1.1 Distance from the nearest health Facility.

The villages that are far from the Health facilities are usually disadvantaged and thus were considered in the selection of the villages.

5.1.2 Safety of the road to the nearest health facility

If the road from the village to the nearest health center is remote and unsafe particularly for women, a particular village would be considered.

5.1.3 Population of the Village

To maximize the impact of the intervention, villages are selected based on their population sizes. A minimum population of 500 people is required for selection to the Kaabilo Project. However, some smaller villages were included and selected due to their location. In doing so, there have been other considerations like ethnic composition,

5.1.4 Utilization of RMCAH Services

Through anecdotal evidence and Health Service records, villages that are under-utilizing RMNCAH services are identified. These villages have always been a priority for the Health Sector. In selecting the villages for the Kaabilo Project, underutilization of Health services became an important criterion.

6.0 A synopsis of the findings of the Community Profiling

Community Profiling was seen as an important tool to unearth the issues surrounding the under-utilization of RMCAH Services in Kiang East. The profiling used a combination of methods, a survey and FGD to collect the requisite information from men and women of the said communities. The findings of both the survey and the focus group discussions have crystallized the livelihood

improvement and reproductive health needs of the inhabitants of Kiang East District. Specifically, specifically the research documented the livelihood activities in which women in Kiang East District engaged in, the constraints hindering their advancement, proposed solutions to these constraints, alternative priority livelihood activities and the strengthening of the livelihood activities of their men folk to generate increased income that improves the affordability of reproductive health services. Also documented are operational strategies, policies and practices at the community level that could enhance the sustainability of project benefits after project closure.

The current state of reproductive health services in the Kiang East District both in public health facilities and the primary health care system at community level have also, to a large extent, been ascertained. The level of understanding of RCH issues by women in child-bearing age in the district has been revealed. The training of health mobilisers to raise community awareness, which has been one of BAFROW's best practices in RCH services, will attempt to improve the level of knowledge on RCH targeting women in child-bearing age, youth and men support groups to sustain such anticipated project benefits.

Constraint in the way of safe delivery in the accessible health facilities and those associated with the current underdeveloped referral system have also been identified by both women and men groups. Preferred solutions to these constraints have also been put forward. Of the strategic importance has been the proposed strengthening of Kaif major health center by addressing its myriad of constraints to improve antenatal, delivery and post-natal services to the extent of minimizing the need for referral to soma health center and Farafenni hospital. The willingness of target beneficiaries to bear the cost of improves services such as the on-going expansion of staff quarters at Kaif by community help readiness to hire ambulance services and to contract a loan for the procurement of a vehicle from referral augurs well for the proposed project given its objective of economic empowerment.

7.0 Representativeness, Community Engagement and Local Capacity building

7.1 Representativeness

The Kaabilo Baama Initiative is implemented in the two Districts of Lower River which has a total of 6 Districts. The two Districts constitute 28 per cent of the total population of Lower River Region. To ensure ethnic diversity, villages were selected based on the proportionality in terms of ethnic composition and tradition.

7.2 Community engagement

The Gambia's social structure have now become entry points for community interventions. These structure principally is the Village Development Committee (VDC). With the support of the Department of community Development, the RMCAH unit of the Ministry of health and other stakeholders met the VDCs of these villages and the village Heads to discuss the project and to obtain their blessings. Every Kaabilo in that village will then be informed of the Initiative so in effect the entire community in which the initiative is being implemented is involved.

7.3 Local institution building

One of the pillars of the Kaabilo Initiative is capacity building of the beneficiary communities. In addition to training of the Kaabilo representatives, the project builds the capacity of the women through live hood skills that can earn them a living and improve their well-being. These funds are usually demand-driven for marketable skills in the communities. The proceeds from the implementation of these skills are saved in an account and used to support reproductive, maternal and child health issues in the transportation of pregnant women in labour to the health facilities

8.0 Sustainability Mechanisms

Sustaining the implementation of the Kaabilo Baama and Faama Initiative at the community level will require innovative strategies. The measures for sustainability include the following:

8.1 Government or Local government funding:

One way to sustain the operations of the Kaabilo Initiative is through Government Subvention or Local Government funding. However, an important pre-requisite for this option is that Kaabilo Baama and Faama committees may need to acquire a legal entity and be fully nationalized for Government to provide direct subvention. An annual allocation can be provided through the Ministry of Health to the Kaabilo Communities to ensure continuation of their activities. Alternatively, the Initiative can be integrated into the National Population or Reproductive Health Programmes. Conversely the Area Councils of the beneficiary communities could allocate part of their budget for the implementation of the Initiative.

8.2 Creation of Revolving Fund:

In the absence of Government funding, the alternative strategy for sustainability is for the communities to raise their own funds to implement and sustain the Kaabilo Baama Initiative. This could be done by creating a revolving Fund which the Communities have done. However, the mechanisms that would ensure viability of this Fund need to be robust and effective. To this end, its creation should be guided by the following imperatives: Firstly, the Kaabilo Baana and should have their local committees registered to be a legal entity; secondly resources have to be mobilized through the following strategies among others: Voluntary contributions, income from the skills acquired through the intervention; fund raising through musicians, cultivation of farms and plantations etc. It should also be noted that to make the Community more complete, their capacities in the skills development during the project should be built sufficiently.

Important pre-requisite for the viability of the revolving fund include: A research on viable marketable skills should be conducted to determine the products for the livelihood component of the Initiative. Capacity Building: The capacity of the communities particularly the Kaabilo Baama and Faama Committees should be built sufficiently in marketable skills to enable them be competitive in their business undertakings. Market outlets: A market research should be undertaken to identify the market outlets within and outside the beneficiary communities

8.3 Fund Management:

This Fund which is revolving will be used to principally to conduct RMNCAH activities in the communities, should develop a Standard Operating Procedure (SOP) which should include Terms and conditions for lending, repayment and interest rate where applicable.

8.4 Mobility for the Initiative

Even though priorities may differ from Kaabilo to Kaabilo, the overarching priority of the Kaabilo Baama Initiative is to improve pregnancy outcome and child and adolescent health. Against this backdrop an indispensable element in this Initiative transportation to health facilities which was reported as the biggest challenge faced by the Initiative. Given the potentially, enormous demand on the Revolving fund, it is imperative therefore for the Kaabilos to find the most cost-effective, viable and safe means of transporting patients to the health facilities.

8.5 Institutional Strengthening

There should be more participation of the Civil Society Organizations. More NGOs have to buy-in. At the Community level, the Department of Community Development which operates at the grassroots and is responsible for Community Development need to enhance its involvement so are the Village Development and Ward Development Committees. The active participation of these institutions will not only help in the implementation of the Initiative but will also help in its sustainability.

9.0 Visit to the Kaabilo Project Sites

Best practices are procedures that have been accepted or prescribed as correct or effective. However, in documenting a Best Practice for replication, it may be helpful to obtain firsthand information from the beneficiaries of the Practice. In this regard, the Consultants embarked on a two-day visit to the project sites to meet the beneficiaries of the Kaabilo Baama Initiative. The visit covered 4 villages, two each in Kiang East and Kiang West Districts respectively. The methodology used was a Focus Group Discussion. The Discussions in all the 4 communities which had a fairly gender balance, with women slightly dominating men were participatory. The composition includes, Kaabilo Baamas and Faama Women, Youths and Village health workers.



9.1 Objectives of the Visit

The objectives of the Visit were as follows:

- To obtain information on the knowledge and understanding of the Kaabilo Baama Initiative
- To obtain information on the benefits of the Kaabilo Baama and Faama Initiative
- To identify the challenges and perceived solutions to those challenges
- To observe infrastructure or equipment for RMNCAH and Livelihood development respectively.

9.2 Knowledge on the Kaabilo Baama Initiative

Kaabilo Baama and Faama trained on the curriculum developed on RMNCAH. The knowledge and understanding of the Kaabilo Baama on this curriculum were discussed. Specifically, the discussion centered on the themes identified in Annex one of this report. When asked to explain the curriculum and modus operandi of the Kaabilo Baama, all the Kaabilo Baamas and Baamas were able to do it at ease. This signifies the extent to which these Baamas and Faamas are familiar with the Initiative albeit almost all of them are not literate.



Focus Group discussions with the Community of Jattaba, Lower River Region

9.3 Benefits/Achievements of the Kaabilo Baamas reported by the Communities

The discussions highlighted the following as the benefits of Kaabilo Baama and Faama initiative in the communities:

A famous quote from a woman in a village called Sare Samba 'before the introduction of Kaabilo Baama and Faama the community was deaf, dumb and blind on health issues especially on reproductive health. Antenatal and infant welfare clinic attendances were not valued and antenatal women and infants are taken to the clinic only when they are ill but not for routine services. Now everything has changed since the introduction of the initiative. More knowledge on RMNCAH with tremendous leading to attitudinal changes and consequently better pregnancy outcomes and decreased child mortality and morbidity among others.



FOCUS GROUP DISCUSSIONS IN KOLIOR

10.0 Partnership

10.1 Overview of Implementing Institutions.

The implementing institutions were the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) programme Unit of the Ministry of Health and, the Women's Bureau of the Ministry of Women and Children affairs. The Reproductive, Maternal, Newborn, Child and Adolescent Health programme unit is responsible for the coordination and monitoring of reproductive, maternal, newborn, child and adolescent health activities with the support of Regional Management Offices in all the health regions of the country, It is also responsible for identification of communities for the project intervention, development and production of guidelines and technical training and monitoring of the reproductive health activities in the project.

The Women's Bureau on the other hand for women empowerment including livelihood skill development and monitoring while Department of Community Development supports in linking the communities to other supporting partners, assisting in building and training of social structures like the Village development committees (VDC) on their roles and responsibilities the national population secretariat was responsible for coordination of funds provided by UNFPA

The Government provides staff at both programme level for coordination, health facility level where cases from the community are referred for management and at community level for monthly supervision of community health workers in the villages by community health nurses. They are responsible for all the logistical support for case management and transfer of cases to higher levels if the need arises

10.2 Civil Society

Civil Society organizations have been playing crucial roles in The Gambia in addressing reproductive and child health, At the community level, Women Groups of the beneficiary communities are involved in the implementation of the Initiative. However, participation of Civil Society Organizations is inadequate and needs to be enhanced.

10.3 Multilateral Agencies

Multilateral agencies provide funding and actively participate in programme monitoring. The initial funding of this project was wholly provided by UNFPA and continued to provide support for monitoring, training and retraining of the Kaabilo Baamas. The construction of a bore hole for availability of safe water supply to the facility was provided by UNICEF

11.0 Monitoring and Evaluation of the Kaabilo Baama and Faama

Monitoring and Evaluation of the Kaabilo Baama and Faama Initiative are done at various levels as follows:

Circuit level: At this level the community health nurse visits the activities of the groups in his circuit on monthly basis to discuss with them their activities for the month and also create a forum for recall on what they were taught during the training as most of them cannot read or write and rely wholly on their memories

11.1 Regional level:

Regional Health Management Teams are responsible for the overall management of health interventions in their respective regions. The regional public health nurse and community health nurse tutor at this level are directly responsible for the supervision at this level. They mainly visit the health facilities and also visit community health intervention areas periodically on regular basis.

11.2 Institutional Level

Reproductive, Maternal, Newborn, Child & Adolescent health programme unit level
The RMNCAH Office conducts quarterly monitoring of communities benefitting from Kabilo Baama Initiative. This is aimed at improving performance by interacting with members to get firsthand

information on their assigned roles and responsibilities. It is normally done with Regional Health Directorates and health facility staff. The visits look into Clinic attendance, institutional delivery, Uptake of contraception, Postnatal care, Nutrition, Immunization, referrals among others. The visits also serve as an opportunity to know their challenges and to come up with recommendations. Additionally, the visits are used to educate the members on Danger signs in pregnancy, Birth preparedness, Blood Donations Nutrition etc.

11.3 Women's Bureau

The Women's Bureau under the Ministry of Women, Children and Social welfare is responsible for managing the livelihood component of the initiative and provides seed money and training for the beneficiary communities to sustain the operations of the initiative and improve their livelihood. Apart from their own scheduled monitoring which is done periodically, the Institution also participate in the Joint monitoring normally done on quarterly basis.

11.4 National Population Commission Secretariat

The National Population Commission Secretariat is responsible for population affairs in the country and are the coordinating body for UNFPA funds and funded activities in the country. On yearly bases the secretariat planned for joint quarterly monitoring visits to selected UNFPA funded intervention sites the team includes representatives from UNFPA office and heads of different programme units. During this information is collected with regards to their performances and the effects of their intervention in the community. The joint monitoring also includes visits to the various communities where the Kaabilo Baama and Faama are implemented.

11.5 Barometer for measuring success

The success of this intervention was measured through the information obtained from the Health Management Information System as well as monitoring visits by various Stake holders including the RMNCAH unit, Women's Bureau, Population secretariat among other. The visit of the consultants to the project site, on the other hand did corroborate the evidence gathered on the success of the project.

12.0 Successes and Lessons Learned

12.1 Successes

Numerous successes have been registered by the Kaabilo Baama Initiative and they include:

The kaabilo Baama and Faama has resulted to an increase knowledge and change in attitude and practice of community members to Reproductive, maternal, newborn, child and adolescent health care and services. Early antenatal care registration has increased to 85% as against 14.82% hence an increase by 70.18% has been observed. Facility delivery has increased to 61.41% as against 38.41%, hence an increase to 32.55%. This has consequently led to reduction in both maternal and child mortality and morbidity in the communities as a result of early identification of cases and referral with provision of transport fares to those who are not able to provide.

Family new acceptors has increased to 78.4% as against 21.6%, hence an increase in the new acceptor rate of 56.43%. In addition, women have stopped keeping their family planning client cards at the health facility for fear been beaten or punished if discovered by their husbands as the practice was accepted by men equally in the community

Community empowerment, livelihood development participation for their own health were all promote. This is evident by periodic visit by kaabilo Baama and Faama in their respective households within the Kaabilos.

12.2 Lessons learned

A comprehensive baseline Survey through Household survey and qualitative techniques like FGDs should have been conducted in the beneficiary communities with a view to developing a more comprehensive monitoring and evaluation system for the Initiative. This would have made it easier to pin-point the results with better accuracy.

The beneficiary Communities reported challenges in implementing the livelihood projects. This may have something to do with the choice of the skill. In this regard a Needs Assessment on marketable skills and their viability in the beneficiary communities ought to be conducted to identify the most suitable skills for the livelihood component of the Initiative.

Beneficiary communities lamented over the inadequate capacity building and lack of equipment to continue their livelihood projects. Few days have been allocated for the skills training and to make matters worse, the equipment used for training was not handed over to these communities and this has made it difficult for continuity of the livelihood component.

At the beginning, the Initiative targeted only women but later there was a realization that men were needed for the project to succeed given that they influence most of the reproductive health decisions. The men were then canvassed into the project and since then they continue to play an active role in the implementation of the project. There is near equal participation of men, women and youths in the project leading to greater successes.

13.0 Challenges and Recommendations

13.1 Challenges

- Soap Making is one of the Skills acquired through the Livelihood component of the Kaabilo Baama and Faama Initiative. A number of Discussants complained of the high input cost in manufacturing soap making their product less competitive in the market.
- Inadequate training for Tie and Dye market & Dye is quite competitive with high quality products being imported from neighboring countries.
- Periodic unfriendly attitude of health workers when pregnant women are escorted to the facility for delivery.
- Inadequate funding for the RMNCAH and Livelihood activities.
- Lack of transport in the community for transportation of obstetric emergencies from the village to the health center.

- Unavailability of adequate water supply for gardening.
- Inadequate modern farm implements leading to increased drudgery of women.
- Inadequate skill training for income generation.
- High cost of materials for tie and dye making.

13.2 Recommendations

- Market survey to determine the most marketable skills that can earn them an income.
- Adequacy capacity for both RMNCAH and the livelihood skills should be built for the Kaabilo Baama and male action group Initiative to ensure sustainability of the Initiative.
- Creating awareness and strengthening quality of Care among health workers to ensure better care and service from Health care providers.
- Create and operationalize the Revolving Fund for RMNCAH activities.
- Kaabilo Baama Faama should develop strategies for cost effective and safe ways of transportation to the Health facilities. Some of the transport recommended was scooters which consume less fuel and its user friendly for pregnant women.
- Provision of water supply for women's vegetable gardens. This will not only help in generating income for the Kaabilo Baama and Faama Initiative but will also boost nutrition among children.
- Provision of modern farm implements for women.
- Involvement of other community structures like the Multi-Disciplinary Facilitation Teams implementation teams will pay a great dividend.

14.0 Future plans: extension that are currently being implemented

The intervention is extended to other 18 communities and community assessment in fifty of these communities including health facilities in some underserved areas of the country for expansion funded by West African Health Organization. Following the assessment, training of Kaabilo Baama Representatives has just been completed at Soma, Lower River Region.

15.0 Replicability and Scalability to promote South-South Cooperation

- Pre-requisites for replication in other countries.
- Awareness creation and advocacy on the Kaabilo Baama and Faama Initiative.
- Political commitment to addressing Population and Reproductive Health issues.
- Availability of Human, Financial and Technical resources in the beneficiary country for the Initiative.
- Seek partnership with and support from Bi-lateral and Multi-lateral Institutions in the domain of Population and Reproductive health particularly UNFPA and the World Bank.
- Community profiling/Needs Assessment to ensure the Initiative is a felt needs in the targeted communities. Otherwise, sustainability might be challenged Perceived solutions to those needs should also be identified by the communities of intervention.

- Following the Community Profiling/Needs Assessment, a comprehensive project document should be developed in a participatory manner which should contain. Among others, a logical Framework, Implementation plan, monitoring and evaluation Mechanism as well as a proper institutional framework.
- Resource mobilization for the implementation of the Initiatives.
- National and community stability.
- Community must be willing to accept the Initiative. The Kaabilo Baama must therefore be all inclusive, participatory and owned by the beneficiary communities to ensure its sustainability.

15.1 Experience in replicability in other South-South Countries

The RMNACH Unit of the Ministry of Health has not reported experience in replicating Best Practices in other countries through South-South Cooperation. However, in 2005, the Unit implemented an initiative which is considered a Best practice with Partners from United Kingdom called Maternal and Child Advocacy International in the Gambia in 2006. The objective of the intervention was to reduce and/or prevent maternal and newborn morbidity and mortality especially in the communities. The intervention two- fold and these are: 1. Training of health staff to enable them appropriately manage obstetric and newborn emergencies during transportation and at the facility and 2. Equipping the facility with basic equipment and provision of an ambulance serviced called the Flying Squad which was used to collect obstetric and newborn emergencies from the community to the health facility.

Training was done by an expert team from United Kingdom comprising of obstetricians, pediatricians, nurse midwife and course coordinator and conducted in batches of 24 for a duration of 3days intensive lectures, scenarios and lifesaving skill demonstrations on various emergency situations.

The National trainers were later deployed to Liberia and Sierra Leone to conduct similar training for the health staff in those countries. So, in essence the RMNCAH unit has some transboundary experience that can be invaluable in replicating the Kaabilo Baama and Faama Initiative.

15.2 Suggested steps for replication in other countries

- Identification of a stable and peaceful country.
- Identification of stable districts in a region.
- With the use of statistics, identify communities with low utilization of RMNCAH services.
- Conduct a Community Profiling in which Baseline data is collected using quantitative and qualitative methods.
- Compile data from the health facility serving the targeted communities.
- Analyze the data from the Profiling and Health Facility.
- Develop a project proposal for the Kaabilo Initiative and male action group. The document should include a log frame, Results chain, baseline indicators, and a comprehensive Monitoring and Evaluation Mechanism.
- Consult Village Heads the VDCs and CSO for them to accept and buy-in the implementation of the Kaabilo Baama Initiative.

- With the guidance and support of the Village Head and community elders, conduct selection of Kaabilo Baamas (2 females) and Faama(2males) by the respective Kaabilos in the village.
- Develop training materials. These materials could be in English or any other language. Pictorials/ Posters should be developed for communities who cannot read or write Training of committees.
- Provision of Guidelines.
- Follow up supervision after training and during implementation.
- Home visits for awareness creation on the Initiative by the Kaabilo Baamas and Faamas using pictorials, flip charset targeting the Households in the homes.
- On-going sensitization and advocacy on the Initiative by the Kaabilo Baamas and Faamas at social gatherings in the communities.

16.0 Potential Partnerships

The Gambia is committed to the promotion of South-South Cooperation in the context of Partners in Population and Development and would be willing to play an active role in any replication of the Kaabilo Baama and Faama Initiative. Both Government and NGOs who played a crucial role in the design and implementation of this community initiative may be willing to lend a hand. Additionally, UNFPA (the main Partners), the World Bank, WHO and other institutions supporting population and development activities could be mobilized to provide financial support in replicating the project., However, given the resources constraints of the RMNACH Unit and other Partner Institutions in this endeavor the Country may only be able to provide the following in any replication:

Contacts

Dr. Marena, Programme Manager, Reproductive, Maternal, Newborn and Adolescent Health Unit, Ministry of Health.

Kanifing. Ministry of women's and Children & Social Welfare.

Annex one

Topics covered in the training Kaabilo Baama and Faama

PREGNANCY

- Booking early for your antenatal care (ANC) Visit
- Eat a healthy diet during pregnancy
- Take your iron folate tablets as prescribed
- Birth preparedness
- Recognizing danger signs during pregnancy

LABOUR AND DELIVERY

- Signs of labour
- Delivery in a health facility
- Put your baby to your breast within one hour after delivery
- Three postnatal care visits for you and your baby

CHILDHOOD

- Give only breast milk to your baby from birth to 6 months
- Good positioning and attachment
- Express your breast milk when you are separated from your baby
- Start complementary feeding when your baby reaches 6 months
- How to prepare an ideal complementary meal for your baby
- Ensure that your children receive adequate amounts of vitamin A either in their diet or through supplementation

PREVENTION OF ILLNESSES

- Immunization
- Growth monitoring
- Sleep under treated mosquito net all year every night
- Wash your hands after defecation, before preparing meals and before feeding your children
- Appropriate home treatment of malaria, diarrhea and pneumonia
- Recognize when a sick child need treatment outside the home and seek care from appropriate providers
- Adolescents 15 _19 YEARS
- What is adolescent
- Changes that girls and boys experience during puberty
- How a woman becomes pregnant
- Delay and prevent pregnancy
- Using family planning
- Feeding at six months
- Acute malnutrition in children
- Services offered by Kaabilo Baama and Faama
- Compound visits to discuss with families on reproductive health issues
- Registration of all pregnant women in the community.
- Monitoring of all antenatal for their clinic attendance.
- Awareness creation in the community on the importance of clinic attendance, voluntary and early registration of pregnant women, family planning, male participation, environmental cleanliness
- Informing the community of their clinic days(schedule)
- Escorting labour cases to the health center for skill delivery
- Tie & dye for income generation for the village
- Scheduled weekly activities/schedule
- Crowd arrangement and health talks at the antenatal clinics

Annex Two

List of Communities in the Kaabilo Baama and Faama Initiative

KAIANG EAST PHASE ONE

1. KAIAF-----	3 KABILOs
2. GENERRI-----	4 KABILOs
3. TORANKA BANTA-----	2 KABILOs
4. MEDINA SANCHA-----	7 KABILOs
5. MUKUTALA-----	2 KABILOs
6. NJOLFEN-----	4 KABILOs
7. SARE SAMBA-----	3 KABILOs

KAIANG EAST PHASE TWO

1. KOLIOR-----	3 KABILOs
2. JASOBBO-----	3 KABILOs
3. JOMARR-----	3 KABILOs
4. JALLOW KUNDA-----	1 KABILO
5. SARE BABOU-----	1 KABILO
6. SARE PATEH-----	2 KABILOs
7. MEDINA CEESAY KUNDA-----	
8. YOROJULA-----	1 KABILO
9. MASEMBEH-----	3 KABILOs
10. SARE MUSA-----	1 KABILO

KIANG WEST PHASE THREE

1, JATTBA-----	4 KABILOs
2. JIFARONG-----	4 KABILOs
3. KULI KUNDA-----	2 KABILOs
4. KARANTA -----	4 KABILOs
5. JANNEH KUNDA-----	6 KABILOs
6. TANKULAR-----	4 KABILOs
7. JALI-----	4 KABILOs

TOTAL OF 77 KABILOs and 308 MEMBERS IN 24 COMMUNITIES FROM 2012 -2020

Annex Three

Funding from UNFPA to RMNCAH

No	Year	Budget Total (GMD0)
01.	2015	D576,028,00
02.	2016	D449,899.00
03.	2017	D195,000.00
04.	2018	D404,800.00
05.	2019	D541,720,00
Total		D2,167,447 USD 43,349.00

It should be noted that UNFPA also provides funds for the Women's Bureau for the Kaabilo Baama and Faama Initiative. At the time of writing this report, the amount involved for that funding component have not been received for inclusion into the report.

CONTRIBUTORS

Lamin Nyabally

Lamin Nyabally is a Demographic Statistician with a Masters Degree in Population and Development, University of Wales UK. Lamin has been in policy and programme development, implementation, monitoring evaluation and coordination for nearly 30 years. During this period, he served as Director of Population Affairs and was responsible for the Population Programme which comprised of 8 projects including Sexual and Reproductive Health and Family Planning, Gender and the Empowerment of Women, Population etc.

Ba Foday Jawara, Consultant The Gambia

CHAPTER 6

GHANA ADOLESCENT REPRODUCTIVE HEALTH PROJECT

Bernard Erasmus Kojo Vikpeh-Lartey

1. Overview of Ghana

Ghana is a country located along the Gulf of Guinea in West Africa. It is bordered to the north by Burkina Faso, Côte d'Ivoire to the west, and Togo to the east. To the south is the Gulf of Guinea, with a coastline of about 560 km. The country has a total land area of approximately 238,535 km². The Greenwich Meridian passes through the port city of Tema, while the equator falls just 30 below the country.

Ghana is a unitary democratic republic headed by an elected President, with separation of power among the Executive, Legislature and the Judiciary. It operates a decentralised local government and administration system consisting of 16 administrative regions which are sub-divided into 260 Metropolitan, Municipal and District Assemblies (MMDAs).

The population of Ghana is currently estimated to be at 30 million. Ghana's population has increased rapidly over the years from 6.7 million in 1960 to 24.6 million in 2010 with more than half of the population (51%) being females. With an inter-censal growth rate of 2.5 percent, the population is expected to double in 28 years. Ghana is a fast urbanizing country with nearly 55 per cent living in urban areas and by 2030 65% of the population will residing in urban areas. The age and sex structure of the population reflects a youthful population with 38 percent of the population under 15 years of age. With such a youthful population, there is an in-built momentum for further growth. Ghana is experiencing a demographic transition with both fertility and mortality levels declining.

Life expectancy at birth is currently estimated to be 64 years (63 years for males and 65 years for females). Maternal mortality is still at 310 from a high 451 deaths per 100,000 live births while under-five mortality has declined from 155 deaths per 1000 live births in 1988 to 60 in 2014.

The use of modern contraceptives among women in Ghana has increased in fourfold between 1988 (5.2 percent) and 2014 (22%) with a corresponding decline in TFR from 6.4 to 4.2 within the same period. However, there is a high unmet for family planning among 1 in 3 women. In 2009, Ghana attained lower middle-income status. Ghana has a GDP of \$66.98 billion and a capita income of \$2,202 in 2019. The largest contributor to GDP is the service sector (53%) followed by agriculture (24%) and manufacturing (10.5%). The remaining 12.5 per cent is made up of mining, petroleum and construction. Approximately 11 per cent of the population lives below the international poverty line of US\$1.90 per day.

2. General Information Sheet on Project setting

- a. Name of country: Ghana,
- b. Name of the State or Province in the Country: Brong Ahafo Region (in all 27 Districts) and Ashanti Region (3 Metropolitan Assemblies)
- c. Type of Community if appropriate: All districts in Brong Ahafo Region Three Metropolitan Assemblies in Ashanti Region.
- d. Number of Beneficiaries: Over 459,000 (Reached with ASRH messages and over 205,000, (Adolescents provided with ASRH Services) and (Over 8,081 Individuals trained).
- e. Kind of Intervention:
Adolescent reproductive health with the following components: 1) Adolescent-Friendly Health Corners, 2) Adolescent Clinic Days, 3) School Health Clubs, 4) YOLO/YMK, 5) Mobile Application.
- f. Implementing Institution: MOH/GHS, GES/SHEP, NYA, NPC, UNFPA, USAID and five (5) NGOs namely, PPAG, HFFG, MAP+, WILDAF and ISRAD.
- h. Details of Institution with e-mail address
- i. Head of the Institution: Ministers, Regional Directors, Executive Directors and Country Directors etc.
- j. Implementation Period: January 2014 – September 2017
- k. Budget: 12.3 Million Great British Pound Sterling.

3. Project overview

The Ghana Adolescent Reproductive Health (GHARH) project provided quality sexual and reproductive health (SRH) services to adolescents as the core mandate. To promote this idea a number of service delivery platforms were rolled out by GHARH partners to meet the special needs and circumstances of adolescents. The project was initially implemented in one region (all 27 districts of the Brong Ahafo Region) and later up scaled to another region (three Metropolitan Assemblies of the Ashanti Region).

The GHARH Project supported the establishment and operationalization of 54 Adolescent-friendly Health Corners, 36 Adolescent Outreach Clinics and 457 School Health Clubs. There were over 459,000 beneficiaries (Adolescents and Youths) who were reached with ASRH messages, over 205,000 Adolescents and Youths were provided with ASRH Services, over 129,000 ASRH information materials were produced, over 8,081 individuals were trained by the project and over 803 Adolescent service platforms were established by the GHARH Project.

The implementation period for the GHARH Project lasted from January, 2014 to September, 2017 with a budget of £12.3 million United Kingdom Government fund through DFID. The ultimate goal of the Project was to improve Maternal and Adolescent Reproductive Health (ARH) outcomes in order to enhance progress towards the achievement of MDG 5. Now SDGs

4. Implementing Institutions/Development Actors

The project Implementation was done through a multi-Agency led coordination framework with the National Population Council Secretariat (NPCS) working closely with the Ministry of Health/Ghana Health Service (MOH/GHS), the Ghana Education Service/School Health Education Programme

(GES/SHEP), the National Youth Authority (NYA) and the Regional Coordination Councils (RCCs) of the Brong Ahafo and Ashanti Regions. The 27 District Assemblies in the Brong Ahafo Region and 3 Metropolitan Assemblies in the Ashanti Region were the direct implementers of the district level grant activities. The GHARH Project was managed by the Futures Group Europe (FGE), now the Palladium Group. The Project oversight was provided by a National Steering Committee which guided programme implementation process.

There were five (5) Non-Governmental Organisations (NGOs) recruited on to the Project as part of the implementing partners (IPs) to support the implementation of the GHARH intervention in the Brong Ahafo Region. These NGOs were: 1) Planned Parenthood Association of Ghana (PPAG), 2) MAP International, 3) Hope for Futures Generation (HFFG), 4) Institute of Social Research and Development (ISRAD) and 5) Women in Law and Development in Africa (WILDAF). The first three (3) NGOs worked in the area of service provision whilst the remaining two (2) also worked in the areas of research and advocacy.

5. Overview of the practice, objectives and results

5.1 Adolescent-Friendly Health Corners:

The 'adolescent-friendly health corner' was a health intervention strategy developed by the GHARH Project to provide a conducive environment for the provision of sexual reproductive health (SRH) services in a clinical setting. The 'adolescent-friendly corners' were intended to serve adolescents better by responding appropriately to their needs, particularly regarding hours of operations, and limiting stigma and other barriers associated with accessing services in regular clinical settings. In collaboration with GHS, the GHARH project successfully supported the establishment of fifty-four (54) 'Adolescent-Friendly Health Corners' within the project period, two (2) each in all the 27 districts in the Brong Ahafo Region. All 54 adolescent-friendly corners were renovated, furnished and supplied with minor medical equipment and are still in use providing services including counseling, family planning, health screening (including for STIs and HIV), pregnancy testing, ante-natal and post-natal care services and health education. The adolescent-friendly health corners are also used for recreational purposes in order to attract adolescents and provide a welcoming environment for the adolescents.

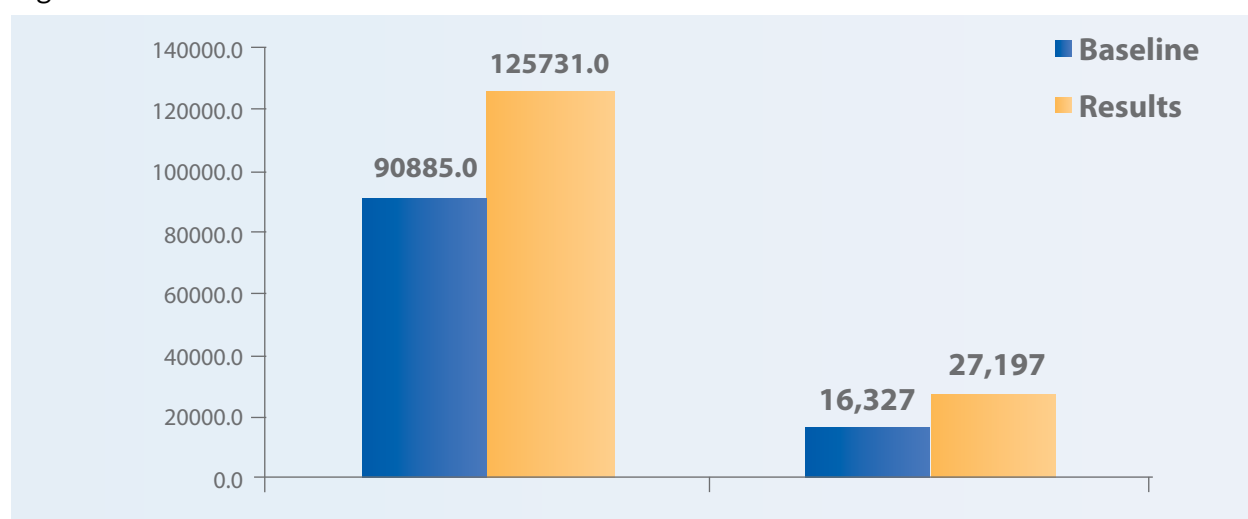


A well-trained qualified nurse providing sexual reproductive health service to an adolescent at a designated 'Health Corner'

5.2. Adolescent Health Outreach Clinics (Adolescent Clinic Days):

GHARH supported the adoption of adolescent clinic days to reach adolescents with SRH information and services. This was done mainly through service outreach. GHARH collaborated with GHS/RHD to set aside one day of the week as an adolescent only clinic day for the provision of free, targeted ASRH and family planning services. This was informed by the realization that adolescents were uncomfortable accessing reproductive health services in the presence of adults. Staff managing these clinics were enthusiastic nurses and healthcare workers who had received specialized training under GHARH. Data obtained from tracking service utilization showed that these outreach clinic days contributed to service uptake among adolescents.

The chart below presents the breakdown of service uptake among adolescents in the Brong Ahafo region.



Source: DHIMS March 2017

Figure 1: Uptake of family planning service among adolescents at baseline and completion

5.3. Adolescent School Health Clubs:

The 27 districts in the Brong Ahafo region committed to strengthen School Health Clubs as platforms to provide health information to adolescents and young people to allow them to make informed decisions and choices. The core values of the clubs were promoting abstinence, responsible sexual behaviour and choices, assertiveness in dealing with peers and adults, leadership, problem solving and communication skills, while also providing counseling and referral where necessary and promoting understanding of sexual and reproductive health issues.

In 2015, 457 Adolescent Health Clubs were set up and inaugurated in junior high schools in the Brong Ahafo region. Peer educators and school-based SHEP Coordinators were also trained to lead and manage the club activities. As part of capacity building for students and teachers, five (5) Non-Governmental Organisations (NGOs) which ones were contracted under the GHARH project to provide technical support to the clubs. Debates were also organized for schools to compete among themselves.



The launching of School health clubs in Sunyani in the Brong Ahafo Region.

5.4. Communication, Mass Media and Advocacy:

Another area of major accomplishment of the GHARH project was communications, use of mass media and advocacy activities. The GHARH project developed, produced and aired a multi-agency coordinated mass media campaign. The project initiated the weekly airing of major television drama series – YOLO (You Only Live Once) and YMK (You Must Know). The combined package was a collaboration between two GHARH partners, the National Population Council (NPC) and Ghana Health Service (GHS).

YOLO was a 13-episode drama series that educated, entertained and provided guidance on issues that affected adolescents, including their sexual and reproductive health. The YOLO series had two (2) target groups. The primary groups were young people between the ages of 10 to 19 and 20 to 24 years. The secondary target groups were parents, guardians and the extended family as well as stakeholders at different levels of policy and decision-makers, community and opinion leaders and the media etc. The GHS 'chit chat' in-studio discussion sessions complimented YOLO and provided a platform to discuss the issues raised in the drama by a diverse team of technical experts, young people, Queen mothers, Chiefs and Opinion leaders, addressing both traditional and modern perspectives in responding to adolescent sexual reproductive health issues.

Active social media engagement was also packaged into the campaign, with YOLO accounts created on Facebook, Twitter, Instagram and YouTube during August and September, 2015. Each of these platforms provided details on YOLO initiative and included content appropriate for adolescents on reproductive health.

5.5. Advocacy:

In addition to the Government partners who were provided with grants under the GHARH, five (5) civil society organisations (CSOs/NGOs) were recruited to implement grants at the community levels. The CSOs/NGOs complimented the work of the district assembly grantees. Hope for Future Generation (HFFG) and Institute of Social Research and Development (ISRAD), two of GHARH's NGO partners, reached out to traditional, religious and community leaders to sensitize them about ASRH issues, and garnered their support. A total of 103 queen mothers and 350 Chiefs, religious and traditional leaders were oriented on ASRH and pledged their support for the advocacy efforts in their districts and communities.

5.6. Mobile Application:

Additionally, GHS completed the first phase of the re-design of the AHDP website and GHS-ADH-Mapp mobile application in support of e-learning for service providers and increased access to information for young people.

The GHS-ADH-Mapp won the Ghana Health Service special award for best innovation for the year 2015. The Mobile Application is available for download on the Google play Store, and there are currently 417 service providers and health managers using the application for various purposes.

The e-learning core system has been designed and an instructional designer assisted with the electronic programming of content.

6. Background and justification:

Within the context of DFID's support for interventions that were meant to assist the achievement of MDG 5 in Ghana, a Business Case was developed in early 2012 to strengthen programming for adolescent sexual and reproductive health (ASRH). GHARH had the aim of improving maternal and adolescent reproductive health (ARH) outcomes in order to improve progress towards MDG 5.

According to the 2010 Ghana Population and Housing Census, adolescents and young people aged 10 – 24 years accounted for about one third of the population. Unplanned/unwanted pregnancies and high rates of abortion (sometimes unsafe) in young people was a significant problem as a result of early initiation of sex (including coerced sex) and low use of condoms and other modern contraceptives. Although there were positive trends (e.g. increasing age at first sex, increasing adolescent contraceptive use and decreasing adolescent birth rates, pregnancy in young people, particularly adolescents), remained a challenge that had important implications for Ghana's achievement of MDG 5.

It was also important for the health and development of adolescents, particularly girls; for their potentials to benefit and contribute to their families and communities as they transitioned to adulthood.

Reproductive health outcomes among adolescents were a challenge, although some notable progress was being observed. Data from the 2014 Ghana Demographic and Health Survey (2014 GDHS) indicated that one in ten teenagers has already had a child (11%) and another 3 percent were pregnant with first child and among 19 year olds, close to one-third (29%) have begun childbearing.

The survey further showed that adolescent childbearing occurred more among rural than urban counterparts (17% versus 12%). In this context rural, hard to reach communities and older adolescents needed to be reached more with appropriate interventions.

On contraceptive use, it was estimated that maternal mortality could be reduced by 25% to 30% if women had access to and used modern methods of contraception. The 2014 GDHS showed that contraceptive prevalence rate for modern methods for all women was only 22 percent. Yet, only 39 percent of the current need for family planning (FP) was being met by modern methods and the gap was greatest among the less educated, the poorest households, and adolescents aged 15 – 19 years, where nearly two-thirds had unmet need.

A study showed that among women (including young people) with an unmet need, 45% had access to and a favorable attitude towards contraceptives, 32% had access but did not have a favorable attitude, and 23% did not have access.

Many factors accounted for the high levels of unwanted pregnancies, both individual factors (for example lack of knowledge and skills) and also more distant determinants; rural domicile, poverty, lack of access to education and health services/family planning commodities and harmful social/cultural norms, including attitudes to pre-marital sex and pervasive gender inequalities.

In Brong Ahafo as elsewhere in Ghana, socio-cultural and economic factors, such as early marriage, inadequate parental communication, low educational attainment (on both parents and adolescents) and widespread poverty made it challenging for young people to lead well-informed and healthy reproductive lives. While some activities existed in the Brong Ahafo and the other regions to address these issues, they needed to be strengthened along with a more holistic model that mobilized local community actors to better integrate service provider efforts.

Comprehensive health and sexual education for in-and-out-of-School adolescents, as well as increase contraceptive usage amongst young people was needed and young people themselves needed to be more engaged in this process. Stakeholders in youth development, who influenced young people's social and cultural environment, such as parents, teachers, traditional leaders and local governments also needed to be more engaged and well informed about adolescent sexual and reproductive health (ASRH) issues.

The GHARH project in the Brong Ahafo region aimed to have a positive impact on young people's sexual and reproductive health by responding to different determinants of ASRH at individual, inter-personal, organisational, community and structural levels, including attention to both the demand side and the supply side aspects of the provision of health services and commodities.

6.1. Why was the Practice/Project important?

The Practice/Project was important because of the following:

- The need to increase young people's access to appropriate health information;
- The need to increase young people's access to and use of health services;
- The need to enhance the social, legal and cultural environment for the improvement of young people's health;

- The need to improved young people's participation in the implementation of services, to generate demand and increase utilization;
- To ensure improved management of programmes for young people's health, including resource mobilization;

6.2. Challenges and Constraints

Some of the main challenges/constraints faced by the GHARH Project in meeting its objectives were:

- Delays in procurement related to the refurbishment of the 54 ARH Corners,
- Extended period of finalizing work plans,
- Personnel changes/turnover at the District Assemblies necessitating the need for additional capacity building,
- Staff turn-over contributing to change in team membership-this affected continuity,
- Utilization of programme's Technical Assistance Fund (TAF) was initially slow,
- Inadequate funding compelling districts to prioritize and plan for few activities,
- Inconsistence in data reporting,
- Poor team work among some districts,
- The period for implementation of project activities was relatively short,
- Social norms as well as religious/Cultural sensitivity served as barriers to ASRH programming,
- Implementation of School Health activities, particularly those aspects related to the content of the curriculum for Comprehensive Sexuality Education (CSE) and the clear focus on abstinence only messages,
- The preparation, analysis and submission of end-of project reports from the Brong Ahafo Region grantees took a much longer time than expected.
- Ensuring sustainability of the ARH programming as the programme came to an end was a big challenge,

7. Goals and Principles

The project had the ultimate goal of ensuring that more girls and women were empowered to achieve their full potential.

The intervention further addressed the following four (4) key objectives:

- Improve access to and utilization of quality health services by adolescents,
- Improve access to appropriate health information by adolescents and youth aged 10 to 24 years,
- Create a supportive environment for the development of the adolescent friendly health services,
- Strengthen the Government of Ghana's capacity to implement and manage delivery of the ARH programme (Multi-Sectoral Coordination and Partnerships).

The implied principles of the project were:

- The right of young people to information on their sexual health
- The right of young people's access to and use of family planning services

- The right of young people to participate in implementation of services that affect their health.

To achieve the stated objectives, the project focused on increasing awareness, knowledge and provision of ASRH services; developing friendly ASRH services and building provider capacity; generating evidence-based data through various operations researches to improve uptake of ASRH services and increasing access to and availability of affordable family planning commodities.

Therefore, in line with the project outputs, in the first year, the project implementing partners conducted sensitization fora with stakeholders, policy makers and the general public, organized community durbars and floats across the 27 districts and promoted the use of radio stations/ community information centres to create demand and use of ASRH services. These awareness-raising activities were designed to create supportive environment in the various communities. Through the adolescents' health corners, access increased for adolescents to benefit from ASRH service provision and awareness was raised about the reproductive health consequences regarding early childbearing. About 54 adolescent health corners were established and assessed for service provision and 457 School health clubs were also established across all the 27 districts in the Brong Ahafo region.

8. Description including Activities, Achievements, Outcomes and Impact:

8.1. Main activities of the project

To effectively tackle ASRH issues in the focused region, GHARH partners across the 27 districts implemented the under listed core activities to increase access to services and create significant awareness on ASRH issues:

- Refurbished 54 ARH Corners to expand service outreach,
- Stakeholders' forum to sensitize gatekeepers on ASRH issues,
- Demand creation activities
- Orientation meeting for GES managers of the School health programme,
- Orientation meeting to sensitize Pastors and Imams,
- Community durbars,
- Talks on ASRH in churches and mosques,
- Orientated women and men's groups on ASRH,
- Used radio and community information centres to create awareness on ASRH,
- Sensitized basic school PTA and SMC Executives on ASRH,
- Used outreach clinic days to targeted adolescents with RH services,
- Formed out-of-school youth clubs,
- Drama/cultural displays in communities,
- Sensitized out-of-school adolescents living with disabilities on ASRH issues,
- Orientation for out-of-school youth parents for increased parental guidance and support,
- Organized fan games/sports "edutainment" for out-of-School adolescents in major communities to create awareness on ASRH issues,
- Sensitized Queen mothers on ASRH,

- Organized Monthly ante-natal and child welfare clinics day for adolescents,
- Established and launched School Health Clubs at the Junior High School level,
- Identified role models to visit selected schools to interact with and mentor in-School adolescents on ASRH issues,
- Organized sensitization programme for out-of-school youth targeting (beauticians, tailors, skilled men associations),
- Capacity building for out School youth leaders,
- Trained head teachers, basic school coordinators and guidance and counseling coordinators at the Junior High School level,
- Trained Healthcare providers and supervisors for 5 days on ASRH counseling and family planning methods,
- Trained and orientated in-school peer educators on ASRH manuals and club activities,
- Trained out-of-school peer educators,

8.2. Achievements to date in respect to outcomes:

Key achievements under the GHARH Project to date included the following:

- Contributed to an improved policy and enabling environment for the prioritization of ASRH in Ghana,
- Three (3) major policy and strategy documents in relations to the project finalized: 1) The Revised National ARH Policy – 2016, 2) The Adolescent Health Service Policy and strategy – 2016 – 2020 and 3) The Revised NPC strategic Plan – 2017 – 2024.
- Established multi-stakeholders coordinating structures at National and Regional levels,
- Over 204,805 adolescents reached with ASRH services,
- Fifty-four (54) Adolescent Health Corners refurbished to provide ASRH services,
- Established 457 Adolescent School Clubs to educate, promote and provide ASRH services,
- Introduced ASRH information dissemination using health Technology to increase demand for and provide quality ASRH services,
- Over 8,081 individuals successfully trained,
- Over 803 services platforms, including School Health Clubs established and made functional.
- Over 129,000 ASRH information materials produced.
- Over 459,000 individuals reached with ASRH messages.
- GHARH's Operations Research findings have increased the ASRH evidence-based and informed programming.
- Built research capacity and leadership within local academic institutions and research centres in fostering policy dialogue in Ghana,
- Created a forum for the National Steering Committee on ARH to share experiences and knowledge on ARH programming and also facilitated effective collaboration amongst partners,
- Use of the Media, both Traditional and Social Media, helped to create an enabling environment for Social Behavioral Change Communication (SBCC),
- Increased in family planning acceptors,
- Reduced Teenage Pregnancy rates among adolescents,
- Improved relationship between service providers and adolescents,

- Outreach services catered for the needs of out-of-school adolescents,
- Increase in the numbers of adolescent friendly health facilities across the Country,
- Establishment of School Health Clubs have deepened the understanding of ASRH issues among in-school adolescents.

8.3. Summary of strengths and weaknesses

In spite of the numerous successes chalked by the GHARH Project, the project had its strengths and weaknesses. These strengths and weakness of the GHARH Project could be summarized into achievements and constraints which have been boldly explained in the above sections. What is the relevance of this section?

9. Outcomes and Impact

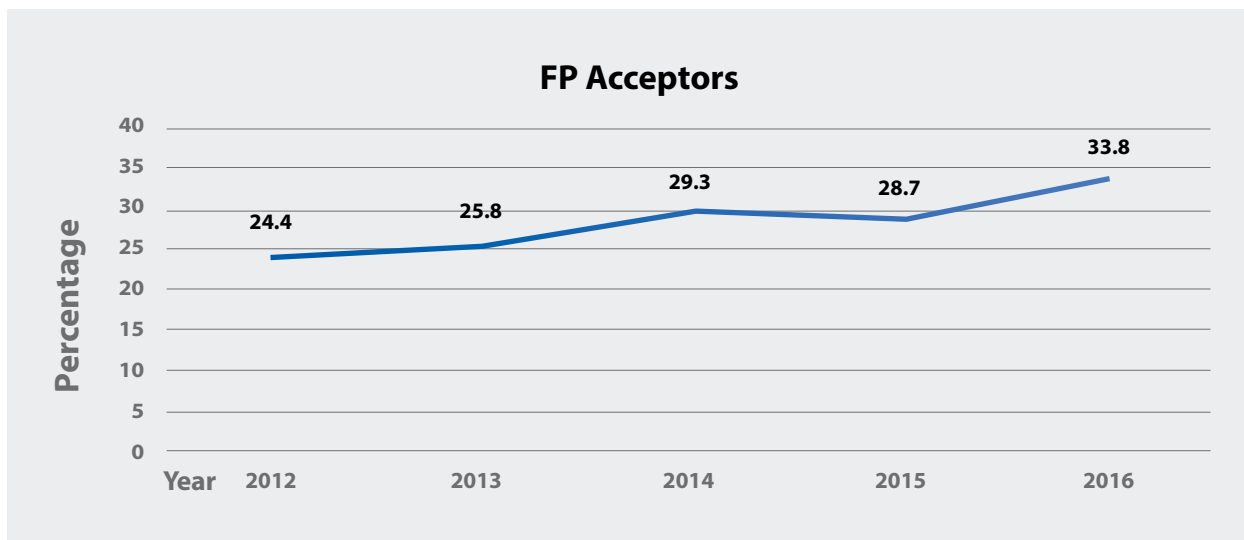
The implementation of the Project in the Brong Ahafo region led to the reduction in teenage pregnancy and abortion rates partly due to the high family planning uptake among adolescents; the effective management of adolescent sexual and reproductive health issues due to the creation of Adolescent Health Corners and School Health Clubs; and improved relations between health service providers and adolescents which has boosted the adolescent's confidence and trust in health care facilities.

The GHARH Project implemented in the Brong Ahafo Region achieved its set objectives and also made impact on the targeted beneficiaries, thus the youth and adolescent population in the focused region. By the end of the GHARH Project there were over 459,000 individuals who had been reached with ASRH messages. The project also designed and produced over 129,000 ASRH information materials which were distributed to youths and adolescents in the region.

These are outputs already stated above.

Concerning service delivery, the GHARH project was able to provide ASRH services to over 205,000 youths and adolescents in the project coverage areas. The GHARH Project also trained over 8,081 individuals who worked on the project as well as targeted adolescents and youths from the communities that implemented the project.

The GHARH Project was able to establish over 803 adolescent service platforms which offered opportunities to the youth and adolescents to chat, exchanges ideas/messages on ASRH issues.



10. Planning and Design Experience

10.1. Process of planning:

The planning and design of the GHARH project was based on the adolescent reproductive health situation in the country and ongoing efforts at improving ARH. Initial planning activities involved extensive review of relevant national strategies and project documents. The review identified five key pillars of the strategy set for the period 2009-2015. Which 5 pillars (refresh)

Capacity strengthening of implementing institutions: The project also identified and defined capacity strengthening needs at national, regional and district levels. The project utilised a facilitated self-assessment exercise to undertake the organisational capacity assessment (OCA). The capacity assessment process supported the NPC and organisations involved in ARH in Ghana to establish a baseline of capacity in key areas. The assessment promoted organisational dialogue, learning, and standard-setting; and informed the development of the capacity strengthening plan for addressing organisational priorities.

Formation of steering and technical committees: At the governance level a multi-sectoral National Steering Committee was constituted as the highest body at the technical level to govern the strategic direction and monitoring the progress of the project at the national level. Similarly, a Regional Technical Committee and District Technical Committees were formed to provide technical direction to the project at the field level and the Regional and District Assemblies, and worked closely with the project team.

Development of Operational Plans: The drafting of the district and ARH sector plans was done to facilitate the grant making process. Two (2) Consultants were contracted by DFID to work with NPC to develop National, Regional and District plans for the GHARH Project. The plans contained activities related to the five (5) Objectives of the Ghana Strategic Plan on the health and Development of Adolescents and young people 2009 - 2015 that would improve the health of and

development of adolescents aged 10 -19 years in Brong Ahafo Region. The Consultants then rated the adequacy of the plans' readiness for grant award.

Selection Approach: The project business case pre-determined the implementation arrangements for the project and made a clear case that the project would be led by Government Partners (NPC, GHS, GES/SHEP and NYA) and the RCC in Brong Ahafo Region. This process was re-enforced through capacity strengthening support to ensure that Government Partners were able to effectively coordinate and manage a multi-sectoral ARH Project.

Inclusion of NGOs: Several consultations informed the importance of including NGOs/CSOs/CBOs and the private sector in the partnership arrangements to implement ARH activities. Particularly for the social environmental context enablers, NGOs have shown strong capacity to develop and implement programmes at the community level. Forging partnership between NGOs and Government Agencies had proved a win – win strategy for delivery on the project objectives. DFID Stakeholders' assessment clearly showed that the Ghana programme environment had seen several strong NGOs emerge with requisite capacities to implement ARH programmes. Organisations such as Planned Parenthood Association of Ghana (PPAG), IPAS, Marie Stopes International, Creative Storm, Christian Council of Ghana and a number of Community-based Organisations (CBOs) had contributed to adolescent health and development interventions.

Proactive Proposal Solicitation: As part of the due diligence requirements and value for money propositions, an active proposal solicitation process was designed to capture the inputs and contributions of local talents and research institutions with the needed capacities to contribute their expertise to project implementation activities.

Grant Making Process: Based on the 'Core Package' of interventions recommended for funding, a phased grant roll-out process was adopted. The GHARH finance and grant management specialist and team developed a system and disbursement schedule to support the roll-out of the grant funds. Using a set of criteria developed and informed by pregnancy rates in the 27 districts of the Brong Ahafo Region, nine (9) districts were selected for the first phase roll-out. The FGE grant management team carried out due diligence assessment in the districts prior to grant awards. This was followed by training and orientation of key finance staff at the district Assemblies on the grant manual and disbursement and fund management guidelines provided to the districts in readiness for grant disbursement. A direct channeling of funding modalities was agreed and endorsed by the National Steering Committee (NSC). Funds followed directly from the project account to an identified account at the District Assemblies and funds were expended and reported on.

Immediately following the completion of the first tier districts grant disbursement, the second tier districts were rolled-out, and then followed by the third tier districts rolled-out. Managing the grant portfolio was a critical success factor and had been considered in all aspect of the grant making cycle. This took into account the conduct of full due diligence and risk assessment to ascertain the level of grantees' financial control systems and support provided where necessary to ensure all grantees met minimum standards. The results from these process and the requirements for fund disbursements informed grantee agreements and setting a framework for evaluation and annual audits.

The grant making process outlined above also envisaged a shift to performance based-payments, when grantees' work plans were fully developed and informed by the results of key action research findings. The grantee agreements would then be adapted to the specific needs of each district and the contribution to the project outcomes as defined in the logframe. The contracts would thus become reimbursable performance-based milestone contract with all their grantees.

In planning to roll-out this component, GHARH recognized that it might not be possible for the districts to pre-finance their activities and thus the project would aim to have agreements that allowed the district assemblies to transition from payment advances to reimbursable milestones payment in alignment with the progression of achievement of their contribution to the project outcomes. Similarly, the timing of disbursements would be adapted for each grantee to optimize the balance between minimizing transactional costs and financial exposure. It was possible that disbursement timelines would vary as this balance evolved with the progress in project execution and achievement of targets.

10.2. Representativeness:

At the Technical level, the National Steering Committee (NSC) was the highest body governing the strategic direction and monitoring the progress of the project and constituted representatives from; 1) NPC, 2) GHS, 3) GES, 4) NYA, 5) MOF, 6) MLGRD, 7) GAC, 8) NDPA, 9) PPAG, 10) UNFPA, 11) DFID, 12) MGSP. The Brong Ahafo Regional Technical Committee and the District Technical Committees controlled the technical directions of the project at the field level. These bodies advised the regional and district assemblies which worked closely with the project team.

10.3. Community engagement:

Another key component of the GHARH Project was community engagement and collaboration with traditional and religious institutions (Chiefs/Queen mothers and religious leaders) to create a supportive environment for smooth implementation of the project. Traditional authorities still wield considerable power in their communities though they are often inaccessible to adolescents and young people. The chiefs, queen mothers, elders and women leaders can also be influential in their communities if adequately sensitized/educated, along with the general community members on ARSH issues.

10.4. Local institution building (including through informal networks):

A rapid assessment of the National Population Council (NPC) and other Government of Ghana (GoG) capacity needs related to technical direction, coordination, implementation, and monitoring of ASRH programmes was carried out to establish a baseline of NPC's capacity needs in critical areas, promote organisational dialogue, learning, and standard setting; and inform the development of capacity strengthening plan for addressing organisational priorities. The final report established a clear plan of support to help the NPC better implement its mandate of coordinating population and reproductive health, including ARH, advocacy and data-use mandate of the organisation.

There were other regional and district capacity assessments that conducted a rapid assessment of the Regional NPC office, district coordinating structures and nine (9) implementing partners to determine their capacity needs for the implementation of the GHARH-funded activities.

The outcome of these assessments was the provision of technical and logistical support to enhance project implementation.

10.5. Sustainability plans (including through links to other projects):

The GHARH project did not develop an explicit sustainability plan; however, sustainability was embedded in its design. To ensure sustainability of the project, most of the programmatic components were built on existing structures. For instance, the youth Adolescent Health corners concept already existed on a limited scope and needed expansion; and the SHEP and school health clubs already existed in some schools but needed to be either expanded or revamped. It also relied on already existing facilities and staff of the implementing institutions. Furthermore, the intervention had a gradual pull-out plan. It is worth noting that implementation thrived on whole-system approach where the teenagers, families, community leaders, political leaders, health staff and educational institutions worked as a team.

10.6. Description of evaluation activities taken to date:

DFID embarked on an independent evaluation of the GHARH programme to assess the model and to inform the design of the follow-on programme which was under development. The operations research (OR) component of GHARH generated a wealth of evidence which addressed gaps in knowledge, and was used to improve programme implementation and informed future ASRH programming in Ghana, and elsewhere. In 2016, there were three OR studies that were undertaken. The findings of the OR studies were not used only to inform the GHARH programme, but national policy as well. For example, the revised National ARH Policy (2016) and the revised Adolescent Health Service Policy and Strategy for 2016-2020 had also been completed and validated by national stakeholders.

The OR component further investigated key areas not sufficiently covered by routine programme data or secondary data sources. The OR tested and validated the Business Case's TOC. Three OR studies completed to date:

- **Enhancing sexual and reproductive health service delivery to adolescents in Ghana:** provided perspectives from adolescents in the Brong Ahafo Region on services and ARSH health concerns. This influenced the training programme for health workers, placing more emphasis on condom availability and influencing the design of "corners". It addressed how best to engage traditional and religious leaders - an important component of the Theory of Change. The NGO grantees therefore strengthened linkage with these society gatekeepers.
- **Adolescents' Views on Sexual and Reproductive Health in Ghana's Brong Ahafo Region:** This revealed dynamics around early sexual debut among adolescents. It also revealed the best means to engage on such sensitive issues (peer to peer support is the most preferred method and social media is increasingly influential). It clearly pointed to the need to provide information on the correct use of contraceptives, especially condom which was the preferred method for adolescents. It also pointed to the importance of internet, and television as trusted sources of information for reaching young people. Social media was identified as an important medium of communication for behavior change. GHARH therefore developed a

mobile app for provision of information and GHARH social media outreach reached many adolescents. The study also recommended means to strengthen youth friendly service provision and trained providers to provide quality services and adopt more approachable presence at facilities.

Only two not three studies synthesized.

11. Partnerships

11.1. Overview of implementing institutions:

The project implementation was supported by a multi-agency led coordination framework which had Futures Group Europe now the Palladium Group, an international advisory as the project manager and technical advisor.

The National Population Council (NPC) which is the statutory body that advises the Ghanaian Government on population matters and coordinates the population sector served as the project coordinator. The NPC coordinated and worked closely with the Ministry of Health/Ghana Health Service (MOH/GHS), the Ghana Education Service/School Health Education Programme (GES/SHEP), the National Youth Authority (NYA), the Regional Coordinating Councils (RCCs) of the Brong Ahafo and Ashanti Regions as the main implementing partners as well as some civil society organisations (CSOs).

As the public health care provider, the Ghana Health Service through its Family Health Division was responsible for the main programme component of providing free adolescent-friendly Health services and commodities through youth corners and outreach clinics delivered through public health facilities.

The GES provided access to in-school children for Sexuality education in schools, including resources for teachers and the facilitation of school health clubs. The in-school adolescents are growing as enrolment rates are increasing in Ghana; at the same time the GES had a School Health Education Programme (SHEP) that provided the leverage on which to expand access.

The National Youth Authority (NYA) which worked mainly with out-of-school youths assisted the project to reach youth groups that were not in school especially in mobilizing youth groups who were registered with the Authority.

Finally, because the project was implemented in districts and at the regional levels, decentralized offices of the coordinating agency (NPC) and the implementing agencies (GHS and GES) present in these regions and districts who were more familiar with the local conditions led in the service delivery and community mobilization together with local CSOs.

11.2. Role of government:

The Ghana Government through its multi - sectoral agencies such NPC, MOH/GHS, MOE/GES/SHEP, NYA, RCCs, DAs etc. played very critical roles in the implementation process of the GHARH Project in the Brong Ahafo and Ashanti Regions. Some of these multi-sectoral agencies already had

existing structures at the national, regional and district levels which came in handy to accelerate the implementation process of the intervention. The GHARH Project only had to rehabilitate these abandoned structures spread over all the districts that implemented the GHARH Project.

11.3. Civil society partnerships:

Selected Civil Society Organisations (CSOs/CBOs) namely: PPAG, MAP+, WILDAF, Curious Minds, Youth Action Movement, Marie Stopes International and ISRAD partnered with the GHARH project to implement the community mobilization component which was essential for reaching most of the out-of-school youth and promoting community acceptance of the programme components targeting adolescents who were out of school.

11.4. Role of multi-lateral agencies:

Multi-lateral agencies such as DFID, USAID, UNFPA, WHO, HFFG etc. played a very important role in the implementation of the GHARH Project. Funding for the GHARH Project was provided by the British Government through DFID. During the implementation periods of the GHARH Project multi-lateral agencies such as USAID, WAHO and UNFPA also funded some components of the project when the GHARH Project was scaled-up and extended into the Ashanti Region from January to September, 2017.

12. Monitoring and Evaluation

The project did not conduct a baseline study because of available data from service statistics and survey reports on the situation of adolescent reproductive health at national, regional and district levels. Why then are stats not provided? The GHARH project however required the submission of quarterly and annual progress reports on the implementation process, success and challenges. Also, in the course of the project there were three operations research studies from which lessons learned were used to strengthen programme delivery. One such lessons learnt from the operations research for example led to the deployment of mobile application to provide relevant information to service providers and young people.

13. Successes and Lessons Learned

The GHARH project had so many successes and lessons that are worth sharing:

- The most remarkable lesson of the GHARH project is the benefit of multi-sectoral collaborations. The collaboration was responsible for the success of the project and the collaborating institutions realizing the benefits of multi-sectoral collaboration continued to work together. This kind of collaboration was required for the success of adolescent programmes because of the diversity in the backgrounds of adolescents. For instance, while some adolescents are in school others are out of school; the involvement of MOH/GHS, GES/SHEP, NYA, and NGOs/CSOs/CBOs ensured that both in-school and out-of-school adolescents were covered.
- Another lesson learnt is that having programme components built around existing structures promoted sustainability. The concept of youth corners existed in facilities and needed

expansion; the expansion relied on already existing GHS and GES facilities and staff. This saved the project additional cost and ensured that when the project ended the existing structures could sustain it.

- Community engagement and accountability, particularly with teachers and local authorities including chiefs, queen mothers, and elders, proved to be key in ensuring support and buy-in for the establishment and ongoing operation of youth corners, and the broader provision of ASRH services at community level.
- Institutionalized national planning and ownership through setting up of the NSC which provided a platform for partners to discuss both policy and operational issues to facilitate ARH programme implementation.
- The importance of accurate, timely and accessible data for evidence-informed programming and on-time reporting was a key lesson for the programme. Findings from OR suggested that adolescent corners were important platforms for delivering health services and information to adolescents, provided services were tailored appropriately and staffed adequately with trained health workers
- While it is already known that both traditional and social media are powerful tools when targeting young people with reproductive health information and messages, the GHARH project has demonstrated that coverage could be wider. The project operated in only two regions in terms of service provision, yet the media components reached the entire nation. The TV series, YOLO (You Only Live Once) became a national sensation overnight and due to its popularity, the TV series has continued up to 2020 after the project ended in 2017. The TV series has been uploaded on YouTube with some episodes exceeding 1 million views at the time of this report. It has also been translated into French for wider circulation beyond Ghana.
- Using peer Educators to share and discuss ASRH information with their peers is an effective way of increasing education and information on ASRH issues,
- Collaboration among all stakeholders (Traditional authorities, IPs, District Assemblies etc.) commitment and thorough planning,
- Effective collaboration has ensured the incorporation of ASRH issues into the School Curricula.

14. Future Plans: extensions that are currently being implemented

The project was initially implemented in only one region (Brong Ahafo). The Government Partners took a decision to recommend Ashanti Region for the scale up plan. This plan was carried out by the Government partners by first consolidating the work in the Brong Ahafo Region and withdrawing gradually based on an exit strategy. After the pull out, components like Adolescent youth corners that were built on existing structures have remained. Other components that fell within the priority areas of some NGOs/CSOs/CBOs and funding agencies continued to receive support. The mobile

app and informational materials continued to operate with international donor funding from the West African Health Organisation and UNFPA. Another media component which is the TV serial (YOLO) for example continues to run in TV stations with national coverage with support from Communicate4Health (USAID) and remains popular among young people.

15. Replicability and Scalability to promote South-South Cooperation

15.1. Pre-requisites for replication in other developing countries:

In order for the programme to be successful in other developing countries the following will be required:

- **Strong institutional collaboration:** – The core implementation support should be directed at key areas of institutional strengthening at the national, regional and district levels. Strong institutional collaboration between Governmental multi-sectoral agencies, funding agencies, NGOs/CSOs/CBOs, religious leaders and Traditional authorities etc. are some of the pre-requisites that will assist other developing Countries within the South-South Cooperation platform to successfully replicate and scale-up Ghana's GHARH Project. Without strong collaborations amongst the above-mentioned institutions and agencies it will be very difficult for any developing Country to successfully replicate and also up-scale the Ghanaian 'Story'. The OR Findings of the GHARH Project indicated that the success of the Ghanaian Project was achieved mainly because of the excellent team work spirit exhibited by the well-trained staff of the implementing agencies.
- **Sustainability planning:** Successful replication of the project will require sustainability planning. In the case of Ghana, since the project was built on existing structures sustainability was largely guaranteed. Countries that are implementing most of the programme components from scratch should have a clear sustainability plan at inception. To ensure sustainability, countries will need to create demand through print and electronic media, churches, mosques, health facilities etc. where there is easy access to information and services.

15.2. Experiences in replicating in other countries through South-South Cooperation:

15.2.1. Suggested steps for replication in other countries

Countries interested in replicating the practice in their own countries could consider the following suggested steps:

- Broader consultations and institutional collaboration to build consensus and develop institutional architecture for coordination and implementation.
- Undertake an extensive review of policies and interventions that have been implemented to improve adolescent reproductive health.
- Adequate planning and consultation at the formative stages of the project with due consideration for building on existing implementation structures, partnership and community engagement.

- Well-coordinated implementation and strong monitoring mechanisms.
- Gradual pull out and/or scale up based on lessons learnt and sustainability planning that was carried out at inception.

15.3. Potential partnerships (what would be provided willingly and upon request)

The National Population Council of Ghana (NPC) played a coordination role in ensuring the success of the GHARH project and is willing to provide any assistance regarding its technical expertise and further documentation on the project. The NPC is prepared and willing to connect/liaise with implementing government institutions in Ghana to member Countries that want to replicate Ghana's success story in the GHARH project. NPC has in the past hosted Countries interested in study tours to learn about good practices and will offer the same opportunity for learning more about the GHARH project.

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Appendix 1: Contact details of implementing institutions

NO.	NAME	INSTITUTION	MOBILE	EMAIL
COORDINATING INSTIUTION				
1.	Marian Kpakpah (Former acting ED)	Ministry of Planning	020 2014115 024 3045264	mkpakpa@gmail.com
2.	Dr. Leticia Appiah (Current ED)	National Population Council	0206301141	Nanaakua0609@yahoo.com
IMPLEMENTING PARTNERS AT THE NATIONAL LEVEL				
3.	David Logan	Palladium		Dzlogan1@gmail.com
4.	Dr. Patrick Aboagye	Ghana Health Service (Family Health Division)	0243283327	Yaboagye2003@gmail.com
5.	Ishmael Selassie	PPAG	0244679597	
6.	Nana Esi Inkoom	GES/ SHEP	027 7406266	esinkoom@gmail.com
	Aron Adarkwah	GES	0208210139	adarkwahaaron@gmail.com
7.	Faustina A. Braimah	SHEP/ GES	0244374007	
8.	Ernest Amoako	NYA	0244232063	ernest@nya.gov.gh
9.	Gifty Ben-Aryee	GHS/FHD	0243176314	Fragi2020@yahoo.co.uk
10.	Cecilia Senoo	Hope for Future Generations	0208120303	csenoo@hffg.org
11.	Roseline Lodonu	Hope for Future Generations	0243206320	relodonu@hffg.org
12.	Anne Coolen	Marie Stopes International Ghana (MSIG)	0556582862	anne.coolen@mariestopes.org
REGIONAL CONTACTS (BRONG AHAFO REGION)				
13.	Moses Nanang	GHARH Project, B/A	0244577666	
SHEP COORDINATORS (BRONG AHAFO REGION)				
12.	Beatrice Manu	D/SHEP/GES	0208229128	beatricemanu@yahoo.com
13.	Agasiba James	D/SHEP/GES	0208311960	agsibajames@yahoo.com
14.	Nsenyi Ama Priscilla	D/SHEP/GES	0206639257	priscillansenyi@gmail.com
15.	Dziwornu Moses Kwasi	D/SHEP/GES	0209423674	

NO.	NAME	INSTITUTION	MOBILE	EMAIL
16.	Brenya Samuel	SHEP/GES	0200880163	Samuelbrenya699@gmail.com
17.	Sakyi Augustine	SHEP/ GES	0502238212	sakyaiaugustine@gmail.com
18.	Kyeremeh E	GES	0208245640	
PARTNERS AT THE REGIONAL LEVEL (B/A)				
19.	Pascal Assan Ed-wards	National Youth Authority	0269241527	pasedwards@yahoo.com
20.	Anthony Nimako	GES	0209057980	anthonymimako@yahoo.com
21.	Dr. O.K. Afreh	GHS/RHD	0243264153	afrehok@yahoo.com
NGOs				
20..	Asante Gilbert	MAP International	0201798920	agilbert@map.org
21.	Patricia A. Boasiako	Mariestopes Inter-national	0206516602	Patricia.antwi-boasiako@mariestopes.gh.org
CASE STUDY DRAFTING TEAM				
22	Bernard Erasmus Kojo Vikpeh-Lartey	Independent Consultant	+233-20 8128541 +233-26-8393307	benvikpehlartey@yahoo.com

CONTRIBUTOR

Bernard Erasmus Kojo Vikpeh-Lartey

Bernard Erasmus Kojo Vikpeh-Lartey is a Community Development Consultant with over 20 years experience in development work. He worked with Population Council and Jhpiego both American International NGOs and others reputed organizations. He was the team leader for a National NGO, called Centre for the Development of People (CEDEP), for ten years. His technical expertise includes managing projects on community health, Malaria, Population, Family Planning, community mobilization and participation, advocacy, conducting training and research, developing HIV/AIDS activities and providing technical support to projects.

CHAPTER 7

INTRODUCTION AND SCALE-UP OF POSTPARTUM INTRA UTERINE CONTRACEPTIVE DEVICE SERVICES: THE INDIA STORY

Dr. S K Sikdar and Dr. Nidhi Bhatt

1. Background

India's Family Planning Program has witnessed a massive growth and adaptation since its inception. The second largest nation in the world also takes the pride in launching first Nation-wide Family Planning program in the world in 1952. The program was then focused on reducing the birth rate to the extent necessary to stabilize the population at a level consistent with the requirement of the National Economy ¹. Over the past half century, the program has witnessed a paradigm shift in its approach i.e. transitioning from a population control centric approach to a reproductive rights-based approach specifically after International Conference on Population and Development, 1994, Cairo. The introduction of the first phase of Reproductive and Child Health (RCH) program (1997), laid the foundation for integrated health and family welfare services to meet the felt needs of community and considerably reduce preventable maternal, infant and child mortality and morbidity. It was also realized during the same time that increasing the use and access of contraceptives is crucial to address the prevailing high maternal, infant and child mortality substantially. India, thus, took a progressive approach and made reproductive health an important element under an integrated RMNCAH+N strategy.

Health of a mother is cardinal to ensure a nation's health. In recent years, India has made a spectacular progress in reducing the Maternal mortality ratio by 80% (from 556 per 100000 live births to 113 per 100000 live births (SRS 2016-18)². With almost 18.9% of the world's live births occurring in India, the global contribution to maternal deaths is only 10%³ now. Studies also reveal that unsafe abortions account for 8% of total maternal mortalities, of which almost 30% deaths can be prevented by increasing access to family planning methods (Cleland J et al, 2006. Lancet). Studies also state that risk of child mortality increases three-fold if the birth interval is less than 18 months⁴. Further, it is accepted that 10% of the child mortalities can be prevented if couples space their pregnancies more than 2 years apart which is an easy and cost-effective alternative⁵.

The policy implications to improve maternal and child health, thus, rests upon an integrated approach to reduce unwanted and closely spaced pregnancies. Evidences further suggest that contraceptive services provided during child birth (postpartum period) has a potential to reduce both unintended and closely spaced pregnancies. Despite this, the unmet need for contraception in postpartum period remains as high as 65%ⁱ. The same source also reveals that 61% of these

1 <http://planningcommission.gov.in/>; Accessed on 29th Sept 2020

2 <https://www.who.int/southeastasia/news/detail/10-06-2018-india-has-achieved-groundbreaking-success-in-reducing-maternal-mortality>. Accessed on 25th Sep 2020.

3 <https://www.who.int/southeastasia/news/detail/10-06-2018-india-has-achieved-groundbreaking-success-in-reducing-maternal-mortality>. Accessed on 25th Sep 2020.

4 Rutstein; DHS Working papers; 2008; <https://dhsprogram.com/pubs/pdf/WP41/WP41.pdf>; Accessed on 4th Sep 2020

5 Cleland J et al; Family Planning-The Unfinished agenda. Lancet, Vol.368, Issue9549, Pg.1810-1827, Nov. 2006

women have a specific need for spacing while the remaining 39% have desire to limit child birth. The postpartum period provides a unique opportunity to meet the reproductive health needs of women, particularly the need for family planning. In addition, women's increased contact with health care services after childbirth affords the opportunity to offer them postpartum care⁶. Realizing the potential of integrating postpartum family planning initiatives in improving maternal and newborn health, thrust was laid on promoting post-pregnancy contraception in the country.

The global efforts to mainstream the postpartum family planning services has a recent history when in 2006, a global technical consultation was conducted in Washington DC. This was fueled by the findings from Lancet studies highlighting that 25-40% of maternal deaths could be averted if unplanned and unwanted pregnancies were prevented⁷. WHO technical committee recommendation in 2006 on HTSP i.e. spacing between birth and next pregnancy by at least 24 months, also played a pivotal role in re-invigorating emphasis on spacing methods, especially Long Acting Reversible Contraceptive- IUCD.

Goal of PPIUCD program: Aligning with the country's goal of 'improving maternal and child health outcomes by addressing unmet need of spacing, especially in Postpartum period', India introduced PPIUCD in its basket of contraceptives in 2009. With the consistent efforts and achievements along the way, ensuring healthy timing and spacing of pregnancies is now considered one of the most important interventions under India's RMNCAH+N strategy.

India's RMNCH+A strategic document delineates the country's strategic priority of protecting the lives and health of women, adolescents, and children. Post ICPD 1994 in Cairo, India was one of the 179 governments that embraced a bold vision for ensuring rights and well-being of its citizens. Further under ICPD+25, India reaffirmed its commitments to sustain gains and achieve the stipulated SDGs. As PPIUCD is a strategy to promote healthy birth intervals it has a direct impact on maternal and child nutrition, morbidity and mortalities, therefore helps in directly addressing SDG 2, 3 and 5.

Text Box 1.2: Concerted efforts to improve contraceptive basket under the National Family Planning program- India:

As a step towards improving healthy spacing between births, the Family Planning program in India was expanded to include more spacing options in the basket of contraceptive choices. Each decade has brought in something new for the program since its launch.

In 1963, India became the first country to introduce male condoms under the brand name 'Nirodh'. This was also the time when 'Lippe's Loop' (an intrauterine contraceptive device) was introduced in the program as a first reliable birth spacing method for women.

Further in the year 1976, oral contraceptive pills were added to the basket. Efforts to provide safe contraceptive choices to the couples under the National FP program continued and in the year 2002, the contraceptive basket was again expanded with newer version of IUCD (IUCD 380 A) and Emergency Contraceptive pills.

6 Kaydor et.al; Barriers to Acceptance of Postpartum Family Planning among Women in Montserrado County, Liberia. Nigerian Postgraduate Medical Journal, Volume 25, Issue 3, July-September 2018

7 Postpartum Family Planning Technical Consultation-Meeting Report, Washington DC; 14Nov 2006; http://resources.jhpiego.org/system/files/resources/ppfp_meetingreport.pdf; Accessed on 12th Sep 2020

Later, the introduction of Cu 375 (known as IUCD 375) in the year 2012 proved to be a breakthrough in the duration of contraception provided to couples through IUCD. Prior to introduction of Cu IUCD 375 India already started its efforts for bringing in postpartum IUCD.

The country did not rest here and in 2016 Injectable MPA and Centchroman (non-hormonal contraceptive pills- Developed by Central Drug Research Institute Lucknow-India) was added in the contraceptive basket, which are safe in postpartum period.

4. India's PPIUCD Program- Interventions, Achievement and Scale up

India's long-standing efforts on Family Planning have largely been identified to be sterilization centric. The country with the second largest population base in the world, thus, had an uphill task to strengthen the spacing services further with an emphasis on postpartum period. As mentioned above, the global efforts for streamlining Postpartum Family Planning started in 2006 and India proactively adopted this strategy. In 2008, the initial dialogues started to revitalize postpartum IUCD in the country (FP Division, MoHFW). Backed by the fact that the women do not prefer use of modern contraceptives during the postpartum period due to sociocultural and gender norms that guide postnatal practices, timing of return to sexual activity, breastfeeding practices and misconceptions regarding lactational amenorrhea, and lack of access to postpartum contraceptive services, Government of India envisioned a holistic approach to provide quality family planning services to its citizens. As a major step towards identifying platforms to improve uptake of IUCD and utilize opportunities to improve client's knowledge and address myths and misconceptions, the program capitalized on the opportunity provided by the increasing number of institutional deliveries (due to schemes like JSY and JSSK). This led to the initiation of PPIUCD services in a pilot mode in the year 2009. The hospital-stay during the postpartum period provided necessary time for counselling and improved ability of providers to make more comprehensive assessment of women's reproductive health needs.

a. PPIUCD Pilot- Key Interventions:

In 2009, Jhpiego started providing technical assistance to the GoI for strengthening PPFP/PPIUCD services in the states of Jharkhand and Uttar Pradesh through the support of USAID. The pilot began with first batch of clinician training in the same year at Queen Mary Hospital, Lucknow. Simultaneously, National Training Centre at Safdarjung Hospital in New Delhi and 3 regional training centers in Mumbai, Jabalpur and Lucknow in 2009-2010 were established. These were competency-based trainings with clinical practicum on humanistic model and supervised clinical sessions with clients. The overall roll out was a testimony to Government of India's strategic approach on gathering program learnings and planning further scale up. The focus was to build technical competency, rationally utilize existing human resource and infrastructure, ensure quality counselling services and build a post training mentorship model.

The program initially started in the district level facilities in a controlled manner. The positive inputs of the pilot in 2 high focus states of India resulted in expansion of PPIUCD service in 19 states as an extension of Pilot (Uttar Pradesh, Uttarakhand, Jharkhand, Delhi, Haryana, Punjab, Rajasthan, Bihar, Madhya Pradesh, Assam, Meghalaya, Chhattisgarh, Orissa, West Bengal, Gujarat, Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh) by the end of 2012⁸.

8 PPIUCD Services in India: The Journey from Start to Scale-up; <https://toolkits.knowledgesuccess.org/toolkits/ppfp/ppiucd-services-india-journey-start-scale>; Accessed on 3rd Sep 2020.

Global Focus and commitment: The year 2012 may also be noted as historic for India's FP programme as this was the time when India was witnessing a paradigm shift; a new integrated RMNCH+A approach was being institutionalized and globally there was a positive shift with a focus on Family Planning through FP 2020. All these put together resulted in strong advocacy with the state governments and other stakeholders.

2.1.1 Achievements of the pilot:

It is imperative to mention here that India was actively implementing the alternate training methodology for interval IUCD services, but for PPIUCD, a new innovative approach in the form of onsite trainings and mentoring was initiated.

The key interventions in pilot phase that laid foundation for effective scale up strategies (2010-2012) were.

1. Involvement of National and State Government in finalization of resource materials including the endorsement and dissemination of Standard Resource material and technical specification (PPIUCD).
2. Finalization of Service Delivery Tools wherein learning resource package of PPIUCD, Counselling training, Job-Aids, Behavioral Change communication materials were endorsed by Government of India. Finalization of performance standards by key representatives from all states and area experts and approval and dissemination of Specifications of PPIUCD insertion forceps by Gol.
3. Field Implementation with onsite technical support where focus was given to high case load facilities (average 2 facilities per state), Decentralization of trainings (17 training sites established in 12 states), On-site orientation and providing insertion forceps, registers, IEC materials to service providers.
4. Institutionalization of Services at Facilities through on-job/ need-based classroom training of all providers, strengthening of counseling by hiring and training of counselors, preparing job-aids for counselors, Strengthening follow-up of PPIUCD clients after 6 weeks of insertion

Text Box 2.1.1: Innovative and strategic steps taken during pilot

- Onsite trainings and onsite post training mentoring and follow up
- Decentralization of trainings
- Strategically designed learning resource packages
- Development of job aids for counselling and onsite trainings for the same
- Planning and mapping of high delivery load facilities for service provision
- Involvement of states and other stakeholders in finalization of performance standards for monitoring
- Innovation and development of specifications for PPIUCD forceps

Trainings complemented by post training support ensured quality and sustainability of efforts undertaken during this pilot resulting in 79,802 insertions by the end of 2013. This approach also supported the identification and increase in PPIUCD training sites from 31 (2010) to 71 (2012)⁹.

This also brought Gol's Policy Shift in 2012 which laid foundation for further Scale Up:

1. Dedicated counselors in the government system: A new cadre of dedicated counselors for busy facilities in all states
2. Task shifting: Nurses were allowed to insert PPIUCD.
3. Scale-up of PPIUCD services at 248 district hospitals in 6 high focus states (2013-14)

2.1.2 Learnings from the pilot:

PPIUCD Pilot provided learnings which were replicated in many other program interventions and also proved instrumental in expansion/scale up of PPIUCD across India. The key learning that proved effective in addressing various challenges in timely manner were collaboration and coordination of Gol and state government which included immediate consultation and feedback on phone, conducting Monthly meeting, sharing of reports and responding to Government's requests. Multiple donors support helped in providing financial and technical support through partner organization and brought the desired focus on the intervention to witness the results. Any new intervention requires response to programmatic, technical and financial concerns and engaging experts from the start of pilot proved effective strategy. Well curated strategies and systematic planning led to implementation in a controlled manner ensuring quality in training complemented by post-training supportive supervision.

2.2 Scale up of PPIUCD Services:

Later in 2013, the program was expanded to the sub-district level facilities. The expansion of pilot was in a collaborative spirit where the development partners technically supported the public health facilities. During this phase, the overall objective was to consolidate the learnings, improve quality of services in the facilities where PPIUCD services have begun and introduce PPIUCD in the primary care facilities (Primary health Centers-PHCs). The National and State government and implementing partners took a deeper dive in identifying the PHCs for the expansion of services.

Encouraging results from PPIUCD pilot paved the path for rolling out the intervention across all states of India in the year 2014. Technical, Financial, Monitoring and Evaluation aspects were meticulously incorporated in the roll out plan for PPIUCD. The pace of uptake of PPIUCD program across states were varied and special emphasis was laid on the states with TFR above the National average.

A multi-pronged strategy was adopted for the Nation-wide rollout. Before expanding the PPIUCD program to all states/UTs of India following parameters were worked upon- Expanding the pool of service providers, influencing provider's perspective, Emphasizing on Counselling Services, Logistics and infrastructure, Demand Generation, Monitoring, Learning and advocacy with the States/UTs.

9 PPIUCD services in India: The journey from start to scale up: https://toolkits.knowledgesuccess.org/sites/default/files/India%20Experience%20in%20PPIUCD_Presented%20at%20PPIUCD%20Zambia%20Mtg_April%202013.pdf accessed on 2nd August 2020.

* Daksh Skill Labs for RMNCH+A services; nhm.gov.in; Accessed on 6th Sep 2020

Text Box 2.2: Collaborative Efforts (Establishment of National Technical Support Unit-Family Planning (NTSU-FP)):

In the year 2014, under the guidance of MoHFW and donor support, a dedicated Technical Support Unit was formed at the national level which acted as an extended wing of Government of India in strengthening Family Planning program and institutionalizing quality in all aspects of FP services. Extensive program monitoring, techno managerial capacity building sessions, updating and development of technical material, regularizing government and non-government review mechanism and aligning program priorities with FP2020 commitment resulted in path breaking success of adding 15.3 million FP users (Track 20, factsheet 2019). State-wise analysis and monitoring tool were developed which was an elaborative exercise wherein the status of functionality of all levels of facilities, service providers, and the capacity of state and district was assessed to guide the development of ambitious but realistic district-wise action plans. Operationalization of PPIUCD services at all the delivery points was institutionalized through this activity and quality of data reporting was specifically emphasized.

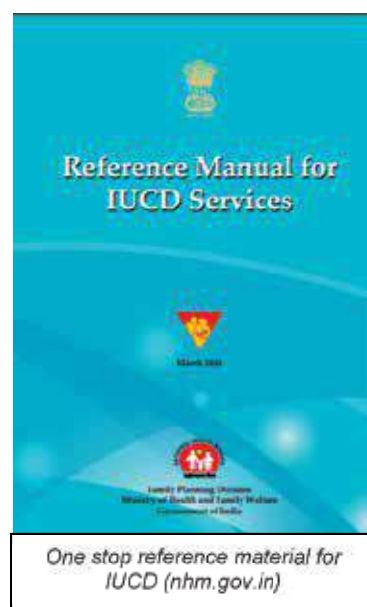
2.2.1 Scale Up Strategies:

Learning and timely proactive responses substantiated the success of PPIUCD scale up through strengthened supply and demand side interventions.

2.2.1.1 Supply Side Interventions:

A. Development of Learning Resource Package and strategies:

Development of standardized training packages for all level of service providers on PPIUCD helped in ensuring quality and adhering to national standards. These training packages and tools were designed to enhance technical knowledge and skills on the clinical procedures and counselling in accordance with the established protocols and guidelines. The packages were based on technological advancements and developments made in the arena of family planning as Government of India generates evidences and makes necessary revisions to the training packages and job aids from time to time. Subsequently, a comprehensive training package was developed, in consultation with development partners, for trainers (facilitators' guide) and service providers (including alternate medicine practitioners-AYUSH) detailing the technical information as well as training agenda and session plans.



The trainings were initiated in a cascade manner; not only updating the providers on necessary technical information but also ensuring standardization of trainings and practices throughout. The training package was constructed for 5 days (comprehensive IUCD training package) and 3 days (PPIUCD training package for providers already trained in Interval IUCD) with a maximum of 10-12 providers per batch to allow for adequate hands-on experience and maintain quality of the training. With revitalization of Post-abortion family planning, PAIUCD was also included in the package with additional 1-day orientation on PAIUCD for those providers already trained

in interval and PPIUCD. The uniqueness of the entire training package was the competency-based checklist that helped the facilitator determine the learning acquisition of the trainee and plan intervention (successful certificate/ re-training) accordingly. (FP Division, MoHFW).

There has been a continuous effort to revise the curriculum as per the field observations. The initiation of the program witnessed multiple guidelines for different cadres. Government of India subsumed all the existing IUCD manuals into one (one-stop reference material for Interval IUCD, PPIUCD and PAIUCD) in the year 2018.

B. Strengthening training sites and criteria:

Programmatic guidelines were also issued to the states for maintaining uniformity and quality of services. These entailed (but not limited to) criteria for selection of training sites, criteria for selection of service sites, eligibility of providers, training need assessment and accordingly securing budget in State Project Implementation Plans annually. These programmatic guidelines provided a roadmap for the states/ districts while planning and implementing the services without compromising on the quality.

At the same time, under the RMNCH+A integrated approach, Government of India took a major initiative to create and operationalize skills labs and undertake assessment and training of the health workers who are providing RMNCH+A services in the public health institutions. Each skill lab was equipped with necessary training material/ mannequins wherein PPIUCD was also made an integral part of skill lab curriculum ¹⁰.

C. Standardization of Equipment:

Availability of Standardized PPIUCD forceps was a prerequisite for quality of PPIUCD insertion. As a first step towards ensuring correct insertion (fundal placement) and preventing infections, specifications of already existing Kelly's forceps were modified and PPIUCD insertion forceps were designed. The product was a result of in-depth discussions and brainstorming by domain experts, engineers, Program managers etc. with an intent to give the service providers an alternative to using hands/ sponge forceps which could either lead to increased incidence of expulsion (due to low placement) or land the clients with infections. All these technical specifications of PPIUCD insertion forceps were uploaded on national information portal to decentralize purchasing and ensure uniform service delivery across all states ¹¹.

D. Strengthening Supply chain for FP commodities:

In the year 2017, MoHFW developed an innovative unified management information system – FP LMIS (Family Planning Logistic Management Information System) with an aim to manage supply chain from national level till ASHA level, reduce the supply disparities and regulate the flow of family planning supplies to the end users. Quantities of IUCD 375 and IUCD 380 A are estimated, supplied and monitored at national level. This software was rolled out across all states of India for which a detailed roll-out plan was developed covering areas like advocacy, finance, capacity building, Infrastructural requirement and monitoring ¹².

10 Daksh Skill Labs for RMNCH+A services; nhm.gov.in; Accessed on 6th Sep 2020

11 https://nhm.gov.in/images/pdf/programmes/family_planning/schemes/24%20Standards%20for%20PPIUCD%20INSERTION%20FORCEPS.pdf; Accessed on 5th Sep 2020

12 https://nhm.gov.in/images/pdf/programmes/family-planing/guidelines/LMIS/Operational_guidelines_LMIS.pdf ;Accessed on 5th October 2020.

E. Expanded Pool of Service Providers:

As mentioned earlier, the high caseload due to increased institutional deliveries (owing to JSY and JSSK) generated the need to increase providers' pool and improve the provision of PPIUCD services. As a response to address this need and to overcome the shortage of trained human resource for providing IUCD services at public health facilities, Government of India took a policy decision to train doctors from alternate medicines (AYUSH- Ayurveda, Siddha and Homeopathy) for IUCD service provision. Task shifting was ensured wherein AYUSH/ nursing personnel could insert PPIUCD and resultantly a greater number of trained nurses (Staff Nurse/ Midwife/ Lady Health Visitor/ ANM) are currently available to provide the Interval and Postpartum IUCD services.

Another milestone in expanding pool without disrupting existing services was the conception of the concept of 'Each One Train One' which the Ministry of Health and Family Welfare endorsed. This was developed to address the difficulty faced by district authorities in letting service providers leave clinical duty for training (due to limited number of service providers). In this concept, one trained provider from the health facility trains other eligible providers from the same facility without compromising on the clinic timings and ensuring round the clock service provision. The specific certification criterion was developed for such trainees.

2.2.1.2 Demand Side Interventions:

A. Capacity Building of Frontline workers:

To accentuate demand generation within the community, frontline workers (ASHAs) were extensively roped in the National Program. MoHFW developed multiple schemes for ASHAs to promote HTSP by ensuring early detection of pregnancy (provision of Pregnancy Testing Kits), Home delivery of contraceptives, and promoting delaying and spacing of pregnancies (Ensuring spacing at birth scheme). Further, performance linked payments were introduced for service providers and ASHAs for mobilization of clients. Technical content for PPIUCD was incorporated in existing ASHA training modules which resulted in institutionalization of regular PPIUCD trainings.



IEC material developed for promotion of PPIUCD Pyar mei Doori/Phir se dulhan developed with the support of Donor partners (nhm.gov.in)

B. Development of Mass Media and IEC materials:

360-degree approach was adopted to generate awareness on PPIUCD and foster informed decision making for the same. IEC/ BCC materials (Video, posters, leaflets etc.) for promotion and uptake of post-pregnancy contraception, especially PPIUCD were developed and widely disseminated. The material was uploaded on the ministry's web portal which was a free source for all the stakeholders and provided opportunity to the states to adapt the material into local language for transmission. These IEC/BCC materials were developed with the technical experts in field of communications.

2.2.1.3 Quality in Service Provisioning:

A. Emphasis on Informed Voluntary Consent:

Despite having a programmatic focus, ensuring voluntary informed decision making was a challenge. Government of India, therefore, laid emphasis on informed verbal consent in all the guidelines, standard operating procedures, review and technical workshops. Further, sample checks of exit client interviews and interviews with clients admitted in PP wards were conducted from time to time to substantiate adherence to these guidelines.

IUCD Card (nhm.gov.in)

B. Data recording and monitoring:

It was imperative to monitor the program implementation for ensuring quality as well as make necessary changes (if any) along the way. Therefore, dedicated facility-based registers for monitoring PPIUCD service provision were developed along with IUCD client card in year 2013. Before the indicators could be incorporated in the National Health Information Portal, performance monitoring was initiated on a quarterly basis through an excel based tool. It encompassed data on not only service provision and provider trainings but also provider-wise service performance (to match the financial bearing of the program). However, realizing the issue of multiple registers for data recording, the mechanism was simplified in 2018 with only two facility-based registers (IUCD insertion and IUCD follow up registers) and IUCD client card (detailing client information and warning signs), whose counterfoil is retained at the health facility. Gradually, PPIUCD service indicators became a part of the Health Management Information System (HMIS) and quarterly excel based reports were discontinued only after the data in National data portal (HMIS) was stabilized. (FP Division, MoHFW).

C. Adequate financing:

To ensure smooth conduction of trainings and service provision to the clients, the budget for trainings, equipment, printing of registers, technical manuals and incentives (for clients, providers and motivator) were included in annual state costed plans since inception of the PPIUCD program (through National Health Mission). This encouraged the states/ districts to plan the pace of program implementation according to the local prevailing situation, while at the same time maintain strides with other states/ districts.

These strategies, innovations and adaptations based on learning helped in repositioning of IUCD (including its use as postpartum and post-abortion contraceptive) and making this less invasive option widely available to the couples. The above-mentioned strategies and intensified efforts also helped the national program in securing a special place for IUCD as a 'Long acting reversible contraceptive' (LARC) in the contraceptive basket and identifying it as an alternative to limiting methods for many couples who don't want to adopt them. This also resonates with India's FP 2020 global commitment to increase modern contraceptive use, expand the basket of choices and increase funding towards family planning needs of the country.

Text Box 2.3: PPIUCD program - Offering solutions to all

It can be inferred that a comprehensive planning was an integral part for the roll out of PPIUCD in India and it entailed all program strategies. The program had something to offer to all stakeholders.

- Program Managers- Specific program guidelines, Advocacy meetings, Review meetings
- Service Providers- Technical Guidelines (learning resource package), Onsite trainings, Post training mentorship, Annual Program orientation sessions, facility-based skill labs with mannequins, Competency based checklists, Incentive scheme, Empanelment
- Counsellors- Learning resource package, onsite trainings and post training mentorship, job aids, counselling corners, refresher trainings
- Field functionaries (ASHAs)- ASHA leaflets, resource material, biannual/quarterly orientations (with special budgetary provisions), Job aids, Incentive scheme
- Store keepers- Logistics management system, annual orientations and review

5. Fostering Partnerships

The success of Postpartum IUCD in India is a manifestation of concerted efforts from Ministry of Health and Family Welfare (MOHFW), Government of India and State governments together with several development partners who supported the service scale up through various projects. Currently the government is harnessing the expertise of various agencies in the field of advocacy, capacity building, IEC and BCC, program management, quality improvement, evaluation and assessments, feasibility studies, development of resource material and E-learning modules as well as software development for successful implementation of the program. Technical organizations were instrumental at various levels of implementation and capacity building to revitalize focus of postpartum family planning, especially PPIUCD. The overwhelming response to PPIUCD as a choice of contraception in postpartum period across the states is a testament to these efforts over the years.

As detailed earlier, USAID supported the Pilot phase of the program in Jharkhand and Uttar Pradesh which later with the multi-donor assistance (USAID, BMGF, NIPI, Packard) under 'Rapid Expansion of PPIUCD Services in India' led to the program implementation through a multipronged approach. To overcome the initial procurement glitches, the newly designed PPIUCD insertion forceps were made available to all the trained service providers as a part of the training package by development partners following the instructions of Ministry of Health and Family Welfare.

Technical agencies worked in close collaboration with Government of India for capacity building of vast human resource pool. Initially, there was a huge challenge of managing inflow of donor money through multiple partners (which initially resulted in overlapping of work areas in different states) along with achieving harmonization of the efforts of involved development partners that came with the program intensification. At this time, Government of India's extraordinary leadership helped in rationalizing all the efforts into one direction and aligning commitments among all stakeholders. With a view to galvanize the unified efforts, a single platform was created for all the partners. Also, a road map for desired actions and areas of work were then delineated. For e.g.: For capacity building through support of technical agencies, a well-defined plan with allocation of work areas was developed. In order to keep uniformity and transparency among them, the agencies were roped in to develop a single window software which helped the implementing states as well as National government to monitor project progress periodically.

To keep up the government's engagement, a biannual meeting was conducted which also witnessed the participation of agencies field staff. These platforms also served as a cross learning opportunity for the partner agencies and helped them in keeping abreast with the current government priorities. The feedback and program improvement loop were completed with the participation of the agency representatives in state level reviews.

In addition to a dedicated software, 'PPIUCD insertion video' was developed comprehensively by the partners to ensure continued training of service providers. The projects also marked inclusion of some innovative solutions to persistent problems which proved extremely beneficial in making the interventions sustainable. The collaborative efforts also provided an opportunity to the government to endorse the technical material and reduce the effort of developing multiple technical materials and job aids.

With time, the ongoing partnerships witnessed an increase in efforts towards health systems strengthening. For eg. Under EAISI project, intensified efforts to scale up PPIUCD services were taken in six high focus states through Jhpiego (Chhattisgarh, Odisha), Engender Health (Rajasthan and Gujarat) and IPAS Development Foundation (Madhya Pradesh and Jharkhand). This support continued in phase 2 of the project starting 2017 and also complemented the achievement of the FP2020 goals. In addition to phase 1 activities, capacity building in commodity management and data handlers' trainings were also incorporated. The project came to close in October 2020.

The carefully navigated collaboration led to increase in number of PPIUCD state level service delivery sites and fostered institutionalization of quality services by improving the supportive supervision capacity of district health managers and improve data for decision making within the health system. Health systems' strengthening has always been an integral part of India's policy framework under National Health Mission. National Technical Support Unit for family planning services provided strategic leadership, advocacy, technical support and guidance for all programmatic interventions related to family planning from 2014 to 2018. As mentioned, the unit was instrumental in not only scaling up PPIUCD but also bringing back focus on quality of service provision and evidence-based decision making by means of regular supportive supervision visits, on-site handholding support, in-depth data analysis, updating the learning resource packages, and review meetings. The 'Reference Manual for IUCD Services' was comprehensively updated (including interval IUCD/ PPIUCD/ PAIUCD) and data recording and reporting mechanisms were simplified for ease of use.

The course of the PPIUCD journey indeed witnessed many roadblocks which warranted the conception of various innovative solutions, from central, state and local level and from both MoHFW and development partners. These, in turn, made the program managers as well as service providers better equipped to manage local challenges and implement context-based solutions.

6. Monitoring and Evaluation

Mechanism to monitor and evaluate the interventions under India's Family planning program existed since its inception. However, the breakthrough in program monitoring came with the advent of District health information system and later with the introduction of "Health Management Information System" (HMIS) in the year 2008. Currently, around 2 lakh health facilities (across all States/UTs) are uploading facility wise service delivery data on monthly basis, training data on quarterly basis and infrastructure related data on annual basis on HMIS web portal¹³. This web-based application captured service delivery data from the facility level for the multiple national programs including family planning on monthly/quarterly/ annual basis.

After successful implementation of HMIS system, India has now developed a beneficiary tracking system to facilitate timely delivery of healthcare services. The Ministry has rolled out an upgraded version, namely RCH Portal, which is designed for early identification and tracking of the individual beneficiaries throughout the reproductive lifecycle and promote, monitor and support the reproductive, maternal, newborn child and adolescent health (RMNCAH) schemes/ program delivery and reporting. It also helps the health worker in generation of work plan for delivery of various services in his/her catchment area.

a. Service Delivery monitoring:

Regular monthly reporting of facility-wise service data has been encouraged since introduction of HMIS. For initial 2 years of PPIUCD roll out, excel based quarterly reports for the same were captured from all states. These reports included training data, provider-wise performance tracking, timing of PPIUCD insertion (intra-caesarean/ post-placental/ within 48 hours), mode of insertion (manual/ PPIUCD forceps/ kelly's forceps) etc.

b. Ensuring data quality:

A fortnightly analysis of HMIS data was initiated at the National level (for state/ district level data), and its triangulation with state submitted reports and findings from supportive supervision visits were undertaken. Simultaneously, for the dissemination of FP 2020 commitment to all states of India, state-wise workshops were organized in the year 2014. These workshops were later institutionalized to provide techno-managerial updates and strengthen data quality by means of a robust feedback mechanism wherein the data gaps were highlighted. Not only service delivery but quality indicators like IUCD removal/ expulsion, PPIUCD acceptance rate etc. were also reviewed and shared with State/ district program managers, service providers and data personnel. From 2014 onwards, a separate budget line was also created in State PIPs, provisioning for similar reviews at the sub-state level (by state teams).

13 Annual Report MoHFW- 2019-19; <https://main.mohfw.gov.in/sites/default/files/02%20ChapterAN2018-19.pdf>

c. Capacity Building on data capturing and monitoring:

National and state teams conducted independent as well as integrated visits to districts and health facilities wherein emphasis was laid on use of new developed standardized registers (Insertion and follow up registers), IUCD client cards and quality of data recording and reporting. On-site capacity building of personnel in service delivery and stock maintenance (IUCD-375 and 380A) as well as matching of financial and program performance (for ensuring optimum utilization of resources) were undertaken. These supportive supervision visits also included mandatory interaction with frontline functionaries and client exit interviews on quality parameters of service delivery, informed verbal consent, continuation/ discontinuation of method in addition to assessing awareness and demand for services. Further, these visits provided pivotal opportunities in addressing technical queries of service providers and other personnel, thereby strengthening program implementation at all levels.

Annual Common Review Mission has been one of the important monitoring mechanisms under NHM. The unique feature of this monitoring mechanism is that a multidisciplinary team comprising national and state government officials, development partners, academicians and civil society organizations visit the states. This gives a widened view of service delivery. In addition, there is a system of feedback to the visited district as well as states. PPIUCD, being an integral part of the FP program, was made a part of monitoring tool in these visits. Twelve Common Review Missions (CRMs) undertaken so far have provided valuable understanding of the strategies which were successful and those which warranted mid-course adjustments.

d. Review platforms for Technical Partners:

As stated earlier, the review of technical partners not only helped in obtaining status update, understand and address challenges and suggest course corrections, but also align the project with the national program priorities.

e. Formalizing monitoring and reporting documentation system:

Realizing the importance of documentation of program efforts, development of comprehensive quarterly and annual reports on Family Planning have been institutionalized in the government system. These reports include data of service delivery from various sources, data on FP schemes, supportive supervision visits and report of technical partners supporting the program; which act as a ready-reckoner to the FP program performance and are used at relevant platforms for sharing information.

f. Independent/ In-house Evaluation of the program:

Independent evaluations have been conducted from time to time and India has been open and willing to adapt/ address the challenges identified in these evaluations. MoHFW is also actively undertaking internal assessments for quality improvement in program. One such assessment was undertaken to understand the influencing factors affecting PPIUCD uptake wherein awareness and knowledge of 682 ASHAs were assessed along with 92 client interviews from 4 high focus states namely Rajasthan, Bihar, Assam and Madhya Pradesh (FP Division, MoHFW)

g. Monitoring Commodities and ensuring supplies:

FPLMIS equipped all levels of stakeholders in the public health system to monitor the inflow and outflow of FP commodities and make timely decisions regarding placing demand, issuance of commodities and reducing stock outs. The commodities supplied to the states were corroborated with service performance of the states. Efforts for accurate reporting and recording of commodities started with baseline assessment of store warehouses, available commodities and store personnel. Institutionalization of standardized mechanism of commodity reporting helped in streamlining supply chain and identify bottlenecks and take corrective actions.

7. Impact of PPIUCD Services

The benefits of contraception go beyond health, affecting demographic and economic environment, thereby impacting all 17 sustainable development goals (SDGs) either directly or indirectly. As part of the Sustainable Development Goals (SDGs), “Ensuring universal access to sexual and reproductive health (SRH) services by 2030” was determined to have one of the two highest benefit-cost ratios (Kohler & Behrman, 2014).

Impact of Family Planning efforts in India over the years can be witnessed from the reduction in country’s TFR which has halved from 4.5 in 1984 to 2.2 as of 2017 (SRS). Recently, the National Health Policy (NHP) 2017 which sets out indicative and quantitative goals for the country also included achievement of Replacement Fertility level (2.1) by 2025 as one of its prime objectives. One of the major reasons behind this inclusion is the considerable influence that contraception has on the maternal and child health outcomes.

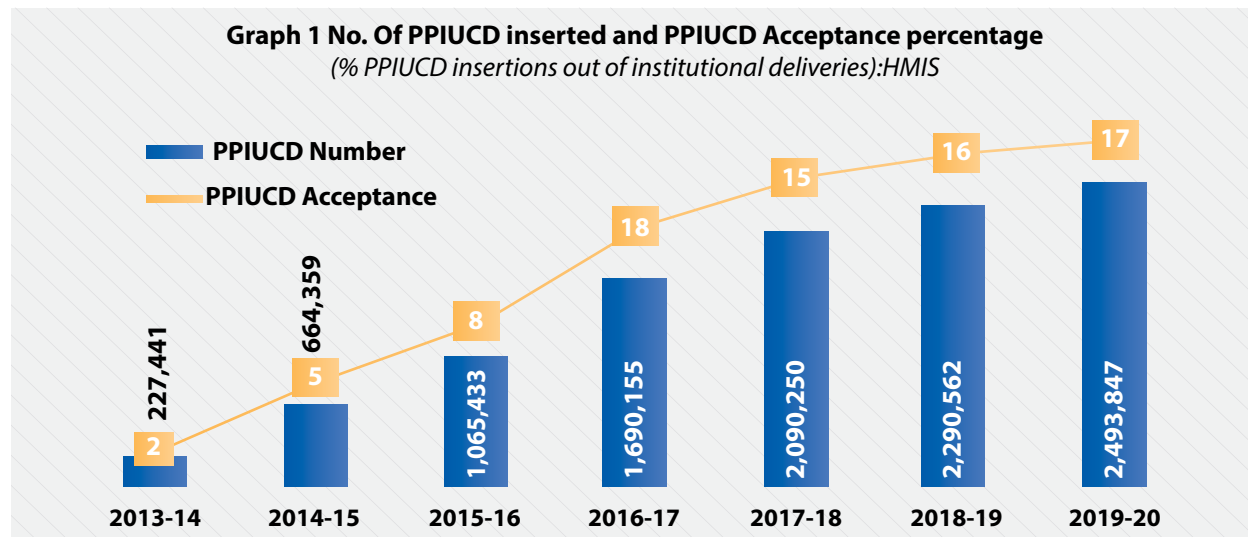
PPIUCD, a focused and strongly emerged method of contraception, has played a major role in contributing to this fact and ensuring better spacing between births. The percentage of adequately spaced births witnessed an increase of 17% from 2011 to 2018 (SRS) (Birth spacing of 36 months and more has increased from 42.4% to 49.6%). Furthermore, India averted 49.6 million unintended pregnancies and 1.7 million unsafe abortions in 2012 which increased to aversion of 55.6 million unintended pregnancies and 1.9 million unsafe abortions in 2019. The overall magnitude of the impact of Family Planning is extremely encouraging with aversion of almost 30,000 maternal deaths each year due to use of contraception. (Track 20).

A focused approach in high TFR states (6 states through support of technical partners: 2015-2020) also paid its dividends by averting 3.9 million unintended pregnancies, 1.3 million unsafe abortion, 2780 maternal deaths, 20294 child deaths and saving an estimated USD 193 million USD** (INR 14.2 billion) in direct health care spending¹⁴.

As mentioned earlier, India made a conscious decision to capitalize on the increased number of institutional deliveries (from 38.7% in NFHS-3 to 78.9% in NFHS-4) and adopted a strategic

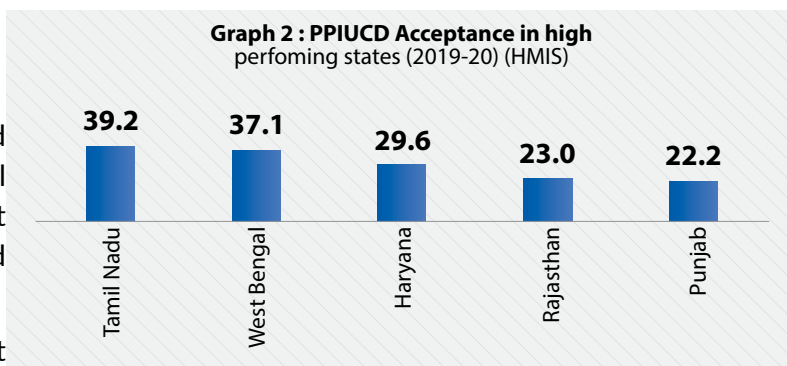
14 (** Costs saved to families and health care systems on pregnancy related care (e.g. ANC, safe delivery, treatment of complications including PAC). The default estimate for costs saved are based on “full coverage” - i.e. all women needing care receive it. Estimates calculated using Impact 2, Marie Stopes International, 2018)

approach resulting in an increase in the overall PPIUCD acceptance rate from 2% in 2013-14 to 17% in 2019-20 (Graph 1)



India's progress in improving contraceptive access in postpartum period led to reportedly more than 10 million PPIUCD insertions since the inception of the program (till 2019-20)¹⁵. Each year has been eventful for expansion of PPIUCD services in the country.

States have enthusiastically picked up the PPIUCD program; Tamil Nadu and West Bengal report PPIUCD acceptance of 39.2% and 37.1% in 2019-20 (Graph2)



Not only the state governments but the efforts of development partners

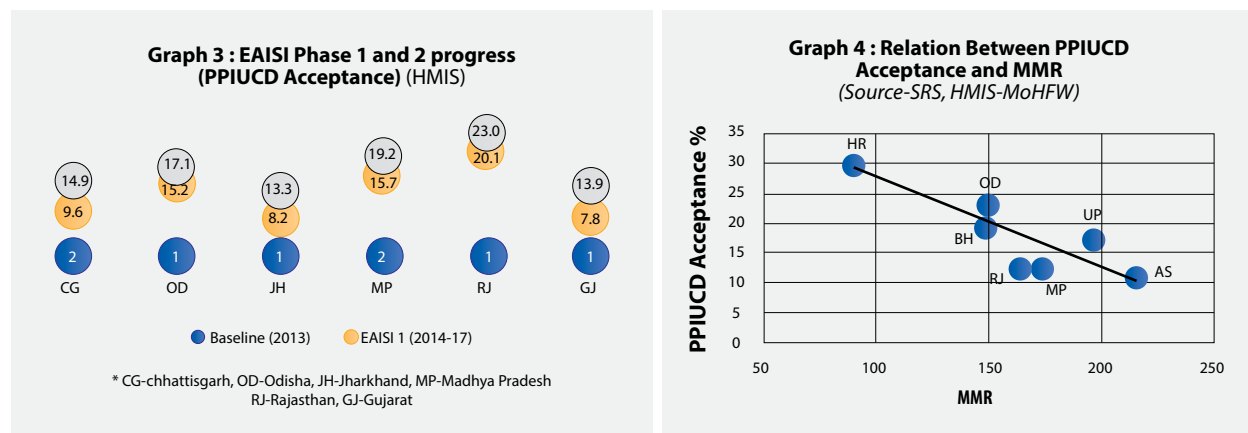
are also noteworthy. The graph below highlights the increase in overall PPIUCD acceptance rate from baseline in the six states supported by Development Partners (Graph 3)

As a programmatic thrust, India laid special emphasis on promotion of post placental IUCD considering the IUCD insertion has less complications and less expulsions if inserted in this period. In initial phases of PPIUCD roll out, post placental method was readily acceptable with almost 43% insertions occurring in post placental phase¹⁶. The complications associated with PPIUCD were also less with only 1% infection and 2% expulsions xviii. This also led to higher acceptance of the method as the program was scaled up in India.

15 MoHFW HMIS Portal; https://nrhm-mis.nic.in/hmisreports/frmstandard_reports.aspx

16 Program Learning for PPIUCD integration with Maternal Health Services- Programmatic experience from multiple countries; USAID-MCHIP

Since India doesn't have a homogenous population, it is also important to note that in terms of health parameters, state-wide variations exist. Majority of the population share is contributed by the high fertility states, where challenges in terms of access to health care and services exist. Therefore, Government of India, as a part of the RMNCH+A strategy is focusing its efforts in these states with allocation of high budgetary share (FP Division, MoHFW).



On comparing the Maternal Mortality Ratio and PPIUCD acceptance in these high fertility states (Assam, Madhya Pradesh, Haryana, Bihar, Uttar Pradesh, Odisha and Rajasthan), an inverse relationship between the two is evident. (Graph 4)

These are the states where the MMR decline from the year 2011-13 to 2016-18 is to the tune of 20-30% and at the same time the PPIUCD acceptance has increased by 14-15% (Sample Registration Survey-SRS, HMIS-MoHFW).

In addition to PPIUCD, postpartum sterilization performance also witnessed a boost in the country. This substantiates the fact that while promoting the concept of family planning, the overall emphasis was to be given to the basket of choice instead of method specific promotion.

8. Way Forward and Extensions that are currently being implemented

Periodic interventions, revisions of guidelines and program monitoring are entrenched in quality improvement process of all contraceptive services under National Family Planning Program. India has been diligently making consistent efforts to strengthen IUCD program and improve access for the same in more ways than one. Some of the recent initiatives are:

a. Strengthening Post Abortion Family Planning, especially Post Abortion IUCD:

India has steered its IUCD program towards ensuring Post-pregnancy contraception wherein PPIUCD efforts are being sustained and provisions have been made to address Post Abortion Family Planning (PAFP) needs also. Recently, the program focus has been directed towards IUCD in Post Abortion period (PAIUCD).

- Technical and Operational reference material for PAFP has been prepared with the experts and partners.
- Inclusion of data element on PAIUCD in Health Management Information System and regular monitoring of the same.
- Standardization of service delivery guidelines for PAIUCD following first and second trimester abortions
- Capacity building of new cadre of 'Community Health Officers' posted at Health and Wellness centers under 'Ayushman Bharat' initiative for promotion of PAFP.
- Training of medical students on PPIUCD to ensure sustainability.
- Indian adapted version of WHO -MEC wheel (2015) developed for strengthening service providers' decision making based on eligibility criteria¹⁷.

b. Updating of Integrated RMNCAH+N Counselor manual:

MoHFW is in the process of revising the existing 'Handbook for Reproductive Maternal Neonatal and Child Health Counsellors (RMNCH) ¹⁸' for counselors posted at high case load health facilities. Post Abortion Family Planning is being incorporated and special emphasis is being laid on Importance of Healthy Timing and Spacing of Pregnancies, role of nutrition and Adolescent Sexual and Reproductive Health.

c. Periodic Reviews and Monitoring:

Since its introduction in the year 2018, monitoring of PAIUCD indicators has become an integral part of the program review process. India has also initiated beneficiary wise tracking of services that will ensure better follow up. A special online system has been developed (ANMOL- ANM Online) for the same and PPIUCD/ PAIUCD messaging is a part of this system.

d. E-modules for ongoing trainings in pandemic times:

To ensure sustainability and ongoing capacity building amidst the pandemic, the current technical material is being converted into e-modules. In addition, a training methodology to guide states is underway

e. National Family Planning Helpline:

A National helpline is being strengthened to ensure better information services to the citizens on family planning services. This is envisioned to address myths and misconception, conduct online survey to assess client satisfaction and act as awareness generation platform for all level of stakeholders

f. Integrated monitoring of Survey and Service Delivery Indicators along with GIS mapping:

As a step towards better utilization of data by equipping policy makers and program managers with ready and customized data analysis, MoHFW is working in close collaboration with Track 20 for development of FP dashboard (as a part of Survey Statistics(SS) to Estimated Method Use(EMU)

17 MEC Wheel; <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=963&lid=470>: Accessed on 27th October 2020
 18 <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=963&lid=470> : Accessed on 27th October 2020

tool) entailing analysis and GIS mapping of states/ districts on various family planning services and indicators. The same is updated monthly and provides background for area specific interventions, if required.

9. Successes and Lessons Learnt from the PPIUCD Program

A comprehensive 360-degree approach resulted in the success of PPIUCD program. Within the decade of introduction as a pilot project PPIUCD has been accepted as a reliable Postpartum option by service providers and community which helped in securing a special place for IUCD as 'Long acting reversible contraceptive' (LARC) in the contraceptive basket.

Focus on monitoring and evaluation in PPIUCD program changed the way the program management was perceived and resultantly shifted from vertical to a horizontal approach. Consistent collaborations between government and development partners at all levels, from policy to implementation level, helped in bridging the anticipated gaps and prepare better for the unanticipated situations. Following dimensions were taken care of from planning to roll out and monitoring which are successes of the program

- **Governance:** Policy focus and response to the constant emerging challenges at national level and dissemination at subnational level with follow up for addressing challenges. Involvement of program managers at state and sub state level gave desired focus and course correction at all levels of implementation.
- **Health Workforce:** Creation of cadre of workforce strengthening counselling at high delivery case load facilities, task shifting, Involvement of frontline workers in demand generation and follow up steered the success of the program
- **Financing:** Multi-donor support at various stages and development and approval of decentralized costed plan for training and demand generation activities.
- **Service Delivery:** Uninterrupted service provisioning through availability of trained service providers at all levels of facility, capacity building of counsellors and field functionaries, Development and roll out of Standardized learning resource package and equipment, IUCD card. The conception of the concept of 'Each One Train One' strategy as well as task shifting in the PPIUCD program were some of the most unique successes of the program which became evidence-based examples for other programs grappling with dearth of providers and stringent training schedules (competing with service provision).
- **Health Information System:** Use of Regular reporting and monitoring framework, Facility-wise data recording and reporting in national data portal, Institutionalization of standard indicators and quality checks for program review and strengthening.
- **Access to commodities:** Family Planning Logistics information system to build capacity of states in demand estimation, unified platform for ensuring uninterrupted supplies and reduce stockouts

PPIUCD has brought many learning in its journey of roll out and before becoming one of the established component of India's Family Planning program, many learnings were simultaneously translated to actions to ensure quality in service provisioning and setting an example world-wide:

1. Constant need of demand generation activities for entire basket of Family Planning choices especially post-pregnancy contraception
2. Developing mechanisms to bust several myths and misconceptions around IUCDs equally among service providers and community.
3. Strengthening Quality of care and periodic monitoring of service delivery (post training follow ups, onsite visits, data quality checks, client interviews etc.)
4. Institutionalization of program strategies within the country costed plans.
5. Equal emphasis on PAIUCD for strengthening Post Pregnancy contraception

7.1 Continuation of IUCD services during and Post Pandemic Covid-19:

It is well documented that in a scenario of a pandemic, RH services are one of the first which need to be restored. The essential RH services focus primarily on provision of modern short and long-acting reversible contraceptives, information, counselling and services (including emergency contraception). Regulating fertility is thus an imperative. Government of India emphasized on the need of ensuring essential RH services during and post Covid-19 and developed 'Guidance note for provision of Reproductive, Maternal, Newborn, Child, Adolescent Health plus Nutrition (RMNCAH+N) services during & post covid-19 pandemic'¹⁹. Special emphasis was laid on continuation of LARC services (PPIUCD and PAIUCD) and generating awareness on its benefits (like one-time procedure, duration, limited facility visits) were highlighted during reviews. The guidelines also mentioned the health system approach for delivery of these essential services including facility mapping and planning, alternate service delivery mechanisms (Telehealth, modified outreach, home visits), Triaging, Management of human resources, ensuring supplies of medicines and diagnostics, program management (including monitoring), finances and accountability systems. Opportunities like institutional deliveries and client availing walk in services for reproductive health are prioritized and with consistent guidance and support from national level resulted in continuation of IUCD services.

10. India: Harbinger of PPIUCD (South-South cooperation)

Regions/ countries try to learn from interventions that have been successfully implemented elsewhere to realize their own objectives of health. These objectives may include (but not limited to) reducing burden of disease/ health risks, reducing health inequalities, promoting favorable social, economic and environmental determinants of health, encouraging participatory approaches, and ultimately moving towards attainment of Sustainable Development Goals²⁰. Therefore, program leaders and public health specialists are often involved in scaling up effective and proven interventions to reach more people and/ or broaden the effectiveness of that intervention.

As discussed above, with persistent and intensive efforts, India soon became a forerunner in provision of PPIUCD services across all states of the country and all levels of facilities. Carefully crafted and navigated, India's PPIUCD journey. To ensure that other countries in the region learn from PPIUCD intervention in India, as a key member of South-South learning cooperation, the country participated in cross-learnings and exposure platforms.

19 Guidance note for provision of reproductive, maternal, newborn, child, adolescent health plus nutrition (RMNCAH+N) services during & post covid-19 pandemic:24th May 2020: <https://www.mohfw.gov.in/pdf/GuidanceNoteonProvisionofessentialRMNCAHNServices24052020.pdf>

20 Improving the Replication Success of Evidence-Based Interventions: Why a Pre implementation Phase Matters; Elaine M. Walker, et.al; Journal of Adolescent Health 54 (2014) S24- S28

Ministry of Health and Family Welfare, Government of India together with development partners working in the area of family planning made collective efforts to ensure maximum learnings from other country programs and invited delegations from other countries of the region for exploring possibility of scale up of good programmatic interventions. This exchange of ideas is accomplished through various platforms like exposure visits, Conferences, training programs and cross-country learning visits etc²¹. India conducted a cross-country learning exposure visit with Indonesia in 2018, wherein the Indian delegation learnt about implants as a potential contraceptive method for National Family Planning Program while the officials from Indonesia learnt about the implementation and roll-out success of the PPIUCD program. Similarly, experience sharing is done through 'International Conference on Family Planning', wherein delegates from different countries come together for a common cause; increasing universal access to contraceptives

These platforms enabled the countries to think about possible steps for replicability and showed the way to many countries for maximizing benefits of the intervention²² :

- The first and foremost step is to assess the intervention which determines if and to what extent an intervention is replicable. Assessing PPIUCD example for scalability involves assessing the need for intervention, extent of scale, political will, administrative situation, system readiness, required resources (both monetary and human; from inside the system and external support), opportunities and constraints etc.
- The second step is to develop an intervention plan based on the assessment. The plan details the roll-out design (detailing roles and tasks for each level), budgeting, defining clear goals and objectives as well as relevant stakeholder analysis. An in-depth scale up plan is extremely crucial as it allows better dealing with unprecedented and unexpected bottlenecks during the intervention.
- The following step is to prepare for the intervention scale up. This usually encompasses preparation of the technical and administrative team in terms of deployment, trainings/ orientation, incentive provision (if any), equipping them with necessary technical/ SBCC material; preparation and mobilization of resources; preparing the health facilities; ensuring availability of necessary equipment etc. for uninterrupted service provision.
- The last step is the result of careful planning accomplished in first three steps; i.e. actual implementation of the intervention as planned. However, while implementing the strategy, it must be considered that experiences may sometimes warrant slight changes in the plan and sticking to the roll out plan completely may not be in interest of the intervention. Therefore, having a latitude and resources to make necessary changes mid-way is always helpful. Also, in addition to the implementation, concurrent monitoring and evaluation is also an integral part of the last step of replicability. A robust monitoring and evaluation system help in ensuring program quality and measuring impact of the intervention from time to time.

21 <https://www.partners-popdev.org/about-ppd/partner-institutions/national-institute-of-health-and-family-welfare-nihfw/> accessed on 5th October 2020

22 https://www.euro.who.int/__data/assets/pdf_file/0004/318982/Scaling-up-reports-projects-concepts-practice.pdf; accessed on 3rd September 2020

India was vigilant in following these steps with not only partnership from development partners but also convergence with other relevant government departments like Ministry of Women and Child Development and Ministry of Panchayati Raj (Local Governance). This convergence resulted in better awareness generation through their platforms (Anganwadi Centres- Early Childhood Care and Development Centre) and their orientation on the subject.

These strategies became a harbinger and paved the way for the success of India's PPIUCD journey. The learnings and experiences not only helped in improving access to IUCD in postpartum period (PPIUCD) but also revitalize IUCD in post-abortion period (PAIUCD) and expand the basket of contraceptive choices.

11. Details of implementing institutions

Ministry of Health and Family Welfare,
Government of India,
Maulana Azad Road, New Delhi-110001
Website- nhm.gov.in
Practice documentation:
Dr. Nidhi Bhatt,
Consultant
Email : neidhi03@gmail.com
Contact number: +919654159875

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CONTRIBUTORS

Dr. S K Sikdar, MBBS, MD

Additional Commissioner, In-charge: Immunization Division, Ministry of Health & Family Welfare, Government of India.

Dr. Nidhi Bhatt

Dr. Nidhi Bhatt is a science and medical graduate (B.Sc, M.B.B.S) with post-graduation in Public Health. She has more than 12 years of experience working in government and non-government sector on diverse areas viz. RMNCAH+N, Quality assurance, Climate change and microinsurance. With her profound blend of technical knowledge and program skill set she has been instrumental in strengthening National Family Planning Program specifically through development of technical manuals and program strategies for Government of India.

CHAPTER 8

POLICY COMMUNICATIONS BEST PRACTICE IN KENYA 2014 – 2019

National Council for Population and Development

Overview

The Fifty-sixth Session in 2006 of the WHO Regional Committee for Africa adopted strategic directions and a related resolution on knowledge management²³ to enhance knowledge-sharing and replication. Knowledge management (KM) is taken here to refer to the process of providing the right knowledge for the right people (i.e. policy-makers, practitioners, health systems managers and the public) and in the right format to strengthen health systems and improve health outcomes. Part of the process of KM is the identification and documentation of best practices because information is a global resource. A best practice is commonly defined as a technique or method that, through experience and research, has proven reliably to lead to the desired result²⁴. These practices need to be shared and adopted to benefit more people.

In the context of health and related programmes and services, a practical definition of a best practice is knowledge about what works in specific situations and contexts which can be used to develop and implement solutions adapted to similar problems in other situations and contexts²⁵. However, one of the significant barriers to knowledge-sharing and replication of experience in Africa is the limited culture of information and knowledge documentation and sharing²⁶.

The Population, Health, and Environment approach, (PHE) recognizes the complex inter-connection between people, their health, and the natural resources upon which they depend. In view of this interconnection, a number of organizations initiated integrated programming to address both social and environmental challenges dating back to the mid-1980s²⁷. Since then a subset of these programs have employed an integrated approach referred to as Population, Health, and Environment (PHE), aiming to simultaneously improve access to primary health care services, particularly family planning and reproductive health, while also helping communities conserve the critical ecosystems and natural resources upon which they depend²⁸. The number of PHE projects

23 WHO Regional Committee for Africa resolution AFR/RC56/16. Knowledge management in the WHO African Region: strategic directions. In: Fifty-sixth WHO Regional Committee for Africa, Addis Ababa, Ethiopia, 28 August– 1 September 2006 (<http://apps.who.int/iris/bitstream/10665/92662/1/AFR-RC56-16.pdf>). Engaging for health: Eleventh General Programme of Work 2006–2015: a global health agenda. Geneva: World Health Organization; 2006 (http://apps.who.int/iris/bitstream/10665/69379/1/GPW_eng.pdf).

24 Best practices. In: Bitpipe [website] (<http://www.bitpipe.com/tlist/Best-Practices.html>).

25 Ibid

26 A Guide to Identifying and Documenting Best Practices in Family Planning Programmes. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

27 Yavinsky, R. W., Lamere, C., Patterson, K.P. and Bremner, J. June 2015. The Impact of Population, Health, and Environment Projects: A Synthesis of Evidence, Working Paper. Washington, DC: Population Council, The Evidence Project

28 Yavinsky, R. W., Lamere, C., Patterson, K.P. and Bremner, J. June 2015. The Impact of Population, Health, and Environment Projects: A Synthesis of Evidence, Working Paper. Washington, DC: Population Council, The Evidence Project

increased throughout the early 2000s²⁹ and proponents of such integrated approaches argue that they can be more effective and more efficient than single sector programs for many reasons³⁰. A list of major PHE projects and placed in Annex 1.

Among the previous lessons learnt was the continued lack of documentation with regard to the benefits of PHE integration and therefore projects needed to document the benefits to fill this data gap³¹. Similarly, early interventions faced skepticism about the value added of the integrated PHE model³².

During the first international training on PHE held in Kisumu Kenya in January 2017³³, with participants drawn from East and Southern Africa, there was a call among others to:

- Strengthen documentation for PHE and experience sharing among stakeholders;
- Undertake countrywide awareness campaign and institution building;
- Mainstream PHE in all government planning and structures.

At the same time, the evaluation of HOPE LVB program in 2018 recommended that at national level, there was need to:

- Provide additional resources to undertake intensive advocacy and technical assistance at all levels, and provide support and supervision at the community level;
- Continue to work on demystifying misconceptions around some of the PHE issues and continue advocacy and training;
- Prioritize institutionalization by engaging all sectors at all pertinent scales to ensure scale-up and continuity of PHE programs;
- Promote PHE in the Country Integrated Development Plans (CIDPS).

In order to address these challenges, there was need to galvanize efforts of several stakeholders whether in public or private sector. Such efforts require strengthened policy advocacy and communication activities that have clear messages³⁴, supported with evidence generated from reliable data and information systems. In today's world there has been a paradigm shift in policy process because communication is part of the policy mix. In addition, policymakers today want to govern in partnership with citizens by helping them understand why changes in their everyday behaviour will lead to better social outcomes. These actions demand ingenious approaches to communication structures because the policy objectives should be anchored on the management of a wide range of stakeholders. Previous policy communication approaches were mainly based on written forms³⁵ that cannot meet the demands of several audiences simultaneously. In this

29 Yavinsky, R. W., Lamere, C., Patterson, K.P. and Bremner, J. June 2015. The Impact of Population, Health, and Environment Projects: A Synthesis of Evidence, Working Paper. Washington, DC: Population Council, The Evidence Project

30 Honzak, Cara, Judy Oglethorpe, and David López-Carr. 2012. "Conservation and family planning: What is the value of integrating family planning into conservation projects?" Papers of the Population Association of America Annual Meeting 2012, May 3-5, 2012.

31 Edmond Janet, K Holbrook, A Macharia, J Mandima, and N Simonea 2017 Exploring Cross-Sector Linkages Between Population, Health, Environment, Nutrition And Food Security: A Review of Best Practices and Lessons Learned

32 www.pathfinder.org/wp-content/uploads/2017/01/Pathfinder_Kenya_Policy_Brief.pdf

33 Short course on integrated population-health-environment (PHE) programs for a sustainable Eastern and Southern Arica, 23rd January to 1st February 2017. This course was organized by University of Nairobi with support from Pathfinder International.

34 Good communication is about getting the right message to the right person in the right medium at the right time.

35 Examples of such tools include policy briefs and media briefs. Policy briefs are short documents that present the findings and recommendations of a research project to a non-specialist readership-. See Nicola Jones and Cora Walsh 2008: Policy briefs as a communication tool for development research. Background note Overseas Development Institute. May 2008

report, the main argument is that strategic policy communications should be understood beyond messaging activity by including, comprehensive strategic engagement effort which integrates; multi-media, multi-outlet, community outreach and face-to-face efforts in a single campaign designed for adaptation to a complex and changing environment³⁶. Altman and Petkus (1994) noted that legislators are more likely to place the problems on the policy agenda if these problems become salient issues among individuals or groups³⁷.

Integrating Population, Health, and Environment for Sustainable Development in Kenya is an ENGAGE project that serves as an advocacy tool to promote integrated population, health, and environment (PHE) approaches, and the value of family planning/reproductive health (FP/RH) investments by decision makers in health and non health sectors, such as natural resource management and conservation³⁸. It is based on the previous lesson which demonstrates that population, health, and environment initiatives (PHE) can be more effective than single-sector efforts in improving people's lives³⁹. In addition about 12.6 million deaths could be prevented every year by making our environments healthier worldwide⁴⁰.

This report was done by National Council for Population and Development in Kenya with support from Partners in Population and Development (PPD).

Implementing Institutions/development actors

The ENGAGE project was implemented by The National Council for Population and Development (NCPD) with support from Population Reference Bureau (PRB) under the Policy, Advocacy, and Communication Enhanced for Population and Reproductive Health (PACE) project.

Summary: brief overview of the practice and overview of objectives and results

The ENGAGE presentation toolkit offers the best available knowledge and information dissemination platform that can act as catalyst to trigger or stimulate policy dialogues to promote, and advocate for PHE programs and policies in Kenya. The main elements include information about:

- a) integration benefits, PHE links, and emerging issues;
- b) Experiences about program design, training materials, implementation, monitoring and evaluation, and scale-up and replication of PHE efforts;
- c) PHE research outputs.

In this project, a multimedia presentation was developed (in both English and Kiswahili) which highlights many of Kenya's development successes, including the national climate change strategy and national population policy. It breaks down complex concepts and uses nontechnical language which shows the connections between people's access to FP/RH information and services, their health, and their reliance on natural resources. It draws on examples of successful PHE efforts in Kenya.

36 Paul Cornish, Julian Lindley-French and Claire Yorke Strategic Communications and National Strategy. A Chatham House Report. September 2011. www.chathamhouse.org

37 Altman, J., and E. Petkus. 1994. Toward a Stakeholder-based Policy Process: An Application of the Social Marketing Perspective to Environmental Policy Development." *Policy Sciences* 27: 37-51.

38 <https://www.prb.org/for-sustainable-development-in-kenya/> accessed 16th September 2019

39 <https://www.prb.org/engage-population-health-environment/> - PRB's ENGAGE presentation, "Population, Health, and Environment Working Together"

40 WHO department of public health Issue 84 / May 2016 e news

Background and justification, including origin of the project

In 2007 National Coordinating Agency for Population and Development (NCAPD) carried out a study to assess the state of integration of Population, Health and Environment (PHE) in Kenya with assistance from Population Reference Bureau (PRB) of USA. The lessons from this assessment, suggests that integrated programs require greater efforts in planning, coordination, and communication⁴¹. In addition to research reports as well as experiences from projects both in and outside Kenya, this tool kit was developed in 2017 by the PACE Project in collaboration with Kenya's National Council for Population and Development (NCPD) and an ENGAGE task force made up of Kenyan experts in the fields of health, FP/RH, conservation, and PHE⁴². PRB also drew from lessons from series of previous PRB dynamic multimedia ENGAGE presentations (both at local and global level) on issues related to family planning, reproductive health, and other key development issues. The overall purpose was to document and collate important materials that are publically available that can help plan or develop a PHE project/program, conduct research, or learn about emerging issues from current and past PHE projects/programs around the world. Policy, advocacy, and communication remain an important aspect of PHE implementation, and are crucial to the uptake and buy-in of PHE integration by decision makers and practitioners in other development sectors that align with PHE⁴³.

Goals and Principles

Goals

The main goal of the project was to promote policy dialogue among various stakeholders by enhancing the understanding of how PHE addresses the complex and interrelated challenges in the areas of family planning, access to health services, management of natural resources, and livelihoods faced by families and communities. The specific goals were to:

- Increase awareness of population issues among policy makers, FP advocates media and religious leaders Explain how the PHE approach works to improve health, livelihoods, food security, and natural resources.
- Highlight success stories from select PHE projects in Kenya.
- Foster discussion among audience members about the need for increased investment in integrated PHE

Principles

This policy communication and advocacy tool is anchored on clear messaging derived from reliable data, and stunning visuals that draw the audiences into critical conversations about development. It uses innovative technology to offer a new perspective on cross-cutting development issues such as family planning, reproductive health, population growth, the environment, and nutrition, and highlight outcomes across sectors.

41 National coordinating agency for population and development (NCAPD): Integrating Population, Health and Environment in Kenya. Policy Brief number 8 June 2008

42 This was developed following success story of Kenya Leading the Way developed in June 2011 which highlights both the improvements in development indicators over time as well as the disruptions and “stall” in family planning use in 1998- 2003. The focus of the initial ENGAGE multimedia was on the high level of unmet need for family planning, consequences of un-planned pregnancies, including high-risk births, maternal mortality, and rapid population growth.

43 www.pathfinder.org/wp-content/uploads/2017/01/Pathfinder_Kenya_Policy_Brief.pdf. <https://toolkits.knowledgesuccess.org/toolkits/population-health-environment-toolkit/policy-advocacy-communication>

The other principle is the extent to which the tool can be used at several levels and different audiences. The ENGAGE presentations are an effective means for advocates at the grassroots, national, and international level to promote policy dialogue about the costs, consequences, and proven solutions to today's challenges, and achieve a positive impact through greater knowledge, policy changes, and increased funding.

Description including Activities, Achievements, Outcomes and Impact

Main activities of the project are the organisation, implementation and monitoring the of policy and advocacy engagements for dialogue. The presentations are available online to stream or download for future use. Presenters at various engagement activities can choose to use narrated videos or to deliver ENGAGE presentations live themselves. In addition, ENGAGE “Snapshots” can be embedded into other platforms such as PowerPoint. Supplemental presentation materials, including discussion guide and references, are available for each presentation at PRB websites. A separate PHE toolkit hosted by K4Health provides current and high-quality resources for the PHE community and others interested in learning more about the PHE approach and integrated development.

For audiences who intend to design new projects or scale up their projects, these materials can be supplemented by toolkit developed by pathfinder on policy brief based on the experiences from the integrated population, health, and environment (PHE) initiative called Health of People and Environment— Lake Victoria Basin (HoPE-LVB), in partnership with several environmental and health sector partners in Uganda, Kenya, and the US.¹ Funded primarily by the David and Lucile Packard Foundation, and the John D. and Catherine T. MacArthur Foundation, with technical support from the USAID-funded Evidence to Action project .

In addition, these toolkits taken together can be used for training of various cadres of personnel involved in PHE projects following the lines of PRB policy communication training workshops⁴⁴.

Achievements to date in respect to outcomes

Because of its simplicity, the presentation has enabled a number of users to engage non-technical people and change views about issues on family planning. It has also triggered policy discussions even among the media fraternity. Some of existing projects have expanded with reports of great success⁴⁵ while new projects have been initiated⁴⁶. The policy engagements and dialogue have resulted in the development of PHE strategy paper 2018-2022 which is expected to guide future intervention packages and projects. Following engagements with policy makers and politicians HomaBay county government (sub national government) in Kenya have embedded PHE into County Programming.

44 Population Reference Bureau (PRB) has trained researchers and advocates to communicate to policy audiences, bringing small groups of Ph.D. candidates, family planning experts, youth leaders, and health advocates together to learn how to translate health and family planning for over 30 years.

45 HOPE LVB by pathfinder along Lake Victoria.

46 FHI 360 implements Afya Uzazi, project which means “healthy parenthood” in Kiswahili. The goal is to improve access to quality, client-centered and linked health care services that include family planning and reproductive, maternal, newborn, child and adolescent services. The project’s work is focused in Baringo and Nakuru counties in Kenya. For more details see <https://www.fhi360.org/projects/afya-uzazi>

Summary of strengths and weaknesses

Summary of strengths

The following are some of the key strengths of the toolkit:

- The toolkit has been based in previous experiences by PRB which span over 30 year of training of research as well as developing policy communication tolls worldwide⁴⁷ .
- Simplicity and use of both English and local language Kiswahili to expand access and use at various levels of policy and advocacy engagement s and dialogues.
- Use of non-technical language also ensures understanding and discussion with both technical and non-technical people such as media personnel (journalists)
- Ease and flexibility of use⁴⁸ expands platforms for communication such use of on line, broadcasts as well as PowerPoint presentations.
- Capability to be adapted to other situations – can be used at grass root level, national and at global levels and scope expanded.

Summary of major Weakness

The following summarizes some of the key weaknesses that need to be taken into account:

- 1) At the time of its inception, there was no explicit policy supporting integrated PHE programming, although many previous such as the Sessional Paper Number 3 of 2012 on national population policy calls for greater multi-sectoral collaboration and integration⁴⁹. Pathfinder in their report of experiences in supporting HOPE LVB hoped that there will be a national level Kenya PHE strategy in response to a call from the East African Community, which policymakers could reference to guide activities and allocations⁵⁰.
- 2) So far there is no elaborate M and E system for implementing activities based on the ENGAGE project at the national level to document how well other stakeholders are using the both the resources and the multimedia tools. In addition, concerns are still raised on clear documentation and producing evidence on “added value” of PHE projects, and therefore PHE projects need to pilot new approaches to document the “added value” of PHE projects. Part of this difficulty stems from the fact that at national level, the low or lack of implementation science and substantive technical assistance partnerships with research and academic institutions including assistance and data on ecological assessments, livelihoods, climate change adaptation, and resilience, where applicable.
- 3) A number of lessons have been drawn from the use of experiences from HOPE LVB supported by pathfinder international, yet there are no other situations different from experiences around Lake Victoria Basin.
- 4) Currently, support for national activities is heavily dependent on donor (PRB and USAID). There is need for diversity as well as national resources for the implementation of key activities of such projects.

47 Ibid

48 The presentations are available online to stream or download for future use. Presenters can choose to use narrated videos or to deliver ENGAGE presentations live themselves. ENGAGE “Snapshots” can be embedded into other platforms such as PowerPoint. Supplemental presentation materials, including discussion guide and references, are available for each presentation.

49 www.pathfinder.org/wp-content/uploads/2017/01/Pathfinder_Kenya_Policy_Brief.pdf

50 Ibid

- 5) There were no mechanisms for updating the presentations especially where was new data from surveys and evaluation.

Planning and Design: Experience

The planning for the project several stages during which specific information needs to be gathered from project areas, such as during proposal and/or workplan development, strategy development, activity design. The planning process involves analyses and production of evidence-based materials that communicate clearly to policymakers at all levels and across diverse geographies, targeting messages and products using state-of-the-art social media analysis tools to enhance digital communications.

Several stake holders were involved including mapping, bring together experts from population, health and environment together and jointly developing the materials. The tool kit itself is designed for community engagement with local individuals and institutions however it can as well be used for high level discussions at national and global levels. A review of evidence in Kenya as well as other African countries with similar projects, PACE anticipated 10 key ways that the tool can help to reach policy makers⁵¹. These are:

- Interpret data to provide the “so what”—the underlying stories and their implications for policy action.
- Communicate complex concepts such as the demographic dividend through well-crafted analyses and accessible presentations.
- Produce multimedia presentations, such as PRB’s ENGAGE, that can catalyze commitment to FP/RH goals among decision-makers, at global conferences, and during in-country policy trainings.
- Construct a roadmap for your policy-focused work toward reaching FP2020 and SDG objectives.
- Create infographics that tell stories about your country in compelling and innovative ways.
- Conduct thematic media trainings for print, broadcast, and digital journalists to make sure relevant stories are told, and told accurately.
- Develop new influencers and leaders in FP/RH through our policy communication trainings.
- Conduct demographic analyses to help explain key trends.
- Explain linkages among population, health, and the environment to inform your integrated programs.
- Sharpen the gender lens and highlight gender’s critical role for NGOs, countries, and communities.

Successes and Lessons Learned

ENGAGE presentations are an effective means for advocates at the grassroots and national level to promote policy dialogue about the costs, consequences, and proven solutions to today’s challenges⁵² because strategic policy communications should be a comprehensive strategic engagement effort integrating multi-media, multi-outlet, community outreach and face-to-face efforts in a single campaign that seeks to address complex issues .

51 <https://thepaceproject.org/about/>

52 <https://www.prb.org/engage-presentations/>

The ENGAGE multimedia tool for PHE was anchored on the success story of Kenya Leading the Way developed in June 2011 which highlights both the improvements in development indicators over time. In addition to the long collaborative partnerships with PRB who had trained researchers and advocates to communicate to policy audiences, family planning experts, youth leaders, and health advocates together to learn how to translate health and family planning for over 30 years.

A key lesson can be derived from the experiences of the HOPE LVB in which NCPD participated in supporting the scale and institutionalization of PHE project in Homabay and Siaya the use of materials already developed for continuous advocacy. The findings from evaluation of these projects revealed that the PHE approach has helped many local government officers from different departments do their work effectively. They were able to engage with stakeholders and the community, which enhanced integration through PHE activities. The second important message is the contribution is the development of PHE strategy document.

The success in which PRB leveraged digital platforms to extend the reach and ease of use of our policy training programs and tools is an aspect which can not only scale up PHE activities but also be used to support other complex programmes and projects.

PRB developed a new, self-guided Population, Health, and Environment (PHE) e-learning course designed to engage and educate users. The course, housed in the United States Agency for International Development's Global Health e-Learning Center, which is managed by the Knowledge for Health project (K4Health), includes new modules on policy, advocacy, and communication; scale up; and the Sustainable Development Goals, as well as information on PHE linkages with climate change adaptation and mitigation. This aspect of the entire ENGAGE projects is worth taking up at national level in order to expand scope of use since information a global asset. This is to enhance gathering and using information needed for exchange of ideas and to pursue collaboration⁵³.

Prospects for Future Plans

Since the presentation includes recommendations for civil society, and national and county leadership. It is expected that stakeholders from diverse sectors within Kenya will continue to use this resource to promote a policy dialogue about the critical role of population dynamics with health and the environment, and the ways that investments in FP/RH can propel progress towards Kenya's many development goals.

Policy, advocacy, and communication are crucial to the uptake and buy-in of PHE integration by decision makers and practitioners in other development sectors that align with PHE. The Resources are divided into three sub-sections related to global, regional, and national/local development priorities and frameworks. It also has a sub-section on Communication, which highlights resources focused on crafting messages and working with the media⁵⁴. It is thus important for improving knowledge management for those responsible for gathering and using information to exchange ideas and pursuing collaboration, and dissemination of results⁵⁵. PRB has creates these spaces for data users and for those focused on priority themes in population, health, gender, and the

53 <https://www.prb.org/communities-of-practice/>

54 <https://toolkits.knowledgesuccess.org/toolkits/population-health-environment-toolkit/policy-advocacy-communication>

55 <https://www.prb.org/communities-of-practice/>

environment. It is important to note that a separate PHE toolkit hosted by K4Health provides current and high-quality resources for the PHE community and others interested in learning more about the PHE approach and integrated development.

The ENGAGE project will be a useful tool to promote the implementation of the forthcoming, PHE strategy specifically that of advocacy and awareness creation on PHE integrated approaches whose outcome is to enhance better awareness and support for PHE integrated approaches at all levels. For this to take place there will be need for periodic updates based on new data and information including the development of a simple monitoring and evaluation tool to measure the progress made.

Replicability and Scalability

Lessons from the projects will be used to develop and support the dissemination and communication for the forthcoming PHE Strategic Plan for increased access, awareness and ownership of the plan document. It is envisaged that effective communication of the PHE Strategic Plan will be based on web-based tools (such as ENGAGE multimedia), mass media and inter-personal communication channels to enable exchanges between PHE stakeholders and Development Partners.

Suggested steps for replication

- Advocacy is an important component of PHE programs. Other projects should apply the lessons learned by the HoPE-LVB project to the extent helpful to advance their work and PHE as a movement to address the Sustainable Development Goals but advocacy takes time and is labor-intensive. A very intensive process of community engagement is required especially in the start-up phase, but also continuing through the project as new community members became involved. Experiences for replicability and scalability can be obtained from the experience based on lesson on the experience of “HOPE LVB in Homabay⁵⁶ and Siaya and Afya Uzazi in Nakuru and Baringo.
- There is an opportunity to guide a next generation of PHE projects to use standard frameworks and metrics to better link PHE and family planning integration with emerging priorities such as resilience and climate change adaptation⁵⁷.
- There is need for periodic updates to the multimedia projects to take into account new data and information derived from evaluation of projects and new studies on the interlink ages.

56 HoPE-LVB worked with County-level officials to form a steering committee with terms of reference. The Committee was tasked with promoting the integrated Population, Health, and Environment approach, as a mechanism for sustainable development, to all stakeholders, including the County government. Led by the County representative of the National Council for Population and Development (NCPD), under the Ministry of Devolution and Planning, the committee meets quarterly to review progress, share ideas, and set new targets. While this steering committee is not directly involved in project implementation, they have been kept informed of the data and results achieved by the HoPE-LVB project and have used this evidence to advocate with policymakers to advance the PHE agenda.

57 Yavinsky, R. W., Lamere, C., Patterson, K.P. and Bremner, J. June 2015. The Impact of Population, Health, and Environment Projects: A Synthesis of Evidence, Working Paper. Washington, DC: Population Council, The Evidence Project.

- There is need to re- introduce policy communication trainings especially the revised versions that can be implemented in either two or five days. Tools for implementation are already available from PRB website.
- Cornish et al have noted that strategic policy communication ought to be self-sustaining and iterative system of information and exchange which involving leaders, communicators, agents and stakeholders to foster a dynamic, versatile and responsive approach to policy⁵⁸ . Strategic communications also operate within a complex ecosystem involving a broad range of organizations, actors and individuals, many of whom may be unaware of the communicative value of their role⁵⁹ . The message is that ENGAGE project should also be extended to policy communication in other policy thematic areas.

58 Paul Cornish, Julian Lindley-French and Claire Yorke Strategic Communications and National Strategy. A Chatham House Report. September 2011. www.chathamhouse.org

59 Paul Cornish, Julian Lindley-French and Claire Yorke Strategic Communications and National Strategy. A Chatham House Report. September 2011. www.chathamhouse.org

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Annex 1: Present and Past PHE Projects in Kenya

SI	Project Name	Implementer	Funder/Donor	Geographical Coverage	Status
1	PHE Engage Project	National Council for Population and Development	USAID (Population Reference Bureau)	National	On-going
2	Health of People & Environment in Lake Victoria Basin (HoPE-LVB) project	Pathfinder	USAID, the John D. and Catherine T. MacArthur Foundation, the David and Lucile Packard Foundation, the Barr Foundation, the Margaret A. Cargill Foundation, and the Winslow Foundation	Lake Victoria basin in Kenya and Uganda	On-going
3	LVBC Population, Health and Environment (PHE) Programme	East Africa Community (Lake Victoria Basin Commission)	USAID	Lake Victoria basin in Kenya, Uganda, Rwanda, Burundi, and Tanzania	On-going
4	Afya Uzazi Project	Family Health International 360	USAID	Nakuru	On-going
5	Il'Ngwesi Group Ranch Project	International Livestock Research Institute	International Livestock Research Institute	Laikipia County	On-going
6	Kibera Water and Sanitation Project	Kenya Water for Health Organization (KWAHO)	Kenya Water for Health Organization (KWAHO)	Kibera slum, Nairobi	On-going
7	Kiunga Marine National Reserve Project	World Wildlife Fund	World Wildlife Fund	Lamu County	On-going
8	Sauri Millennium Village Project	Government of Kenya	United Nations	Siaya County	Completed
9	SRHR and Sustainable Development Project (Pambazuko)	Family Health Options Kenya, and Danish Family Planning Association	DANIDA	Siaya and Kisumu County	Completed
10	SRHR, Environmental sustainability and Climate Change Project	Family Health Options Kenya, World Wildlife Fund, and Danish Family Planning Association	DANIDA	Kilifi County	On-going
11	Green Belt Movement PHE Project	Green Belt Movement and FHI 360	FHI 360	Central Kenya Region	Completed

Source: NCPD (forthcoming)s

CONTRIBUTOR

National Council for Population and Development (NCPD), Nairobi, Kenya

CHAPTER 9

AN INNOVATIVE INITIATIVE TO REPOSITION LONG-TERM METHODS IN THE NATIONAL FAMILY PLANNING PROGRAM IN MOROCCO

Abdelylah Lakssir

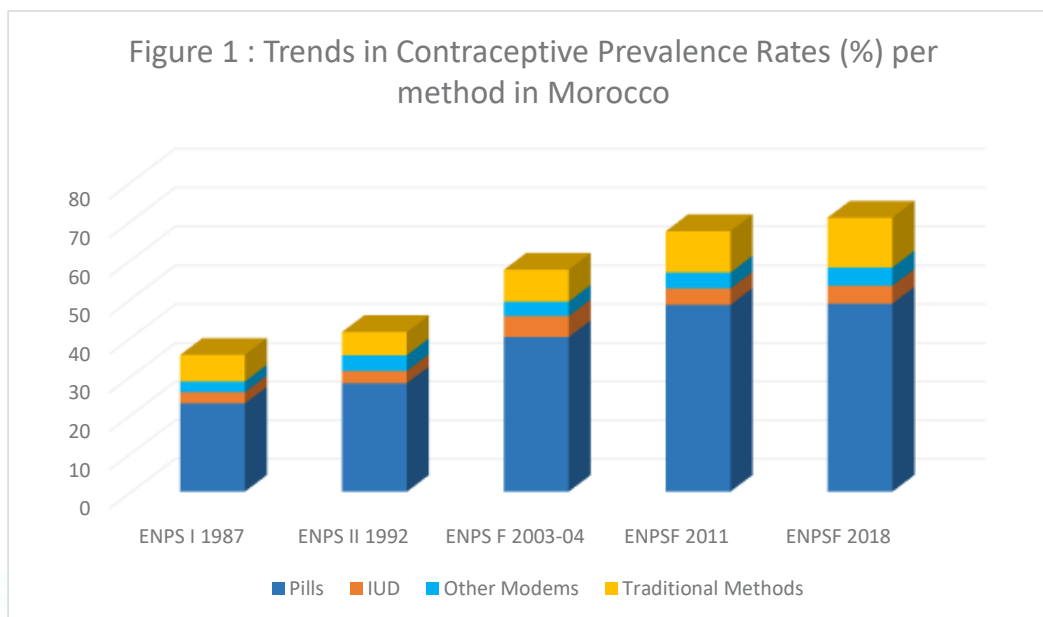
Introduction

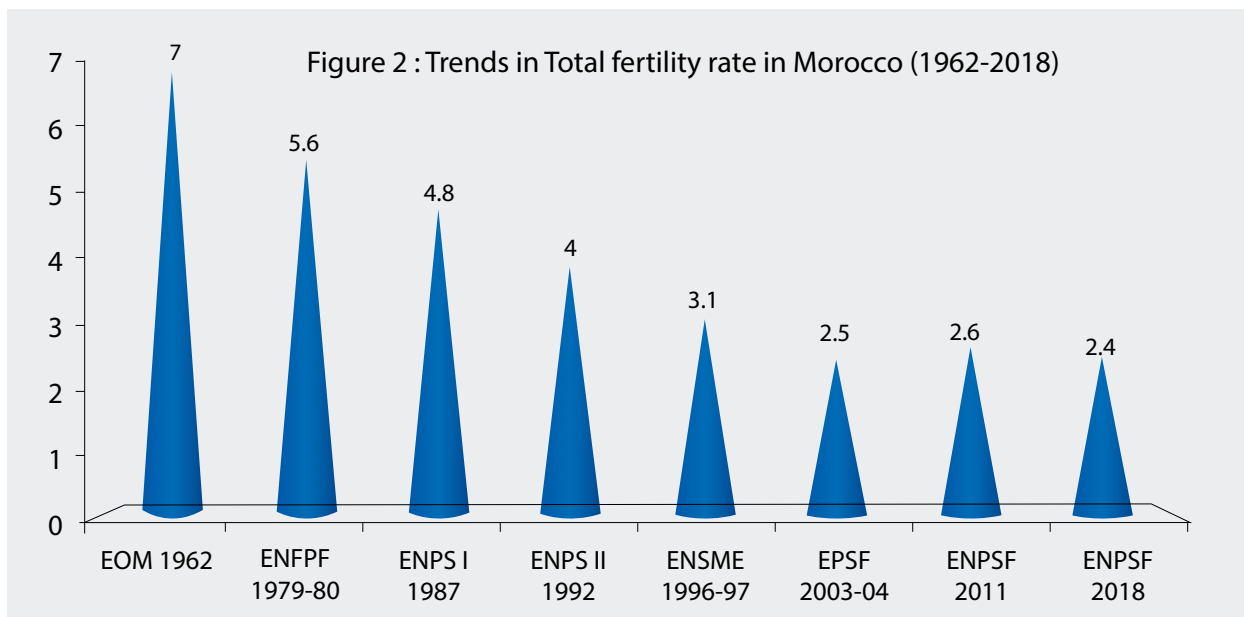
The mid-1960s marked the beginning of the National Family Planning Program (PNPF) in Morocco. In 1966, the program was established as a health program under the full responsibility of the Ministry of Health (MOH) with the aim to improving the health status of the mother and child in particular and the well-being of the family in general.

Since that date, family planning (FP) has been an integral part of the country's various development plans, and its related activities have been integrated among the primary healthcare services of the MOH. Thus, the PNPF has evolved over the years and has experienced continuous strengthening and progressive development.

This program development has been accompanied by a continuous increase in contraceptive prevalence rate that jumped from 19 percent in early 1980s to 71 percent in 2018 (Figure 1).

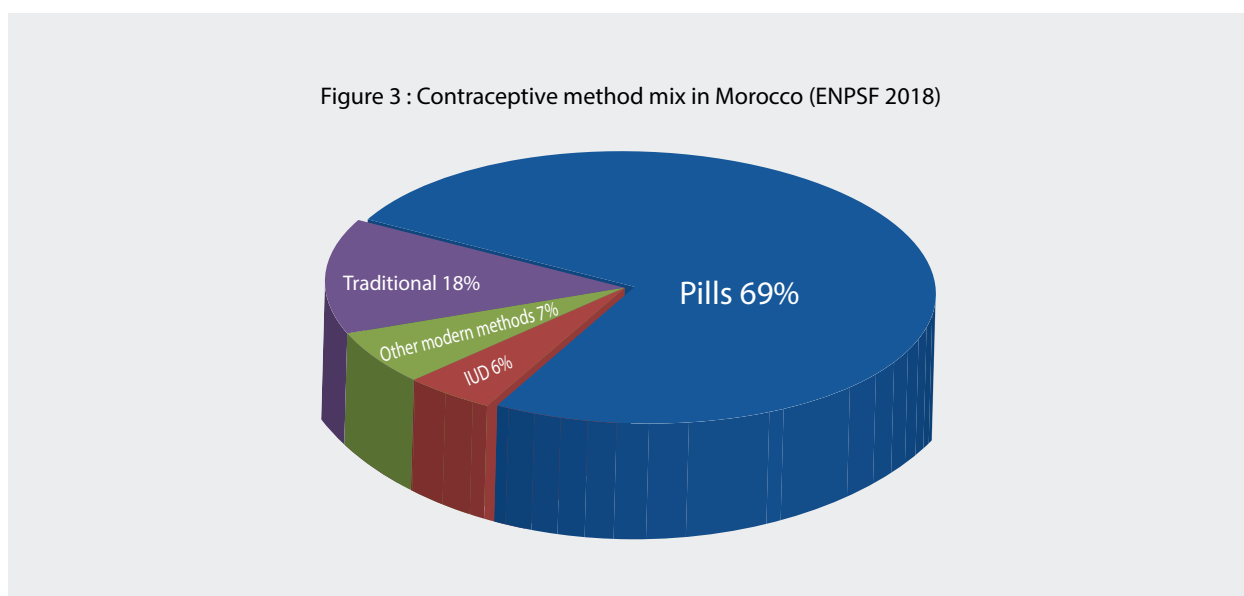
In parallel with this increase of contraception use, the fertility of Moroccan women has also fallen considerably. It has dropped from 5.6 children per woman in 1980, to reach the level of 2.4 children in 2018 (Figure 2).





This program success is mainly explained by the adoption of innovative and pragmatic initiatives: 1) provision of FP services through several channels including the primary healthcare centers (PHCs); 2) The establishment of the family planning referral centers (FPRC) , as support structures for PHCs, ensuring supervision and technical reference in FP; 3) Bringing services closer to the population through mobile teams (home visits and points of contact points); 4) The availability and free of charge of a wider range of contraceptive methods (the pill in several forms, intrauterine devices, injectables, condoms and female sterilization or tubal ligation) which are offered free of charge at health facilities of the MOH and 5) Active participation of the private sector and nongovernmental organizations (NGOs) in the service provision .

The analysis of contraceptive use shows that it is oriented towards the use of modern contraceptive methods with a predominance of short-term methods, especially the pill (Figure 3).



The contraceptive method mix has remained invariably dominated by the pill for more than three decades and that FP program managers in Morocco are trying to find an appropriate response by accelerating the promotion and supply of long-acting reversible contraceptives (LARC) such as Intrauterine device and implants. Thus, in 2013 the MOH with support from of UNFPA implemented a pilot project for the introduction of the contraceptive implant. This project started at two sites in Casablanca and Fez for a period of three years (December 2013 - December 2016). The project evaluation took place in 2016 and the extension to other regions of the country is underway.

This report represents a documentation of this initiative related to the introduction of implant into the NFPP as a best practice in sexual and reproductive health (SRH) to be shared as part of South-South initiatives.

Main Objective of the Implant Initiative in Morocco

As mentioned earlier, women PF users opt much more for the short-acting methods, especially the pill. So the main goal of this strategy is to promote the use of long-acting method to balance the current pill-dominated contraceptive method mix in the country.

About The Implant

Introduced 30 years ago, contraceptive implants are one of the most effective FP methods available. Implants are small, thin, flexible rods that are inserted just below the skin of a woman's arm and provide continuous contraception, lasting three to five years depending on the type of implant. Contraception by the implant has evolved, since there was the development of the 6-rod implant, then the 2-rod implant and finally the 3rd generation single-rod implant. This latest one-stick version revolutionized implant contraception. It has been introduced in several countries and has proven its effectiveness and efficiency. It is a three-year long-acting, hormonal, subcutaneous contraceptive. The contraceptive efficacy of implant is guaranteed for three years and begins as early as eight hours after insertion. The Pearl Index is 0.05 to 0.1. The implant has good reversibility with fertility regained as early as one month after its removal.

INTERVENTION IMPLEMENTATION STRATEGY

Adoption of an experimental approach

In order to master and choose the most effective option for the introduction of the implant, the MOH of Morocco, with the support of UNFPA, first opted for the implementation of a pilot project. This pilot was launched in two reproductive health referral centers (RHRC) in the cities of Casablanca and Fez. The project lasted three years (December 2013 - December 2016) and was subject to an external evaluation in December 2016.

After a training of providers in counseling and insertion and removal techniques, adapted to the method, the decision was made to follow a cohort of clients. Therefore, a group of 673 clients was recruited for this follow-up was (336 in Casablanca and 337 in Fez) for a period of three years (period of protection of the method). The analysis resulting from this follow-up showed that the majority of clients (2/3) recruited opted for the method while on the pill and 15 percent were new contraception clients (Bezad, 2016).

The evaluation of the pilot project also showed that the implant insertion was mainly carried out by general practitioners in 92 percent of cases and the remaining part by gynecologists. In terms of effectiveness of the method, the evaluation of the project found that the method is very effective since no pregnancy among the users had been reported. The evaluation also revealed that the level of satisfaction of women with the method was very high with two-year continuation rate of 86 percent.

The project evaluation offered many evidences to prove the acceptability of the method by the population and the providers and the feasibility of its integration into the NFPP service package.

The results generated from this evaluation were also used to back up the development of an advocacy strategy to gain support from highly ranked decision-makers at the MOH to officially approve the introduction of the method among other methods offered by the program across the country.

Adoption of a training strategy adapted to the national context

The training activities were implemented mainly by the teams of the FPD in partnership with the faculties of medicine through the university hospital centers (Rabat, Casablanca and Fez).

Under the leadership of the FPD team, a training curriculum was developed based on the training module used by the program in the IUD insertion training. The implant capacity development program included, in addition to theoretical training on the product, sessions on counseling adapted to the method, practical sessions on insertion and removal techniques on model arms before competence assessed on real cases of patient.



Figure 4. Images from a training session on implant held by the FPD

The training program also included management of side effects and other health problems associated with the use of the method.

This curriculum has been made available to other regions of the country for the local training of their own providers through a decentralized framework. The program managers decided to target two categories of providers. These are medical staff (general practitioners, gynecologists) designated for the insertion and removal of the implant including counseling and the nursing body for counseling and orientation of clients at the level of PHC facilities.

In order to facilitate training and standardize the teaching / learning methodology, a training package kit has been developed. It included in addition to the WHO reference manual on implant eligibility criteria which have been adapted to the Moroccan context, a trainer's guide offering instructions on the theoretical and practical content of the training and a participant's manual to guide trainees throughout all the training sessions. The aim of this learning package is to provide healthcare professionals (HCPs) with a consolidated source of technical information to enable them delivering quality service.

Other informational materials containing information on the implant in the form of cards and leaflets in French and Arabic (Figure 5) have also been developed and were available.

Figure 5: Example of brochures on implants developed by the FPD



Discussions around the training sessions with service providers have shown that most of them are highly satisfied with the training they received, “We were very well trained and by renowned professors in Morocco and experts in the field” declared a service provider from Casablanca. “With the training we have received and the practical experience, we are ready to train our colleagues from other health facilities” added a provider from the Marrakech-Safi region. The providers are also very satisfied with the handouts and reference documents on the method that have been made available to them. Nonetheless, some of the participants trained at the regional level would have liked to have a certificate at the end of their training.

Establishment of strategic partnership with key players

The design, implementation and monitoring of the pilot project and its extension took place in close collaboration and through strategic partnership with several institutions, namely: the Faculties of Medicine through the University Hospital Centers which contribute to teaching university and postgraduate medical clinic and nursing staff; central level through the FPD, as an entity responsible for programming, planning and intersectoral collaboration in FP and reproductive health at the national level, the health regions, as decentralized structures of the MOH, in charge

of the implementation and monitoring of health programs and interventions, and UNFPA, as a development partner (technical assistance, product purchase). These partners have been involved in all phases of the design, implementation and monitoring of this initiative.

It should also be noted that UNFPA has shown a strong commitment in favor to this initiative. In addition to supporting the implementation and evaluation of the pilot project, UNFPA provided implant procurement and supported the regional training as part of the initiative's scale up.

Gradual extension respecting the principles of regionalization

Morocco, like other countries of the world, is committed to the process of strengthening local democracy by promoting the roles of the regions in the implementation of national policies. To this end, the central level delegates several responsibilities to the regions, including that of human resources management and their capacity building. The extension of the implant initiative in Morocco is being carried out while respecting this principle. The central level, through the DPF, made the necessary training tools available to the regions and delegated to them the task and responsibility of training their providers on implant and its introduction in their respective area of influence and competency. Nevertheless, the FPD remains committed to supporting the regional teams in the event of a skills gap and to assisting them through supervision, mentoring and exchange visits between regions.

Monitoring and Evaluation of the Initiative

From the beginning, monitoring and evaluation was put as essential part of the implementation process of the initiative. The FPD ensured that monitoring and evaluation mechanisms were in place to ensure appropriate documentation of the initiative. Thus, for the pilot project, individual forms were established (admission forms and follow-up forms) for clients. These sheets were designed to collect detailed information on the characteristics of the users upon admission and the clinical changes noted during follow-up visits, among other information related to the client's experience with the method. Summary reports were prepared to aggregate the data and transmit them to the central level. A computerized database was also developed to facilitate the follow-up of the cohorts of users.

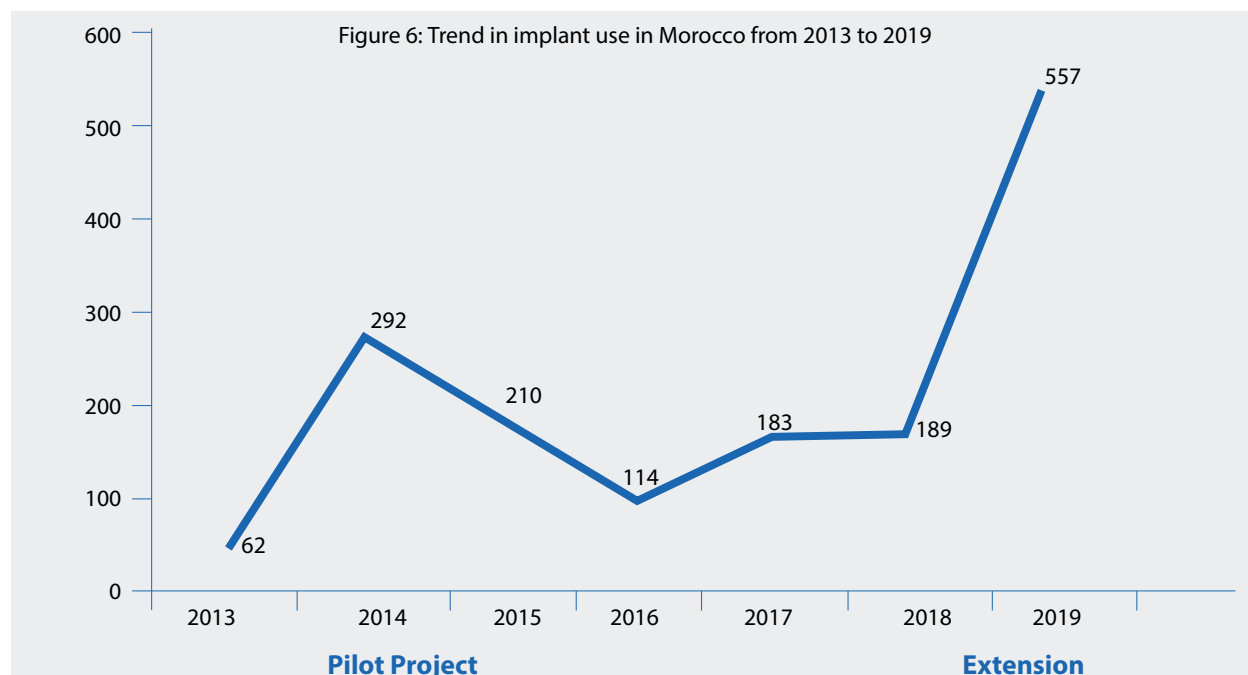
In addition to this quantitative approach used to obtain key evaluation indicators such as the effectiveness of the implant, the continuation rates by period of use, the reasons for stopping use or removal, among other indicators, a qualitative assessment approach was also used. This included interviews with program managers at central and the regional levels as well as focus groups with the users to better understand and contextualize their experience with the method.

The monitoring system also included supervision and mentoring visits carried out regularly by the management team from the FPD.

Along with the initiative extension, information on implant has become an integral part of the national health information system, as it is the case of other contraceptive methods offered by the program. It is worth noting that in order to continue assessing access to the method the regional teams have been called upon to carry out regular implant's evaluations in their respective service delivery sites. So as to broaden the scope of evaluation, the MOH also requested the health training institutions (Faculty of Medicine and Higher Institute of Nursing and Health Techniques) to encourage students to conduct research works and final dissertations on implant, in addition to their training on the method.

Direct Effects of the Intervention

Access to the method has started increasing in line with the extension of the method at the national level (Figure 6). In addition to the two pilot centers, the method is being available in other regions. So far, the method has been offered in 18 RHRC spread over four of the most populous health regions in the country (Fès-Meknes, Casablanca-Settat, Marrakech-Safi, and Tanger-Tétouan-Al-Hoceima). Other regions are in the process of preparing for the implementation of the initiative in the near future.



At the end of 2019, the total number of clients who adopted the method has so far amounted to more than 2,000 clients (FPD statistics).

The evaluation of the pilot project showed that 67 percent of implant clients are former pill users. This was also confirmed through the interviews carried out with the service providers who declared that most clients switched from pills to implant. This demonstrates a change in the contraceptive behavior of Moroccan couples against the pill which dominates the contraceptive structure. Such shift could be seen as a revealing sign of dissatisfaction with the pill and a potential success of the implant in balancing the method mix in favor of long-lasting methods.

Results from the evaluation of the pilot project and the discussions with the HCPs showed that the level of client satisfaction is quite high. In fact, the evaluation of the pilot project showed a two-year continuation rate of 86 percent. This fact was also confirmed by the HCPs who stated that women cope better with the use of the implant than the other methods offered by the program such as the pill and the IUD which accuse premature discontinuation rates at one year of 41 percent and 15 percent respectively (EPSF 2003-2004).

Replication and Transferability

With the successful demonstration of the pilot project in the two cities of Casablanca and Fez, the FPD immediately launched a scale-up strategy to make the method available to the population in other regions of the country.

The model of the pilot initiative has been replicated, so far, in three regions of Morocco and other regions will follow, soon, since the contraceptive implant with a single stick has received marketing authorization and has been officially included in the list of methods offered by the NFPP.

The initiative has been strengthened and implemented in 18 centers. The implant is now, systematically, included in the purchase list of contraceptive commodities through the MOH budget. The involvement of the medical school in the training process was a strategic choice. Through this partnership, the FPD has successfully advocated for the inclusion of implant in the training curriculum for doctors and nurses. Providers already trained in implant and interviewed as part of this work, declared they are able and ready to provide technical training on the method to other colleagues from other health facilities as is the case for other long-term methods, like the IUD.

In addition, the FPD is in the process of advocating for the extension of the method to the private sector so that it is offered by private medical doctors and the associative sector and training sessions have started taking place, in particular, for the benefit of private gynecologists.

In terms of exchange and sharing with other countries, the experience of the pilot project was shared with other countries during a regional meeting, on the preparedness and advocacy for the SDGs in the Arab world, organized by UNFPA and IPPF in Tunisia in December 2017.

The Moroccan experience in integrating the implant into the service package offered by the NFPP can be transferred and reproduced in other contexts. Political support for the MOH as is the case in Morocco is required for the replication of the experience. It is also necessary to ensure the existence of monitoring and evaluation mechanisms and a committed structure at the national level, such as the FPD, to ensure coordination, advocacy and mobilization of resources and partnership with development partners and qualified training institutions.

Strengths and Weaknesses of the Initiative

Strengths

The introduction of the implant among the range of FP methods in Morocco represents an ideal opportunity to support NFPP's efforts to balance the contraceptive method mix in favor of LARCs.

As a successful intervention, the introduction of the implant came to reduce the unmet needs of clients by expanding their informed and voluntary contraceptive choice. By introducing the implant, the Moroccan NFPP is strengthening its objective of ensuring the supply of a diverse range of contraceptive methods through its service delivery channels.

Weaknesses

Up to now, the method is only available at RHRCs as public facilities located in urban areas which limits access to the method.

The decision by program officials to medicalize the insertion and removal of the implant may counteract the promotion and access to the method.

The private sector plays a critical role in the provision of FP services in Morocco. According to ENPSF-2018, 60 percent of urban women and 50 percent of rural ones are private sector clients (All methods). Despite this role, no agreement has yet been done to engage the private sector in the provision of the implant.

Lessons Learned

The introduction of a new contraceptive method among the range of methods offered by a FP program requires institutional support and strong leadership from the structure responsible for managing and coordinating the program at the national level.

In addition to the leadership of the structure responsible for the program at the national level, it is necessary to engage appropriate partners (training institutions, development partners, etc.) and involve them in the development, implementation and monitoring of such an initiative.

Despite the maturity of FP programs in terms of service delivery and coverage, the diversification of contraceptive methods remains an important asset in the sustainability and improvement of the quality of service.

Strategic partnership with local stakeholders, including development partners, is very critical in developing and implementing successful FP initiatives.

The decision to introduce a contraceptive method such as the implant must be evidence-based; hence the importance of pilot projects before any expansion or generalization.

The existence of a decentralized system, reduces effort, costs and strengthens local leadership for program implementation and development.

Recommendations

Recommendations for the program

Extend training for the benefit of other doctors from primary healthcare facilities to involve them in service delivery so to increase access to the method.

Consider the possibility of involving other profiles in service delivery such as midwives who competently perform IUD insertions and deliveries.

Establish a partnership project (agreement) with the private sector (gynecologists) to promote the method use.

Develop an advocacy strategy for the inclusion of FP services, including those of long-term methods, among the services covered by the Compulsory Health Insurance Scheme in Morocco.

Intensify awareness-raising actions in favor of the method through dynamic involvement of NFPP facilitators at the provincial level.

Recommendations for South-South Cooperation

South-South cooperation is a political will of Morocco, and it is included in the preamble of the Moroccan constitution, adopted on July 29, 2011, which affirms the commitment of the Kingdom of Morocco to: 1) Consolidate relations of cooperation and solidarity with the peoples and countries of Africa, especially the sub-Saharan and Sahel countries and 2) Strengthen South-South cooperation.

In fact, in recent years Morocco has embarked on the path of South-South cooperation and participates in the development of several states, particularly on the African continent. With the level of maturity of the national FP program and the experience acquired in health promotion, Morocco has many assets to fully play the role of a 'referent' country, for the countries of the region through the sharing of expertise and technical assistance in the context of Reproductive Health (RH) and population and development through bilateral or triangular agreements. The PPD secretariat may seize this opportunity of the country engagement in favor of south-south cooperation and:

- Develop, in consultation with the Moroccan authorities, a national South-South cooperation strategy for sharing successful experiences in FP / RH, including the initiative relating to the contraceptive implant.
- Facilitate increased communication between Morocco and the PPD member countries and collaborating countries on this kind of best practices, through appropriate channels such as, regional and international forums, study tours, technical meetings of the PPD, blogs, newsletters and other electronic forms of networking and sharing.
- Encourage the coordinators of PPD activities in Morocco (the PPD board member and the PCC) to exploit the current dynamics of the country in its relations with African countries to advocate for better integration of population and development issues in all collaboration and development concluded between Morocco and these countries.
- Submit funding requests to the Moroccan Agency for International Cooperation and to other institutions to facilitate the sharing of expertise and technical assistance in the area of FP / RH and population and development issues.

Conclusion

The initiative worked well thanks to innovative design and implementation in partnership with strategic partners.

The use of an operations research approach through a pilot project facilitated decision making on whether to introduce the method into the program.

The initiative relating to the introduction of the contraceptive implant at the NFPP level in Morocco has contributed to the development of capacities of the health workers and enhanced strategic partnership between several stakeholders.

This initiative is considered a best practice because it is in the right path to achieve its assigned main objective of changing the contraceptive method mix in favor of long-term acting contraceptive methods.

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Annexes

1. General Information Sheet on the Country and Project:

Country name: Kingdom of Morocco.

Name of the State or Province in the Country: Morocco.

Number of beneficiaries: More than 2000 until now.

Kind of intervention: Promoting LARC methods through the introduction of implant

Implementing institution: Family Planning Department, Ministry of Health

Head of the Institution: Dr. Abdelhakim Yahyane.

Implementation period: Since 2013.

Budget: 655.572 MAD (contribution from l'UNFPA).

2. Discussion guide with providers:

What is your opinion on the introduction of the contraceptive implant?

Your opinion on the training received.

Your views on the technical documents and informational supports developed.

Your opinion on the client's experience with the implant.

Your opinion on the extension of the method to primary healthcare facilities.

Your opinion on the demedicalization of the method delivery.

Your opinion on the political commitment to the method.

What is the strategy do we need to involve the private sector and associations in the provision of the method?

CONTRIBUTOR

Abdelylah Lakssir

Abdelylah Lakssir is a public health specialist with more than 30 years of experience in the management and evaluation of FP/RH programs in Morocco and in Africa. He worked for Maries Stopes International as Regional Advocacy Adviser for the West Africa and for PPD Africa Regional Office as an International Program Officer. He is a former head of the evaluation Unit at the FP department at the MOH of Morocco.

CHAPTER 10

THAILAND'S BEST PRACTICE HIGHLIGHTING THE SUCCESS STORY ON SAFE ABORTION POLICY AND ARRANGING UNSAFE ABORTION PREVENTION SERVICE UNDER UNIVERSAL HEALTH COVERAGE SCHEME

Dr. Bancha Kakhong and Dr. Peerayoot Sanugul

1. Background and justification, including origin of the project

Unsafe abortion is a major public health problem in many countries all over the world. According to a study by the World Health Organization (WHO), an estimated 45 million abortions occur worldwide every year and 25 million of them are unsafe abortions.

The majority of unsafe abortions, or 97%, occur in the developing countries including Thailand. The unsafe abortion problems are complicated, sensitive and related to social and economic problems as well as religious teaching, morality, belief, value, culture, politics, law and so on. The unsafe abortion is also the leading cause of maternal morbidity and mortality. According to a surveillance on abortion conducted in 2019, there were 1,931 patients having an abortion in Thailand. Of the total, 44.2% had a spontaneous abortion while 55.8% had an induced abortion. The majority of the women having a spontaneous abortion were at the age of 30–34, amounting to 20.5%, and most of them had an intended pregnancy at 62.8% whereas the remaining 37.2% had an unintended pregnancy. For those with unintended pregnancy, 41.0% of them did not practice contraception. For those practicing contraception, 58.8% took contraceptive pills and 12.3% used condoms. Most of the women in the sample group had an abortion between 9–17 weeks of gestation, representing 39.9%. It was found that 4.4% of the women suffered severe complications from a spontaneous abortion. Most of them had massive hemorrhage requiring transfusion, accounting for 80.6%. According to a situation analysis of adolescent pregnancy in Thailand, approximately 83.9% of teenage pregnancies were unwanted and 53.2% of the pregnant teenagers decided to have an abortion. Most of them had an illegal abortion via various methods such as using either herbal infusions or abortifacient pills at 6.7%, while 1.7% inserting or allowing others to insert solid or liquid items or vaginal suppositories.

There are two methods of safe abortions including surgical abortion and medical abortion. The surgical abortion includes dilatation and curettage (D&C) in which the cervix is dilated and be scraped with traditional tools. At the present, the procedure is not recommended by the WHO and the Department of Health because it is an outdated procedure and it risks uterine perforation, torn and inflamed cervix, and incomplete curettage. Manual vacuum aspiration (MVA) is a surgical abortion procedure during which a healthcare provider uses suction with canulae 4–14 millimeters in diameter while electric vacuum aspiration (EVA) is another surgical abortion procedure which a

provider uses suction with an electric pump plus canulae larger in diameter to empty the uterus. Both of the procedures can be used in outpatient settings, extremely safe and effective. The medical abortion using two medications, mifepristone and misoprostol, is the procedure recommended by the WHO because of its safety, efficacy and user-friendliness. The medical abortion at less than 9 weeks of gestation is 98% effective. The WHO put mifepristone and misoprostol on the WHO Model List of Essential Medicines in 2005.

As a result, the Department of Health has developed the safe abortion service system in Thailand to be more effective, easily accessible, and increase the number of service units that provide safe abortion services across the country. The practices were promoted in accordance with the Act for Prevention and Solution of the Adolescent Pregnancy Problem B.E.2559 (2016), and the 2nd National Reproductive Health Development Policy and Strategy (2017 - 2026) on the Promotion of Quality Birth and Growth.

1) Goals and Principles

Goal

To support broader access to safe abortion among female teenagers and to reduce the number of unintended pregnancies among women of reproductive age with the aim of reducing post-abortion complications and mortality caused by unsafe abortions.

Principles

In order to solve the unsafe abortion problems in Thailand, the Department of Health has implemented the safe abortion policy by continuously developing the safe abortion service system to be more effective and accessible for female teenagers, women of reproductive age and women having an unintended pregnancy, promoting safe abortion literacy among people using reproductive health services, and increasing the number of the service units all over the country. The practices were promoted in accordance with the Act for Prevention and Solution of the Adolescent Pregnancy Problem B.E.2559 (2016), and the 2nd National Reproductive Health Development Policy and Strategy (2017 - 2026) on the Promotion of Quality Birth and Growth.

3. Description of Activities, Achievements, Outcomes and Impacts

Medical Abortion

Activities and Achievements

In cooperation with the Concept Foundation, the Department of Health conducted a pilot study on medical abortion in the healthcare service system in Thailand in 2012 – 2014. The pilot study was divided into two phases as follows:

Phase 1 : During 2012 and 2013, the study was conducted at four sites including Ramathibodi Hospital, Siriraj Hospital and King Chulalongkorn Memorial Hospital – Thai Red Cross Society and

a health promoting hospital. The former three were university hospitals under faculties of medicine in the central part of Thailand and the latter one was under the Regional Health Promotion Center 6 in Khon Kaen Province.

Phase 2: During 2013 and 2014, the study was conducted at five sites including Songklanagarind Hospital, Srinagarind Hospital, Chiang Rai Prachanukroh Hospital, Phrae Hospital and Nan Hospital. The first two hospitals were under the Faculty of Medicine of the public universities, Prince of Songkla University (PSU) and Khon Kaen University (KKU). The third one was a center hospital while the last two were general hospitals.

According to the results of the pilot study in the two phases, the average efficacy of the the abortion pill reached 93.2%. As for the medical abortion safety, 80%, 75% and 64% of the service recipients agreed that they suffered from side effects, pains and hemorrhages, respectively, as much as or less than what they expected.

In the same way, more than 98% of the recipients were satisfied with the medical abortion while 99% of the recipients were satisfied with the services. Furthermore, more than 80% of the women said that the medical abortion procedure lasted shorter or as much as the amount of time they expected. About 90% of the recipients felt that the service respected their privacy and more than 95% supported the provision of medical abortion service in Thailand.

The Department of Health promoted the registration of the abortion pill in Thailand. According to the results of the pilot study which confirmed the efficiency of medical abortion, the Department of Health officially promoted the drug registration of mifepristone and misoprostol filled in the same blister pack on 30 December 2014, and regulated the pharmaceutical import company to only dispense the medicine to the Department of Health, not to any health facilities, drugstores, or other places. Moreover, the use of the the abortion pill would be monitored under the Safety Monitoring Program (SMP) for approximately two years and the results of the usage would be reported to the Department of Health and the Medical Council of Thailand. The Department of Health encouraged the inclusion of the abortion pill into the National List of Essential Medicine (NLEM).

According to the registration of the abortion pill in Thailand, the Department of Health together with the National Health Security Office (NHSO) carried out the safe medical abortion project in the healthcare service system with the aim of encouraging the inclusion of the abortion pill to the Sub-list Jor (1) or E(1) of the National List of Essential Medicine (NLEM) and supporting broader access to safe legal abortion, according to the Criminal Law and the Medical Council Regulations, among women of all ages and all patient rights. The medicine was finally put on the NLEM in the Sub-list Jor (1) or E(1) as cited in the Royal Thai Government Gazette issued on 19 January 2018 under a condition that the the abortion pill is allowed to be used only for medical reasons and for an abortion not exceeding 24 weeks of gestation in accordance with the safe medical abortion project of the Department of Health and the NHSO. In 2015, the first year of the service provision, there were 41 service units that had registered with the Department of Health for the use of mifepristone and misoprostol filled in the same pack, and the medicines were actually dispensed to 39 service units. At present, there are 135 service units that have registered with the Department

of Health for the use of mifepristone and misoprostol filled in the same pack and the medicines have actually been dispensed to 79 service units.

Since 1 October 2017, the NHSO has arranged for a lump-sum payment of 3,000 baht per person for either medical abortion with the use of Medabon® or surgical abortion under both MVA and EVA procedures among women of all ages and all patient rights, according to the Criminal Law and the Medical Council Regulations. Moreover, the NHSO has also offered the expense of Long-Acting Reversible Contraception (LARCs) at the service unit for over-20-year-old women of all patient rights. After an abortion at the service unit under the NHSO, women are also provided with a lump-sum payment of 800 baht for the IUD (intrauterine device) birth control and a lump-sum payment of 2,500 baht per person for the contraceptive implant.

Health Personnel

Activities and Achievements

Establishing the network of the Referral System for Safe Abortion (RSA) in 2014

According to the pilot study on medical abortion at the healthcare service units in Thailand in 2012 – 2014, the Department of Health has established the network of the Referral System for Safe Abortion (RSA) to support a mutual exchange of academic knowledge and ideas between doctors and multidisciplinary staff and to operate the referral system through the Unwanted Pregnancy Hotline 1663 Centre for the broader access to safe abortion among service recipients.

On 9 July 2020, the RSA was registered as a juristic person named Association of the RSA Network to support broader access to safe abortion among service recipients as well as support a mutual exchange of academic knowledge and ideas between doctors, multidisciplinary staff and health personnel. There are presently 157 doctors and 614 multidisciplinary staff working on counseling, safe abortion service and referral system. Providing doctors and health personnel with a training course on innovative safe abortion The Department of Health in cooperation with the Medical Council and the Nursing and Midwifery Council has offered a training course on innovative safe abortion at the service units for 60 doctors, multidisciplinary staff and health personnel across the country in 2020. The training course is in accordance with the guidelines of the Department of Health on medicine distribution in the healthcare service system in 2020.

The Department of Health in cooperation with the Medical Council and the Nursing and Midwifery Council published a handbook titled Standard of Practice for Comprehensive Safe Abortion Care for the training course on innovative safe abortion in 2018. The handbook has currently been printed for three times over 2,000 copies. Following up, monitoring, and empowering the service units that provide safe abortion services.

The Department of Health has supported the RSA staff at the regional level by creating a platform for them to exchange ideas and share their work experience in the different regions, following up, monitoring, and empowering the service units that have provided, are providing and starting to provide the safe abortion services in order to support and encourage the doctors

and multidisciplinary staff to provide and improve medical abortion services . There are currently 149 service units in the Referral System for Safe Abortion (RSA) and 94 of them have offered the abortion services in actuality including 67 units under government sector and 27 units under private sector. There are 22 service units that only adopt the medical abortion procedure with the use of Medabon® while 16 service units adopt either MVA or EVA surgical abortion procedures. There are presently 56 service units in 34 provinces across the country using both of the medical and surgical abortion procedures.

Service System Development

Activities and Achievements

Developing new approaches of medicine management system

Since the Department of Health has carried out the safe medical abortion project in the healthcare service system with the aim of encouraging the inclusion of the the abortion pill to the Sub-list Or E(1) of the NLEM, the Department of Health together with the National Health Security Office (NHSO), two approaches of medicine management have been applied as follows:

Approach 1: Contracted units of primary care, referral units, and the service units in cooperation with the NHSO that have registered for the use of medical abortion with the Department of Health are able to receive the medical abortion through NHSO's drug system programme. The medicine is distributed through the SMART VMI system of the Government Pharmaceutical Organization.

Approach 2: The service units that have registered for the use of the the abortion pill with the Department of Health are able to purchase the medicines from the pharmaceutical import company through the Department of Health.

The service units that want to use mifepristone and misoprostol filled in the same blister pack (Medabon®) are required to register with the Department of Health in order to be able to acquire and use the medicines.

The registration process is the following.

For both public and private service units in cooperation with the NHSO

STEP 1 : Prepare relevant documents and request for the registration number The service unit shall submit the registration form (MTP - 1, MTP - 2) to the Department of Health as a request for the registration number. The request will be responded within 3 – 5 working days from the day the form is received.

The registration number will be sent to the NHSO and the Government Pharmaceutical Organization to activate the medicine distribution system followed by the the abortion pill distribution.

STEP 2: Registration for the abortion pill acquirement through NHSO's drug system and distribution through the SMART VMI system.

The NHSO opens for the registration and medicines acquisition in every October, January, April and July. The medicine will later be dispensed to the service units through the SMARTVMI system with the cooperation of the Government Pharmaceutical Organization. During the process, the health personnel are able to access information about the medicine on the website of the Bureau of Reproductive Health. For private service units not in cooperation with the NHSO, the abortion pill can be purchased through the Department of Health by the following steps.

STEP 1: Request for the 5-digit registration number of the service unit at the provincial public health office.

STEP 2 : Submit the request form for the registration number.

The service unit shall submit the registration form (MTP - 1, MTP - 2) to the Department of Health as a request for the registration number. The request will be responded within 3 – 5 working days from the day the form is received.

STEP 3: Purchase the medicine through the Department of Health.

After receiving the registration number, the service unit is able to purchase the abortion pill through the Department of Health.

The purchase order depends on the amount of the medicine. In general, the pharmaceutical import company will place an order when the amount of order exceeds 2,000 packs of the medicine and such order processing takes about 6 months. It is probably faster if the amount of the medicine is in stock.

At present, there are 135 medical service units that provide medical abortion service and 79 of them have actually provided the service, including 57 service units under government sector and 22 service units under private sector. Creating and improving an innovative training course on safe medical abortion services The Department of Health in collaboration with the Nursing Division under the Office of the Permanent Secretary of the Ministry of Health, the Medical Council of Thailand, the Royal Thai College of Obstetricians and Gynaecologists, the Nursing and Midwifery Council, the National Health Security Office (NHSO), the Thai Health Promotion Foundation, the Referral System for Safe Abortion (RSA) network, the Choices Network Thailand and other relevant organizations created, has improved and offered both in-person and online training course on safe medical abortion services for health personnel interested in safe medical abortion services.

The innovative training course is comprised of four modules as follows:

Module 1	Safe Abortion Policy and Criminal Law
Module 2	Attitude, Concept and Understanding of Safe Medical Abortion
Module 3	Comprehensive Safe Abortion Care (CAC)
Module 4	Management of Safe Abortion Service

The Bureau of Reproductive Health, Department of Health, Ministry of Public Health has developed an online course on “Innovative Safe Abortion” for medical and health personnel working for hospitals and service units with the aim of broadening the knowledge of safe abortion and encouraging the personnel to achieve the adequate standard of safe abortion services and

to provide recipients with birth control service after having an abortion to prevent unintended pregnancy properly and accurately.

The course takes 3 hours and 30 minutes. After completing the four modules of the course, the medical and health personnel who pass the post-test, and have completed the overall assessment as well as the satisfaction questionnaire on the online course will be certified that they have completed the course and will be able to print the certificate of achievement on the online course, download the Standard of Practice for Comprehensive Safe Abortion Care handbook and other relevant documents. The personnel will also be eligible for the registration for the use of the the abortion pill (mifepristone and misoprostol filled in the same blister pack) with the Department of Health in order to legally operate the medical abortion service at the service unit. The registration form for the use of the the abortion pill (MTP 1 – 4) is available on the website of the Bureau of Reproductive Health, Department of Health.

Developing guidelines for legal abortion service

According to the offence of abortion in Sections 301 – 305 of the Criminal Code and other laws relevant to abortion, the Department of Health, Ministry of Public Health, the Medical Council of Thailand and the Royal Thai Police have been working together to develop the legal abortion guidelines in order to improve the understanding about the process of legal abortion service among the personnel at the Royal Thai Police. The guidelines also serve as an approach to objectively review the law enforcement, and help the abortion service providers to better understand the operation of the police. The guidelines for legal abortion services also bolster confidence among the health personnel who operate the safe legal abortion services.

Developing the medical abortion service system through telemedicine

Regarding the COVID-19 pandemic, the World Health Organization declared the outbreak a Public Health Emergency of International Concern in late January 2020 and the Thai Government has listed COVID-19 as a dangerous communicable disease in accordance with the Communicable Disease Act, B.E.2558 (2015).

Moreover, the Prime Minister declared a state of emergency following the Emergency Decree on Public Administration in Emergency Situation, B.E.2548 (2005) in response to the outbreak of COVID-19. The measures implemented to minimize the spread of COVID-19 in Thailand including social distancing, wearing a face mask, COVID-19 screening to at-risk groups and immigration detention, for example. Consequently, it is harder for people to travel between provinces, and the service units that provide abortion services are not available in some provinces.

The Department of Health in collaboration with the Referral systems for Safe Abortion (RSA) network and the Unwanted Pregnancy Hotline 1663 Centre has developed an approach to provide safe medical abortion services through telemedicine in order to provide the recipients with easier access as well as to formulate the action plan for possible crisis in the future. Telemedicine refers to a modern practice of caring patients remotely when the health provider and patient are not physically present with each other. To reduce the risk, the practice includes online counseling before and after the use of the the abortion pill. The medicine is allowed to be used for an abortion under

12 weeks of pregnancy and the pregnancy ultrasound result is required. Every health facility under the Ministry of Public Health have been informed to offer ultrasound service for women without requirement for antenatal care. It is also an alternative service for the health personnel willing to ensure the patients' safety and make the safe medical abortion accessible during the crisis. Such practice would effectively reduce post-abortion complications and mortality rate caused by unnecessary unsafe abortions.

Goal

1. To issue a set of guidelines on the provision of medical abortion that meets the standards through telemedicine system
2. To make safe abortion an optional service for doctors willing to ensure the patients' safety
3. To make safe abortion service accessible during the crisis
4. To reduce risk of post-abortion hemorrhages and mortality caused by unsafe abortions

The provision of medical abortion through Telemedicine system can be adopted under the following conditions:

1. Telemedicine for medical abortion can be adopted in the epidemic or in the crisis affecting the access to safe abortion such as the COVID-19 pandemic.
2. Telemedicine for medical abortion can be adopted when the safe abortion service unit is not accessible to recipients in the respective health area or in the province.
3. Telemedicine for medical abortion can be adopted for recipients under 12 weeks of gestation who have been taking the abortion pill.
4. Women having unwanted pregnancy are provided with online or phone counseling but the referral for medical abortion requires the pregnancy ultrasound result.
5. Reports on the use of the the abortion pill and the medical abortion service shall be submitted to the Department of Health and the Medical Council of Thailand.

The provision of medical abortion through Telemedicine system employs two methods as follows:

Method 1: Dispensing the the abortion pill to the hospital at the Primary Care Level or above near recipients' places, in case the service unit at the provincial hospital is not accessible to recipients.

1. Recipients contact the unwanted pregnancy counselor (via the Hotline 1663, at hospitals or at clinics) for information about safe abortion services before making decision. If recipients decide to have an abortion, the counselor will proceed with health indicators assessment according to the laws.
2. The counselor coordinates with the service unit that has registered for the use of the the abortion pill with the Department of Health at which the RSA doctors work, and transfers information of recipients to the doctors.
3. The RSA doctors at the service unit that has registered for the use of the the abortion pill with the Department of Health coordinate with the hospital near recipients' places to dispense the medicine.

4. With the hospital's approval, the service unit where RSA doctors work at that has registered for the use of the the abortion pill with the Department of Health will contact the recipients to get the medicine from the hospital near their places.
5. After the medical abortion, the hospital near recipients' places is in charge of following up and monitoring the post-abortion complications as well as offering contraception services for recipients.

Method 2: Dispensing the the abortion pill by post directly to recipients' door

1. Follow steps 1 – 3 as in Method 1.
2. Without the hospital's approval, the RSA doctors at the service unit that has registered for the use of the the abortion pill with the Department of Health shall request the pregnancy ultrasound results from recipients to ensure the gestational age.
3. The service unit where RSA doctors work at that has registered for the use of the the abortion pill with the Department of Health makes a VDO call to give recipients suggestions on safe medical abortion and the use of the the abortion pill followed by dispensing the the abortion pill by post directly to recipients' door.
4. The service unit where RSA doctors work at that has registered for the use of the the abortion pill with the Department of Health follows up and monitor the post-abortion conditions online. In case of complications, recipients shall go into the hospital nearby to receive treatment.

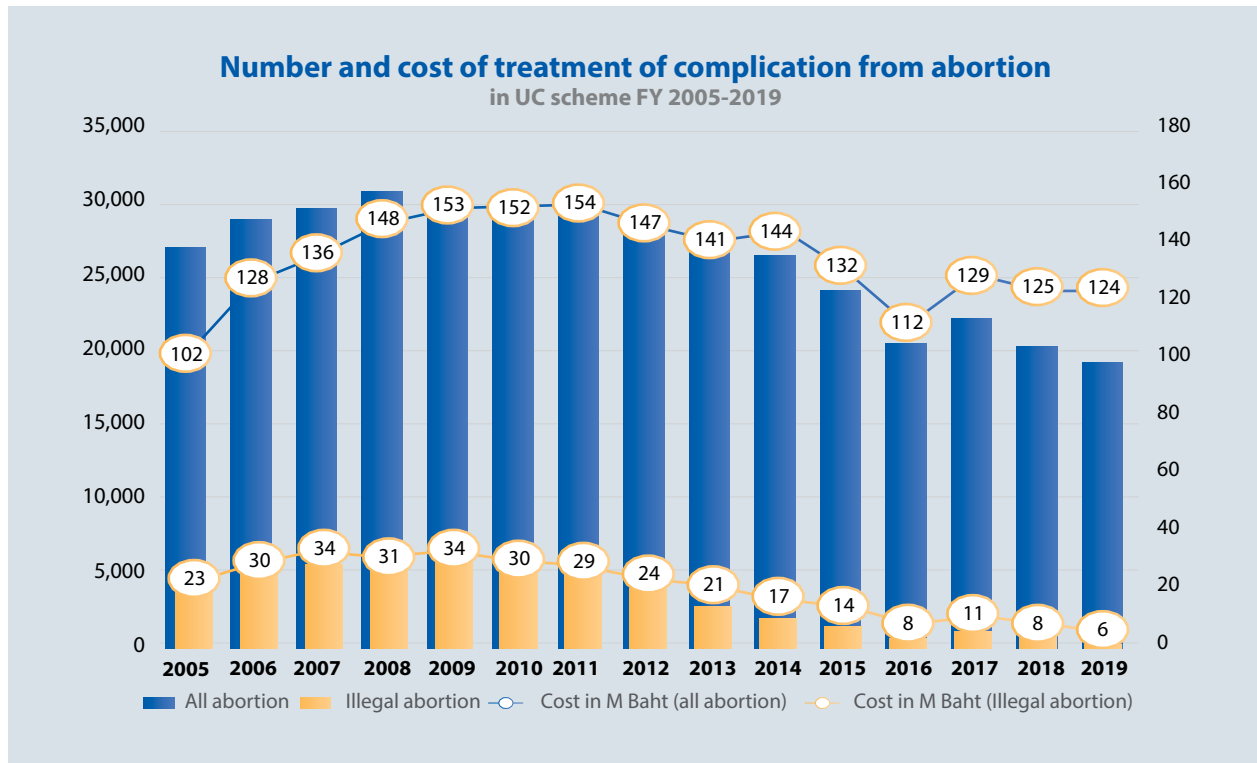
Results

1. The evaluation of the enabling factors and obstacles behind the implementation, and the satisfaction evaluation of personnel working for the service units that have registered for the use of the the abortion pill with the Department of Health showed that 46.6% of the service units offered the medical abortion service, and 41.8% of the service units suspended the service because of the changes in policies and the lack of doctors or supporting personnel. The overall recognition of the service was at high level (= 3.84, S.D. = 0.83). Factors affecting service provision in service units included the administrator's clear policy representing 87.4%, and the personnel's positive attitudes representing 77.7%. However, the disagreement of personnel and colleagues accounting for 64.1% and the personnel's lack of knowledge in the operation accounting for 44.7% were limitations of the implementation. Results of the analysis and development of the medicine management system brought about two methods including (1) The service units that had registered for the use of the the abortion pill with the Department of Health were able to receive the the abortion pill through the NHSO's drug system and the medicine was distributed through the SMART VMI system of the Government Pharmaceutical Organization.

(2) The service units that had registered for the use of the the abortion pill with the Department of Health were able to purchase the the abortion pill from the pharmaceutical import company through the Department of Health. Additionally, the personnel's satisfaction with the management system was at high level (= 3.71, S.D. = 0.83).

- Regarding the accessibility of the service among female teenagers, women of reproductive age, women having an unintended pregnancy and people using abortion services, the safe abortion services were accessible to 8,990 people. From the total amount of service recipients, 50.28% of them were women were at the age of 20 and above, and 18.89% of the women were under 20.

Impacts



There had been impacts from the cost of treatment for complications of unsafe abortion. During 2005 – 2011, great expenses were paid for treatment for complications of unsafe abortions. Then, from 2012 – 2019, the safe abortion policy under the Medical Council of Thailand’s regulations had been carried out. The policy and supports for proper and safe abortions had reduced the cost of treatment for post-abortion complications every year, as shown in the graph above.

8. Partnerships

Overview of implementing institutions

1. Educational Institutions

The Department of Health collaborated with three university hospitals which are under faculties of medicine in the central part of Thailand, including Ramathibodi Hospital, Siriraj Hospital, and King Chulalongkorn Memorial Hospital, and also with two hospitals under the government’s Office of the Higher Education Commission situated in regional parts of Thailand, including faculties of medicine of Prince of Songkla University and Khon Kaen University.

These institutions had played a vital role in piloting the use of the abortion pill in healthcare service system in Thailand in 2012 – 2014.

2. The Medical Council of Thailand, the Royal Thai College of Obstetricians and Gynecologists, the Royal College of Family Physicians of Thailand, Thailand Nursing and Midwifery Council, and medical schools The Medical Council of Thailand, Royal colleges, medical schools, and Thailand Nursing and Midwifery Council serve crucial roles in developing curriculums and training doctors and nurses to be knowledgeable and skillful in providing and upholding safe abortion service. The schools also support and promote the integration of medical abortion content in medical and nursing curriculums so that the students could spread out practices of medical abortion, as well as refer and operate medical abortion service. Moreover, the schools have arranged workshops for training medical personnel in different levels to be able to run safe abortion services.

The World Health Organization (WHO)

The WHO had joined in a pilot study of safe abortion in Thailand's healthcare service system. The WHO also had a role in supporting technical information on WHO's certified and authorized pharmacopoeia for the pilot study of safe abortion in healthcare service system in Thailand.

Role of government

1. *The Department of Health has played the following roles.*

- 1) Pushing forward the pilot study on medical abortion at the healthcare service units in Thailand
- 2) Pushing forward the inclusion of medical abortion in the healthcare service system by promoting the registration of the the abortion pill and expanding the service to regional hospitals
- 3) Encouraging the inclusion of the the abortion pill to the National List of Essential Medicine (NLEM) in the Sub-list Jor (1)
- 4) Establishing the network of the Referral System for Safe Abortion (RSA) in 2014 and promoting the network as Association of the RSA Network.
- 5) Carrying forward the enactment of the Act for Prevention and Solution of the Adolescent Pregnancy Problem, B.E. 2559 (2016), and the Ministerial Regulations on Types and Operations of Entertainment Places in Prevention and Solution of the Adolescent Pregnancy Problem, B.E. 2562 (2019)

2. The Government Pharmaceutical Organization (GPO): It takes parts in purchasing the the abortion pill (Medabon®) via Rajavithi Hospital and distributing the medicine through SMART VMI system.

The National Health Security Office (NHSO) has undertaken the following activities:

- 1) The NHSO supports the budget for the purchase of Medabon® and the medicine management system.
- 2) The NHSO arranges for a lump-sum payment of 3,000 baht per person for either medical abortion with the use of Medabon® or surgical abortion under both MVA and EVA procedures

among women of all ages and all patient rights. Moreover, the NHSO has also offered the expense of the LARCs at the service unit for over-20-year-old women of all patient rights. After an abortion at the service unit under the NHSO, the women are also provided with a lump-sum payment of 800 baht per person for the IUD (intrauterine device) birth control and a lump-sum payment of 2,500 baht per person for the contraceptive implant.

Civil society partnerships

1) Choices Network

The Choices Network is a network supporting unintended pregnant women by providing them with choices. The network had participated in a pilot study of the use of the the abortion pill in healthcare service system in Thailand. Choices Network also has been campaigning for broader access to safe abortion services among women in Thailand.

2) Thai Health Promotion Foundation

The Thai Health Promotion Foundation offers financial support for the project aiming to provide safe and friendly alternatives for teenagers and women having an unintended pregnancy. The budget has been used for developing the management of safe medical abortion service, publishing the Standard of Practice for Comprehensive Safe Abortion Care handbook for service providers, and the training course on innovative safe abortion in order to enable service providers to operate medical abortion service with the standard of practice for comprehensive safe abortion correctly and properly. The course is now available online. Moreover, the Thai Health Promotion Foundation has also developed other online channels for safe medical abortion service including the website “rsathai.org”, a Facebook page “RSA THAI”, a YouTube channel “RSATHAI”, a Twitter “RSATHAI”, and Line official “RSATHAI.ORG”.

3) Concept Foundation and Safe Abortion Action Fund (SAAF)

Concept Foundation funded for a pilot study on medical abortion in Thailand’s healthcare service system in order to find out the best and most suitable way to offer medical abortion service in Thailand, with respect to the Criminal Law and the Medical Council Regulations. The purpose of the study in two phases was to examine the approach of medical abortion by using mifepristone and misoprostol filled in the same pack, at the healthcare service units in the nine participating hospitals in 2012 – 2014.

Monitoring and Evaluation

In order to monitor, frequent visits are ensured to the service units that are providing the safe abortion service, the service units that have suspended the service and the service units that would like to operate the service in their areas, in order to encourage medical personnel in providing safe medical abortion service, and to assist teenagers, women of reproductive age, women having an unintended pregnancy and people using reproductive health services, to get the best and safest abortion service.

The evaluation shows that there have been more service units that provide abortion service. Currently, there are 94 service units offering safe abortion services – both medical and surgical abortion procedures. Out of the 94 service units, 22 of them exclusively adopt medical abortion

procedure, while 16 of them exclusively provide surgical abortion service by adopting either MVA or EVA procedure. There are presently 56 service units in 34 provinces across the country using both of the medical and surgical abortion procedures.

In addition, there are many medical personnel applying to be RSA volunteers, 157 of them are doctors, and 614 of them are multidisciplinary staff who run safe abortion, counseling and referral services.

Successes and Lessons Learned

Factors for the Achievement

The achievement of the safe abortion service comprises of two factors.

1. Recipients

Recipients' knowledge and attitudes towards safe abortion have a great impact on the service and continuation of the safe abortion services. If the recipients are well-informed or thoroughly knowledgeable about procedures, pros and cons, possible post-abortion complications, how to handle them or where to get help and advices from, and have positive attitudes towards safe abortion, they will be able to make a decision to get a safe abortion on their own.

Family is also another crucial factor. If a recipient's family is optimistic about safe abortion, the recipient will be pleased to get a safe abortion service. Medical personnel sometimes need to provide knowledge and information about safe abortion to the family, so that a safe abortion is perceived as a positive method by the family.

2. Service System and Service Providers

2.1 The clear service system makes the service accessibility effective and supportive for the achievement of the safe abortion service. Besides, there must be sufficient medical supplies for the service. Administrators should manage medical supplies and devices in clinics properly. They should also provide adequate safe abortion service units.

2.2 The number of service providers must be sufficient for the recipients' need. Furthermore, service providers' competency in and attitudes are essential for service provision; consequently, activities for developing service providers' competency must be promoted, so that they are equipped with knowledge and skills in operating the service correctly and appropriately, and become positive about safe abortion service operation.

Limitations and Solutions

The major limitation to the implementation of safe abortion services is the lack of personnel. There are personnel who disagree with abortion. There are also personnel who have retired or get transferred to other offices, making them unable to maintain the services. Other limitations were lacks of medical supplies and devices for safe abortion service operation.

The problems also led to the limited coverage of the safe abortion service in Thailand.

Solutions to the problems mentioned above were that officials from the Department of Health visited the service units to broaden academic knowledge to the personnel as well as deepen their understanding about safe abortion services. A training course on safe abortion service was offered for the personnel and the service units interesting in the safe abortion service provision in order to make the services easily accessible and to expand the service units across the country.

Future Plans: extensions that are currently being implemented.

1. Encouraging the inclusion of the the abortion pill, from the Sub-list Jor (1), to other sub-lists of the National List of Essential Medicine (NLEM)
2. Expanding service units to cover 77 provinces of Thailand
3. Applying guidelines for legal abortion services on actual abortion cases and incidents in order to share lessons learned and suggest more practical guidelines for the services
4. Adopting the provision of safe medical abortion service through telemedicine system as an approach for safe medical abortion during the possible crisis in the future as well as suggesting more practical guidelines for the practice

Contact Persons

a) Details of implementing institutions

i. Project Head

Head: Renu Chunin, Retired Officer, Department of Health

Address: 103/101, Moo 9, Phibun Park View Village, Phibun Songkhram Road,
Suan Yai Sub district, Mueang District, Nonthaburi Province, Thailand 11000

Email:renuchunin@hotmail.com

ii. Leading Members

1. Dr. Prawich Chawachalasai, Medical Physician, Expert Level
2. Dr. Manus Ramkiattisak, Medical Physician, Senior Professional Level
3. Patchareewan Jensarikorn, Public Health Technical Officer, Senior Professional Level
4. Wanvisa Yupensuk, Public Health Technical Officer, Practitioner Level
5. Narongrit Lertarwut, Public Health Technical Officer, Practitioner Level

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CONTRIBUTORS

Dr. Bancha Kakhong, M.D.

Deputy Director-General
Department of Health
Ministry of Public Health, Thailand

Dr. Peerayoot Sanugul, M.D.

Director
Bureau of Reproductive Health
Department of Health
Ministry of Public Health, Thailand

CHAPTER 11

MOBILE SERVICES STRATEGY FOR FAMILY PLANNING AND MATERNAL HEALTH WITH REFERENCE TO THE TUNISIAN PROGRAM FOR REPRODUCTION HEALTH: EVOLUTION AND DEVELOPMENT

Farouk Ben Mansour

Introduction

The present study was prepared at the request of “Partners in Population and Development” with a view to presenting « the mobile strategy of the FP and RH services of the Tunisian program. In order to comprehend the status of this strategy in the offer underlying the FP RH services, we deem it useful to submit it within the overall framework of the institutions entrusted with the implementation of the national demographic strategy. The Tunisian program, launched more than 50 years ago (1964), was at the service of a more adamant project calling for the modernisation of the country. Its implementation contributed greatly to controlling population growth and improving the health and fertility indicators of the Tunisian families.

1) Overview about the country and population problems

In 1956, the year of independence, the Tunisian population was 3,448,000 ha (1). With a surface area of 164,000 km², Tunisia did not witness any serious of demographic growth. It is in fact the mismatch between the population per se, on the one hand, and the socio-economic and health environment, in which this population live, on the other, that poses a real problem. Indeed, the socio-demographic indicators at the time were very marked by (2):

1. A population predominantly rural (71% in 1956) (3)
2. A natural growth rate assessed to 3%
3. An illiteracy rate affecting more than 80% of the population

This trend has seriously impeded the economic development of the country. As a result, the state, led by President Bourguiba, opted for a population policy that is embedded into the overall development strategy and based essentially on controlling the population growth. The first and subsequent three-year development plans included quantitative objectives to be achieved in terms of contraceptives and demographic growth.

In his speeches (4), Bourguiba was quoted as saying: “... We were facing, on the one hand, an increasingly growing birthrate, and it behooves us the subsistence of the population, on the other, in a country that is provided with meager agricultural and industrial resources...”

To judge by the results of the C.A.P. (5) survey, conducted in 1964, the female population seem to be quite receptive of this policy that has revealed that women wanted an average of 3.6 to 4

children per household, (whereas the TFR was around 7). Moreover, 72% of women aged between 30 and 39 no longer wanted children, and 85% of them had no idea about modern methods of contraception (2).

To encourage and motivate governors to implement FP programs in their respective governorates, a presidential award, called the President Bourguiba Award, for the Enhancement of Family Planning policies, was established as early as 1974 (6).

2) Principles and objectives

a) The principles, underlying the guidelines of the FP program, have clearly laid down by the CEO of the ONFP (Mezri Chekir) as follows (7): “ The guideline of our program shall be put at the disposal of all out citizens, along with the adequate, health-education tools, as required, to help them enjoy their natural FP rights... Through these actions and family-planning services, we aim at underscoring the humanitarian aspect of the FP policies....”

Thus, we can deduce, from this concept, three main principles and adopt three convenient approaches:

a) Basic principles : 1. The right of the citizen to be informed and to use contraceptives 2. The service delivery for the closest target population and 3. The free choice for couples about the most adequate method to use.

b) Three convenient approaches: 1. Delivery of public services free of charge 2. Decentralisation of the program management for the regional units and 3. Need to coordinate interventions at the regional level.

c) The overall objective (8), as displayed by the program, consists in decreasing demographic growth and keeping it under control.

Moreover, the specific objective, deriving from the mission entrusted to the ONFP, as spelled out in the law N° 73-17, dated March 23rd 1973, calling for the need to establish the ONFP; as advocated in the following points:

1. To undertake studies and carry out economic, social and technical research topics view to providing the population with better welfare conditions...
2. Draw up and implement any program that is likely to establish and uphold the family equilibrium and protect the health of its members...
3. To guarantee, for natural and legal persons, operating in hospitals and health-care facilities, doctors' surgeries, pharmacies, clinics, health centers and any other unit deemed useful, the means to be informed and intervene, in various ways, so that we can contribute to the achievement of the objectives underlying the family balance and welfare.
4. To undertake the necessary training measures required by medical, paramedical and social training units.
5. To undertake a permanent outreaching program geared towards the targeted population....

The breakdown of the demography and health indicators is displayed in the various development plans of the country. In to reach these objectives, the program targets a twofold trend: First: to reinforce the FP service offer and Second: to further enhance the target population demand. In the same vein, priority has been given to the rural area where women are hardly informed by messages related to education and FP service availability. We definitely need such MOBILE CLINICS to guarantee the achievement of these objectives.

3) Context and rationale of the mobile strategy

For various reasons, the program did witness a rather slow start which has somewhat impeded its dissemination:

- 1) The mindset, which is rather conservative, among some fathers and opinion makers, such as the imams in the rural areas notably, who would consider the boys, unlike, girls as a potential sources of free production in farmlands. This traditional mindset was mainly prevalent among the less educated, and even illiterate, population segment living mainly outside the urban areas.
- 2) Health indicators (2) that display a low level as follows:
 - a. A TFR higher than 6 children per woman.
 - b. A life-expectancy at birth of 42 years in 1960
 - c. A crude -death rate of 19 per thousand (in 1961).
 - d. An infant-mortality rate of 145 per thousand.
- 3) Shortage of medical staff: According to the World Bank: in 1960, there was 1 doctor for 10 000 inhabitants. Also, the first group of students, from the faculty of medicine of Tunis, graduated in 1971. The number did not exceed 24 students (2)

The shortage in the female medical staff members, among gynaecologists, was offset by the hiring of foreign doctors (and notably from Bulgaria). These doctors were working in tough conditions due to a lack of communication with the patients. This language handicap jeopardized the communication process with women, and notably about the contraceptive methods to be prescribed by doctors.

That is why, between 1975 and 1978: 149 doctors, 846 midwives, caretakers and nurses, as well as 1485 social officials and senior national organizations were trained. (9) .

Since FS have been officially authorized to handle IUDs (insertion and removal), this has largely contributed to the spread of IUD use. (9) .

- 4) The inadequacy of first-line health units, in 1964, there were only 12 centers de Maternal and Child Protection, 9 of them were located inside the Great Tunis district (10).

In view of these main constraints and the unfavorable environment for the generalization of FP services throughout the country, and in order to make the best use of the limited staff available for the program, there was no other alternative, right at the outset, but to create mobile information and education units, in addition to other centers that were meant for service delivery. This approach of bringing the mobile units of FP services closer to the target has proven successful on the field, and notably in remote areas.

4) STRUCTURES REQUIRED for the IMPLEMENTATION of FIXED and MOBILE SERVICES

Five formal structures have taken over the management of the FP program, starting from its experimental phase, in 1964, to the present day. These changes in structures are explained by the gradual extension of the program's coverage in the different regions and the upward development of the beneficiaries of the program. In chronological order, these structures are displayed as follows:

- a) The Programming and Prevention Division: within the State Secretariat of Public Health. This division was entrusted with the management of the experimental phase of the program from 1964 to 1966 and the following year (1967). Its mission ended in December 1967. Throughout this period, the FP program was managed without any particular distinction from the other medical activities which were under the responsibility of this division as well (2).
- b) The FP Maternal and Child Protection Directorate (11). This division was established in January 1968 within the State Secretariat of Public Health in order to implement the FP program and within the premises set up for the SMI. The Directorate was managed by a gynaecological doctor. It was provided with four technical services as follows :
 1. A communication service.
 2. A training service.
 3. A statistical services.
 4. A medical service.

Under the aegis of this directorate, the program witnessed an increase in terms of the number of beneficiaries as displayed in the table below:

Unit entrusted with the program	Year	Female users of contraceptives (public sector)	Voluntary abortions and tubal ligations
Directorate of SMI-FP at the MPH	1968	8 765	3 878
	1969	10 400	5 373
	1970	13 390	5 244

Three and a half years after its establishment, this directorate was unable to handle the increasingly-growing expanded program.

- c) The National Institute for FP and Maternal and Child Protection (12). This institute was established on August 2nd, 1971. It is a public institution that operates under the direct aegis of the Ministry of Public Health. Its main task consists in "... ensuring the welfare of the family within the framework of the national economic, social and cultural development process...".

The life span of this institution was relatively short (less than two years), due to the rapidly growing workload of the program, in addition to its growing material and human needs. In view of the new users, the results recorded during this period are positive, as displayed in table (12) below:

Unit entrusted with the program	Year	Female users of contraceptives (public sector)	Voluntary abortions and Tubal litigation
Institute of SMI-FP	1971	17 040	5 477
	1972	18 310	7 088

The general fertility rate has been steadily decreasing between 1966 and 1972. (12)

Year	FMAR	births	% of Total fertility rate
1966	95 700	206 734	216
1972	1 245 000	198 785	161

In order to meet the increasing needs of the program, the state has opted for the establishment of a « specific » unit to be entrusted with the management of the FP and Population program. Thus, we have heralded the emergence of the fourth unit, i.e.; the ONFP.

- d) The ONFP (14). It was established on March 23rd, 1973. It is a '...public institution... that is endowed with a civil personality and financial autonomy ... and operating under the aegis of the Ministry of Public Health ». This unit became the strong leverage underpinning the population strategy as decided by the "Senior Population Council" (CSPop). This Council, that was chaired by the Prime Minister, gathered all ministries involved in the population strategies, organizations. Equally, the Council was required to lay down the trends underlying the ONFP actions and set up the guidelines of the action plan. To underscore the highly significant political strategies of the ONFP program, the CEO of the ONFP would endeavor to submit an annual report to President Bourguiba.
- e) The ONFP (15) This former unit has been revamped to illustrate the shift of the program towards a comprehensive family-health policy. This unit, which was established on August 6th, 1984, still exists until this very day.

One had to wait until the inception of the ONFP, that is entrusted with the specific components of the FP program, to concentrate all efforts on the attainment of the overall demographic objectives. This is operated on the basis of a thorough revamping of the program-management system.

5) Evolution of the FP program on the basis of mobile services.

Terminology:

1. Mobile Team (MT) means a non-commercial vehicle that is equipped with 4 or 5 seats and a rear trunk. This vehicle is used to transport service providers and their equipment to front-line health centers to provide FP RH services. Example: Land Rover, Peugeot 504 family car
2. Mobile Clinic (MC) means a truck with a long chassis and carrying a compartmentalized cabin. This facility is equipped with a gynaecological examination table, running water and various storage units for medical equipment, medicines, medical records, etc., It is amenable for medical consultations. The MC is meant to transport providers and offer FP RH services in areas where fixed health units do not exist.



Inner side of a MU

Gynaecological examination table

Washbasin and workspace

3. EM and CM these two acronyms stand for 'Mobile Units (MU)'.

Right at the outset, the offer of services has gone through several successive stages, often dependent on the availability of adequate health units, as well as the service-providers who are specifically trained in the medical and communication fields. These steps can be summarized as follows:

a) Experimental Phase (2)

In 1963, an agreement was concluded with the Ford Foundation, to carry out an experimental FP program over two years (1964 - 1965). Thanks to the technical support of the Population Council, this program was placed under the aegis of the Secretary of State for Public Health.

It is worth indicating here that “...this experimental phase took place in an adequate political and social context that was conducive to the use of contraception. The obstacles encountered were generally related to a precarious mindset (and notably religion). Massive information on contraception was smoothly and widely disseminated. This was amenable thanks to positive role played by the mass media...”. (12)

The program comprises the three major components: training the stakeholders, information-education and FP services. These services were provided on the basis of two intertwining approaches:

1) Fixed services:

FP services were initially offered in 12 PMI centers (2), entirely free of charge, including 9 in Tunis, where women were entitled to oral contraceptives, spermicidal creams, as well as jellies and condoms. A few months later, the offer of the “Boucle de Lippes”, a kind of* IUD, gave the program fresh impetus. In view of the greater acceptability of the IUD, compared to other contraceptives, it was decided to extend the offer of this method and equip the 39 regional hospitals with competent staff. It should be noted that, at that time, the gynaecologists considered IUD insertions and removals to be medical acts that fall under the scope of the exclusive competence of their specialty.

2) Mobile Services:

During this phase, “Mobile Teams”, numbering five (5), were created and attached to regional hospital, in 5 of the 13 governorates of the country. Their function consisted in offering FP services to the populations in the PMI and health centers located in the relevant governorates.

These MT depended on the availability of the gynecologist (the only one authorized to handle the IUD). They would operate on the field only 4 working days a week and visit peripheral units that are provided with the minimum equipment to provide FP services, and notably the gynecological

examination tables (needed to handle the IUD). The rest of the essential equipment was provided from the hospital.

The results of this phase were encouraging and allowed about 30,000 women to visit, on average one fixed or mobile center, at least once and helped use about 20,000 IUD insertions.

This achievement has encouraged both the Ford Foundation and the Population Council to extend their assistance for another two-year period.

b) Extension Phase (2) :

1) IEC Services:

In each of the 13 governorates of the country, a man and a woman, recruited from among the regional senior staff members, to make a pair in charge of disseminating the public information and education program in the area where FP modules were applied. They received basic training focused on the principles of communication and the messages to be conveyed to the population.

The work of these “educators” was done through group meetings that were organized by professional stakeholders operating in specific settings of the public and private sectors, as well as through individual or small group meetings held for the community population.

2) Medical Services

Based on the positive results, achieved during the previous phase, the managers have decided to extend services to encompass the 13 governorates of the country. Therefore, a Mobile Team is ready to deliver services, right at the outset, for each one of the governorates.

Scheduled visits were made on the basis of 1 to 3 centers, on average, per outing. The traveling distances are often long and take the medical staff members up to great 100km beyond their location. i.e. (the regional hospital), at the risks of diminishing the number of new IUD insertions to 10 and sometimes even less.

3) Results and discussion:

The IEC activities, undertaken according to standard practices, constitute a “sine qua non” condition to reshape the mindset of people and attract new users of contraceptives. Unfortunately, the messages conveyed by during this phase by peers, operating as educators, did not generate the expected impact required for the popularization of contraception. To judge by the number of new users* and the number of new DIU insertions, we can state that during the two extra years (1966-1967), we have registered (10):

- 22 280 new users (NU), in other words, an average of 38 per working day for all fixed and mobile centers of the country.!!!
- 18 800 new DIU insertions. This figure is far below the expected number which had been scheduled for 120 000 insertions over 2 years.

* users and acceptors: Widespread words in Tunisia to refer to the people who use modern contraception methods

Results yielded by the « national » FP program (1966-67)

		User of contraception (public sector)	Voluntary abortion and tubal ligations
Program extension phase (MSP)	1966	11 150	2 162
	1967	10 630	2 073

This setback of the program is ascribed, up to a large extent, to a certain mistrust on the part of women regarding the side effects deriving from the insertion of the IUD (temporary lengthening of the duration of menstruation during a few cycles following insertion); and for which they women not fully prepared. There was also a lack of information on the part of service providers such as gynecologists. In sum, the educational messages were not as accurate as they should have been.

It should be noted, however, that use the gynaecologist, for unprofitable mobile services, constitutes a shortfall for a specialized skill that would have been more profitable, if employed otherwise, such as in abortions and tubal ligations. This is all the more relevant as the medical density was 1 doctor per 10,000 inhabitants (in 1960).

6) EVOLUTION of the FP CONCEPT

Since its inception, the FP program has gone through several stages. The initial concept of FP has changed in meaning depending on the achievements. From birth control to birth spacing, it has evolved to family health, then to reproductive health and now to service quality with a pledge to abide by the Millennium Development Declaration.

7) DESIGN and PLANNING

The reorganization process, undertaken by the ONPFP, is based on the decentralization of the program to be devolved to the regions. With this in mind, the following achievements have made:

a) The establishment of the regional FP centers in education (C.R.E.P.F):

The CREPF is an administrative and technical unit that ensures the planning and implementation of the ONPFP program at the governorate level. A CREPF has been established in the principal town of each governorate (18 in 1974).

This unit consists essentially of an administrative area and an area allocated for medical and surgical services. The regional staff is composed of: 1) a regional delegate who is the team leader and who represents the ONFP vis-à-vis the regional authorities. 2) a midwife supervisor (SFS) who is in charge of organizing and supervising medical activities and managing technical staff. 3) a Regional Administrator who is in charge of administrative and financial affairs, in addition to the collection of regional statistical data.

b) Activities planning and implementation:

The regional staff members are accountable for all regional activities. Also, they organize all these activities on the basis of their regional characteristics. With regards to mobile activities, the CREPF managers are entrusted with:

1. The assignment of the staff members to operate in each unit,
2. The preparation of the weekly programs, in terms of outings, while identifying the units to visit and laying down to road map. This preparation is conducted jointly with the regional manager of the public health in the governorate.
3. The recording of the data relevant to the local authorities and staff members of the units to be visited, in terms of dates and times of the shifts of the mobile teams.

8) MOBILE UNITS

a) Organisation

1. Staffing:

At the beginning of the program, the gynaecologist's presence was systematic because the handling of the IUD was considered as a medical act that only doctor could handle. This idea has proven to be wrong and reality, on the ground, has shown that competent midwives were capable of taking over from doctors. (2).

This team is made as follows:

- A driver
- A competent midwife
- A nurse and a caregiver
- An educator is not an immutable member within the health team

2. Equipment and specific material:

- -gynaecological examination box containing sterile material (speculums of various sizes - neck forceps - tongue forceps)
- Pair of scissors
- Pad drums
- Sterile gloves
- Medical and obstetrical stethoscopes
- Tape measure
- Tensiometer
- Disinfectant solutions (Dakin - iodised alcohol - 90° alcohol)
- Adult bathroom scale
- Ayre spatulas for cervical sampling
- Pap smear fixative
- Cervical smear slide with identification label

3) Contraceptives :

- Oral contraceptives
- DIU
- spermicides
- Condoms
- Injectables

4) Medications:

- for pregnant women (iron-based medicines)
- for the management of STIs
- other commonly-used medications.

5) Working documents:

- blank medical records
- the statistical data register
- the booklet of referral forms for specialized consultations
- The medical records file is often kept at the health facility level.

6) . Health services delivered:

- delivery and monitoring of contraceptive methods
- clinical diagnosis of pregnancies and pre-natal examination
- postnatal consultation
- gynaecology

After addition of RH services :

- Syndromic management of STIs
- early detection of cervical cancer
- clinical breast examination (early detection of cancer and other pathologies)
- referral for infertility and sexology consultations

b) Circuit and organizational chart

The organizational chart of each mobile unit was devised to help the maximum number people profit from the mobile services. As a result, the frequency of visits to the different areas would vary according to the density of the beneficiary population. The number of units visited was also variable, given the distances to be covered daily. The organizational charts were revised according to the results achieved and the vagaries of the weather conditions that sometimes prevented women from travelling. Also, and in order to reduce the distances and save fuel, the MT were often decentralized, at the level of delegations, and stay in the parking lots of the regional hospitals instead of returning to the principal town of the governorate where the CREPF is located.

c) Distribution :

All ONFP regional centers are equipped with MU, except for the capital Tunis, where urbanization has reached 100%.

The MT, assigned to the Regions, increased from 15 in 1972 to 50 in 1979, then to 86 in 1994 and 100 in 1999 (10).

In fact, this coverage hides obvious disparities in terms of use. In 1978, only 28% of rural FMAR used contraceptive methods, compared to 59% in Tunis and 58% in other urban areas.

The VIth Development Plan emphasizes "... the need to increase the supply of services in rural areas..." Furthermore, it is recommended to build new primary health centers and increase the number of mobile clinics. However, the commissioning of these vehicles was initially confronted with serious problems such as the one mentioned in the 1983 activity report, which states that the triggering of some MCs was somewhat delayed due to the lack of available FH on the spot. Hence, it was necessary to wait for a redistribution of available personnel and new FH assignments in order to launch mobile services in the rural areas.

d) Reorganization of mobile teams

The mobile strategy of the program, adopted as early as 1980, had made it possible to cover many of the country's front-line fixed units. In contrast, the majority of the rural population, living in deprived areas and without fixed health facilities, were unable to enjoy the services provided by the MT. As a result, and despite being a target population, they still could not have full access to the services of the IHP program.

In the same year, a seasoned woman, in the field of social affairs, was appointed as head of the ONPFP. Only then, was the Mobile Strategy given a new lease of life by planning to extend services to rural and remote areas and consolidate the breakthroughs performed in this sector.

Thanks to the support of the Population Council and financial assistance from USAID, provided in 1982, the program was able to consolidate its achievements and expand the scope of its mobile services:

- a. 56 new cars "Dodge Omni"
- b. Funds to train about 50 FP facilitators and assign 2 senior officials to monitor the activities conducted on the ground.
- c. Funds to produce eight (8) new mobile clinics.



Dodge Omni car (MT)



a former MC on the ground



Arrival of consultants

It is a three-pronged approach of creation and innovation that responds to the needs on the ground as follows:

1) Extension of services to encompass the deprived areas: The new MC were designed to work in rural areas lacking first-line health units. This mobile unit could accommodate gynecology and FP consultations (especially IUD insertions and removals). It is equipped with an external TV screen that can transmit visual information and education messages to the population at the assembly points. In order to ensure good quality of the services and guarantee their acceptability by the

beneficiaries, the Education MT would arrive one day ahead of the MT members to pave the ground and inform the population of the visit.

To be fully discharged of its duty, the clinic was well equipped with a gynaecological examination table, an adequate light source, the necessary medical equipment, a sink with running water from a tank, toilets, an external generator, a table, stools, storage drawers, shelves and other functional utilities. It should be noted that the clinic is air-conditioned in order to offer the best working conditions to service providers.



Midwife working in a MC



Blood-pressure measurement



Video-integrated education session
at the MC

The new MC were assigned to 8 governorates: in the north, west, center, south and border regions (in 1975, the country had 17 governorates, now the number has reached 24). Each CM works jointly with an education MB comprising a driver and one, or more, FP animators.

2) Establishment of education MT: A new profile of education staff called “FP Facilitators” has been set up to work on the ground in the rural areas. For this purpose, about 50 girls from rural areas, in the 17 governorates of the country, have been trained for 6 months to disseminate information and provide education. The training program covered, in particular, the state’s demographic policy, the medical aspect of FP, the demographic component, communication and message transmission, the psycho-social profile of the rural population, data deriving from the latest fertility survey, the socio-cultural profile of Tunisian families and their attitude towards contraceptive use.

After graduation, the new facilitators were assigned to their home regions. At the same time, new drivers holding heavy-truck driving-licenses, were recruited to drive MC staff members all over.

3) Revamping the MC vehicles : Une partie des voitures “Dodge Omni” avait servi pour remplacer un certain nombre de voitures vétustes des EM, dont certaines avaient dépassé 10 ans d’âge. L’autre partie a été réservée pour la création des voitures destinées à l’éducation en général et essentiellement dans le milieu rural nouvellement desservi.

Some of the “Dodge Omni” cars were used to replace some older cars that had been used by the MT staff members form more than 10 years. The remaining vehicles were spared to be used for education purposes, and notably in the newly-set rural areas to be receive FP services.

e) Results performed after 1 year (12):

The 1983 ONFP activity report has revealed that the 1982 results were quite positive. We display the following points:

- The recent reinforcement of mobile services has made it possible to visit 762 health centers and assembly points with activities in SPFSR. This performance accounted for 78.8% of the actions undertaken with regard to the national program. The remainder was distributed as follows:
- The 38 CREPFs and ONFP clinics accounted for 3.9%
- The 167 centers, operating under the aegis of the Ministry of Public Health accounted for 17.3%.

These results do prove the paramount status that the mobile strategy holds in terms of success of the Tunisian FPRH program.

9) IEC Status within the National Program

Right at the outset, the education program was preceded or accompanied by the modules of FP services. Hence, the education staff members were either integrated with the mobile teams or operated through independent units that are specifically dedicated to education.

Even though IEC activities were aimed at the overall population, what happened on the ground is that some categories enjoyed some preferential treatment as the program evolved. Thus, WARMS was considered as a prominent segment in the IEC strategy given the paramount importance that was granted to fertility control. Subsequently, with the advent of the concept of “family health”, increasing attention was paid to men as partners in the field of reproduction health. Also, and since the expansion of services to encompass the various components of RH, the IEC focused on the young category of both sexes, be it in terms of sexuality of reproduction health.

Given the decline in foreign aid to the program, the ONFP has concentrated its services on the rural areas, reinforced its activities in its own centers (the CREPFs) and devolved part of its activities to primary health care teams, as well as to certain maternity hospitals, particularly those qualified as university hospitals, since they were equipped with real clinical, operative and educational FP services (Rabta - Sousse - Sfax and Bizerte).

10) Influence of Education On Service Delivery (13):

In Order to Evaluate the Effect of IEC Activities on the Performance of FP medical services, a prospective study (12), based on a comparative experimental method, was conducted in a predominantly rural governorate, Mahdia, in 1984. This governorate was divided into four zones.

1. A first area that had not previously benefited from educational program and where a facilitator was assigned to work with local officials and social services to identify women who had recently given birth and who would be in need of FP services. She also made home visits to disseminate information on the availability of FP services and to ensure better follow-up for contraceptive users.
2. A second area that has benefited from a new service site that consists in introducing a new mobile team without adding any new IEC component.

3. A third zone, believed to be more rural than the previous ones, and that benefited from both types of interventions with the introduction of a new mobile clinic and the assignment of 6 new facilitators.
4. The fourth zone has not been granted any assistance. It was rather used as pilot area to double check the needs of this study.

The results, as displayed by the number of new acceptors, the results have revealed that:

1. All the areas that have received assistance have performed better than the pilot zone.
2. The highest rate was registered in the area that has been granted a dual support in terms of new service and educator sites
3. In terms of new acceptors, the introduction of the new IEC activity did generate a greater impact on recruitment than the area which was strengthened by the advent of a new service site.

To judge by the figures obtained, IEC activities can even double the volume of services provided by a MT, as the number of new acceptors more than doubled compared to what would normally be expected, if the team had continued working without any more contribution from the facilitator. This finding makes it possible to reduce the cost of the program by making the existing MT activities more cost-effective. This would be amenable simply by strengthening the IEC component, rather than by creating new service sites.

IEC activities are considered a key factor in FP programs, as they have a two-fold objective: a) To inform the population about the availability of contraceptive methods and services. b) To educate women about the correct use of contraception and inform them about what to do in case of discomfort due to possible adverse effects.

In 1982, the ONFP set up a program to extend services in 9 predominantly rural governorates by providing 8 mobile clinics and assigning 36 new FP facilitators. These facilitators were recruited among the women in the community. They were trained in communication techniques and equipped with a range of teaching materials, including figurative materials specially designed to meet the learning demands of the illiterate population in rural areas (flipcharts).

In 1983, one year after the launching of the program, the recruitment of new acceptors had increased by 27% in the regions covered by the program. One year later, the rate increased to reach 24%.

Furthermore, there is strong evidence showing the contribution provided by IEC in terms of new contraceptive users. In 1982, the purchase of the new mobile clinic, which was to be delivered to the governorate of Siliana, along with the assignment of the new facilitators, was delayed by one year. The IEC work carried out for one year, without the addition of a new service site, resulted in an increase in FP services of 57% over the previous year.

The facts mentioned above do confirm the possibility of taking better profit from the existing FP services. This would be amenable if we simply reinforced the educational activities imparted to the stakeholders concerned.

11 Multidisciplinary Mobile Health Caravans (14):

(a) Presentation: The Multidisciplinary Mobile Health Caravan (MMHC) consists of the common use of vehicles belonging to different health units and organizations, to transport paramedical and medical personnel, of various disciplines, in order to offer their services free of charge, in the same place and on the same day, to the population of any given locality that suffers from a lack of adequate health units.

(b) History: The ONFP was the first actor to introduce this kind of mobile service, by means of an educational-test caravan carried out in September 1988, in the El Achaba locality of the El Jem delegation. After this first successful experience, the ONFP decided to launch this kind of service by involving the staff and the resources of three neighboring governorates under the name of “Triangular Multidisciplinary Caravan”.

(c) Objective: To operate jointly with the various ministries and professional organizations working in the field of RH, to bring health services, particularly specialized health services, closer to poor rural categories.

(d) Organization: The area of intervention is laid down by the regional delegate of the ONFP. An organizing committee, representing the participating units, is set up to ensure the availability of the material and human resources. On average, there are about twenty vehicles carrying 5 to 6 people each. As far as the ONFP is concerned, each outing involves 3 neighboring delegations which intervene with medical and educational MT, as well as a mobile clinic (if available).

(e) Areas visited and services provided: Between 11 June 1989 and 29 August 1992, 17 areas were visited and services provided in various governorates. In addition to primary health services and medical specialties, FP, pre and post-natal services, as well as information and education service, are presented by the ONFP team. At the same time, the facilitators fill out individual cards to collect the population’s opinions on these MMHC, to have an idea about the knowledge, attitudes and practices of the local population in terms of FP.

f) Evaluations: Analysis of the data collected by the ONFP showed that the evaluation of the populations, in the visited areas, about the organization of the MMHC were positive for 66% of the people surveyed, acceptable for 23.5% and mediocre for 10.5%. With regard to contraceptive use, the differences were significant, since the percentage of contraceptive users ranged from 11% to 79.7%, and the percentage of women who had never used contraception ranged from 9.7% to 82.7%. The number of men contacted is 1257, the number of women visited at home is 4839, whereas the number of women transferred for special consultations is 1206.

These results are taken into account for the reorganization of ONFP’s mobile services in each region in order to take better profit from field activities.

12) Family Health in Rural Areas :

Prior to 1992, there were two kinds of mobile teams operating on the ground:

(1) Public Health MT: These teams are managed by the regional public health directorates (one per governorate), in order to cover the front-line health units that are not provided with fixed medical and paramedical staff. The periodicity of visits is fixed according to the territorial density of the population to be treated. The services offered are of the classic curative type.

2) MT operating under the aegis of ONFP: They visit the same kinds of centers to provide FP-RH and prenatal services.

In order to avoid this duplicated activity, a project called “family health in rural areas “* has been developed. It falls within the framework of UNFPA - ONFP 1992-96 cooperation program and covers 11 governorates in the centre and south of the country. The aim is to ensure “operational coordination between MCH and FP programs. It provided for, among other things:

- (a) The inclusion of all FP activities in the CSSB
- (b) The reinforcement of vehicles for ONFP, replacement of obsolete cars, creation of new MS and acquisition of 15 CMs to cover rural areas
- (c) The training and recycling of CSB staff in the field of contraceptive technology and communications
- (d) The training of nurses who would be called upon to prescribe contraceptives, in order to make up for the lack of FS in the relevant areas.

This project created mixed SSB and FP MT. As a result of this redistribution of tasks, some ONFP teams redesigned their services to better serve the underprivileged or poor rural areas.

For a better profitability of medical and paramedical staff, those who conducted the mid-term evaluation (16) recommended to reinforce the technical skills of providers in order to provide better psychological and medical care to FP consultants. However, this project comes to ensure a wider coverage of front-line health centers and of bringing together two units that illustrate the same concern, i.e.; to foster family health.

13) Follow-up and monitoring of fixed and mostly mobile activities

(a) Regional supervision: Activities are monitored by the midwife supervisor, who ensures that medical acts are performed in compliance with the standards and procedures, set forth, by the ONFP and provides on-site technical supervision for service providers:

1) The stress is put on the need to present the various methods available to new consumers of contraception, while taking the characteristics of each of them into account, so that woman can make a free and deliberate choice and choose the method that suits her. The midwife’s role is to ensure, through clinical examination, that there are no contraindications to the use of the selected method.

- (1) In addition, it pays particular attention to the conduct of service providers concerning possible adverse effects related to the use of contraception and particularly those related to the IUD, the most widespread method. Emphasis should be put on the psychological preparation of users for the occurrence of temporary side effects during the first menstrual period following IUD insertion.
- (2) It is used to double check the recording of the data of the consultation, for the same day, on the medical file of the consultant.
- (3) Furthermore, the method provides any data that could be requested by the midwife or nurse. This contribution is valuable as it is part of the “training on the job” approach.
- (4) Taking into account the various problems encountered during its visits, the SFS has organized ad hoc training sessions for specific persons or for the whole team. Also, it may request the support, whenever necessary, of the medical directorate for a medical opinion or for the holding of a local training seminar.

b) Central supervision:

In addition to this regional supervision, the supervising physicians of the central medical directorate pay scheduled or unexpected visits to the regions. This is in line with the monitoring of activities and the application of the instructions and directives contained in the document “Standards and Procedures of PFSR”.

Subsequently, and like the supervising physicians, a new profile was created: that of “Supervisor of educational activities” who is in charge of the activities of the educational staff (communication techniques and educational and informative materials).

c) Processing and analysis of statistical:

The information relating to each consultant is recorded over time on a special statistical register which comprises the following parts:

- (1) Identifying the consultant by means of four pieces of data. (name, age, address)
- (2) Information on contraception with specific method and follow-up: IUD - pill - condoms - spermicides - injectables - implants - request for LT / surgical abortion / medical abortion.
- (3) Information related to RH services with its different components (STIs - Breast examination - cervical cancer screening - gynaecology - infertility - menopause - Adolescents and unmarried people – more likely examinations could be requested).
- (4) Prenuptial consultation (Certificate of good health before marriage is mandatory).
- (5) Prenatal consultation with research on risky pregnancies.
- (6) Postnatal consultation on the 8th day, the 40th day, or any other dates.

The day’s statistics sheets are submitted to the Regional Secretary/Administrator who would forward them to the ONFP at the end of each month. They will be used as a basis to draw up the monthly statistical report of activities. In addition to the statistical data, produced by the ONPFP staff at the national level, the regional authorities receive additional statistics from their governorate.

d) Regular meetings between senior officials and regional staff members

The General Management of ONFP organizes regular meetings with regional delegates. More meetings with regional secretaries are equally held, along with meetings with supervisory midwives, in order to discuss with each of these participants the state of progress of the program and the difficulties encountered in different areas. These meetings, which are held on a shift system in each area, last for one day only (and rarely two). The decision to hold a meeting once a month, as set forth, in the beginning of the program, is not always respected.

f) Research: studies and surveys

Afin de suivre les activités du programme de PF/SR et d'évaluer leurs impacts sur les familles tunisiennes ainsi que sur l'environnement socioculturel, économique et environnemental du pays, l'ONPFP a entrepris des travaux de recherche souvent à étendue nationale et parfois ponctuelle, avec ou sans la collaboration d'organismes internationaux. Ces travaux de recherche constituent un précieux instrument d'aide à la prise des décisions stratégiques et politiques des décideurs. Nous citons à titre d'exemple les enquêtes suivantes (20) :

In order to monitor the activities of the FP/RH program and assess their impact on Tunisian families and on the country's socio-cultural, economic and environmental environment, the ONPFP has undertaken research work, often at a national level and sometimes on an ad hoc basis. This work is conducted jointly with international organizations. This research work is a valuable tool to assist decision-makers in their strategic and political decision-making. The list of the research work conducted is displayed below:

- Tunisian survey on fertility - 1978
- Global survey on fertility - WFS - 1978
- Tunisian survey on the prevalence of contraception methods (CPS) - 1983
- Evaluation of the FP mobile units in Tunisia in 1985 - 1986
- Health and FP survey in the center and south of the country - 1987
- Demography and health survey in Tunisia - 1988
- Tunisian survey on mother and child - 1994
- Tunisian survey on family health - 2001
- - Multiple Indicator Cluster Surveys: MICS 3 - 2006
- Multiple Indicator Cluster Surveys: MICS 4 - 2011
- Multiple Indicator Cluster Surveys : MICS 6 - 2018
- Tunisian Health Examination Survey - 2016 The health of Tunisians - ISP - February 2019

All of these follow-up activities (including supervision) have made it possible to ensure the continuity and consolidation of services, as well as the maintenance of satisfactory quality and compliance with established standards and procedures in the areas of education, information and medical practices.

14) Evaluation of the FP mobile units during 1985 (17)

Among the research studies carried out by the ONFP, there is one that stands out in terms of its subject matter. It is the survey conducted in 1985, entitled "Evaluation of mobile family planning units in Tunisia during 1985". This research (17) "...responds to one of the Office's major concerns, namely the identification of the difficulties and constraints which prevent the 62 mobile units from making the best use of the means available and making the most of the financial and human resources made available to them".

It is the only study of its kind, to be carried out by the ONFP, that discusses a subject closely related to the theme of this work. Due to its paramount importance, the study deserves to be highlighted in a full paragraph on its own in the present report.

a) Presentation:

This work, which was completed in 1985, was carried out jointly by ONFP researchers and the Population Council. The data sources, embedded in the present work, fall under two categories:

- (a) service statistics reflecting daily activities.
- (b) a questionnaire designed specifically to collect information on vehicles, education activities and the number of women requested to undergo tubal ligation and abortion.

b) Purpose of the study:

The main objective was to measure the profitability of the 63 MU, to analyze the factors influencing profitability and to compare the efficiency of the MU with that of the fixed centers.

In the same vein, the objective was to diagnose the obstacles that prevent MT from making the best use of the resources allocated to them and getting the most out of the funds invested and the human potential made available.

c) Means to measure indicators:

Performance was evaluated through 4 parameters which are: 1) The total number of visits (or consultations) 2) The number of new contraceptive applicants 3) The number of gynaecological visits 4) The estimated duration of fertility blockage through the use of contraceptive methods expressed in Couple Year Protection (CAP).

d) Results:

This study highlighted the important role played by the 63 MIUs (55 MT and 8 MC) in promoting the national FP program by carrying out one third of the total number of activities through education and the delivery of contraceptive services.

1. Geographic coverage:

- (a) Change in the number of units visited by each type of MT, from 322 in 1971 to 868 in 1985. It has multiplied by 2.65 in 15 years.
- (b) Number and types of centers: Three-quarters of the centers cover rural areas (rural dispensaries and health care wards).

2. Performance: Average activities per MU

Total number visits: the median number of visits per unit is 4027, of which 61% are for contraception purposes. The average gain in Couple Year Protection per MI is 1211 years of protection.

3. Cost :

- (a) The overall cost of MT is estimated at 44% of the operating budget allocated by the Government.
- (b) The median annual cost per MT is 15,000 dt (\$20,667).
- (c) Salaries account for 58% of the overall cost of CM.

4. Factors impacting MC performance indices:

Plusieurs facteurs interviennent à différents degrés, en particulier :

- (a) Several factors come into play to varying degrees, in particular:
- (b) (a) Population density and spread
- (c) (b) The % of educated population
- (d) (c) The number of centers served per month
- (e) (d) The monthly frequency of visits to health centers
- (f) f) The annual number of kilometers travelled
- (g) (g) The level of educational activity
- (h) (h) The annual number of activity days

5. Activity days

The study showed that the number of days off was very low : out of 296 annual working days, the EM worked for 291 days.

- (a) 19% of the days off were due to the absence and non-replacement of SF
- (b) 40 % are due to the non-replacement of the broken down vehicle
- (c) 40% are due to other factors

The study reports that MC have more days of inactivity than MT due to the fact that they break down more frequently because they work in more rugged and rocky terrain than MT.

6. Comparison of the MU with the non-mobile centers:

On average, the MT carried out 1/3 of the program activities with: 1) 32% of the total number of consultations

- (2) 26% of new contraceptive users
- (3) 33.4% of follow-up visits
- (4) 31.3% of gynaecology visits

The study reported one of the major problems faced by CM in coping with the lack of availability of midwives in some areas of the southern and central parts of the country. For example, in Kasserine, the MC, that was assigned to this governorate, was never put into operation (1985!) because of the unavailability of a FS. Therefore, the vehicle was transferred to the governorate of Zaghouan.

7. Conclusion and recommendations:

- (a) The study highlights the high status held by MT within the general program of the ONFP.
- (b) The study indicates that the rural program consumes 25% of the ONFP's budget, even though it provides only 33% of the program results.
- (c) On average, the performance and cost of MT are fairly comparable to non-mobile centers.
- (d) Most vehicles are more than 10 years old and should be replaced.
- (e) Up to 46% of the cases, the causes of SF absenteeism are for annual leave and 27.8% of cases for maternity.
- (f) The replacement cost of FS represents 6.3% of the salaries of mobile staff.
- (g) The cost-effectiveness of MT could be improved through better management to ensure on-going service (availability of staff and operational condition of the vehicle).
- (h) Nevertheless, they remain the most practical and cost-effective means of provide education and deliver services to the populations in the underprivileged areas.

15) PROGRAM SHIFT during 1984 :

In 1984, 20 years after the launch of the FP program, the country had already begun to reap the benefits of its population policy. To judge by WB statistics (19) for Tunisia, we can state that:

- (a) The fertility rate (births per woman) rose from 7.01 in 1964 to 4.59 in 1984
- (b) The fertility rate fell from 7 in 1964 to 5 in 1984
- (c) Life expectancy at birth increased from 45 years in 1964 to 64 years in 1984.
- (d) The population, aged 60 and over, rose from 4.3% in 1964 to 6.7 in 1984.

These indicators, and others, that display the evolution of the population and its fertility level, encouraged the political authorities to change the name of the National Office of Family Planning and Population to the National Office of Family and Population. Thus, FP and contraception are no longer the major assets of the program, although they still play an important role among the components of the services provided to the beneficiaries.

16) ADOPTION of the CONCEPT 'REPRODUCTIVE HEALTH' and IMPLEMENTATION of its VARIOUS COMPONENTS

In 1994, the program underwent a further transformation which consisted in including the reproductive health services and their various components, and more notably: combating IST, early detection of breast and cervical cancer, infertility, sexual and reproductive health of young people and combating violence against women. In order to equip itself with the necessary means to implement its new policy, new units have been set up, such as The Information and Documentation Centre, The Audiovisual Production Center, Specific units for young people offering education and sexual and reproductive health services.

More attention was paid to the underprivileged areas with the launch of a specific program called: "Strengthening mobile activities in grey areas".

17) REINFORCEMENT of MOBILE ACTIVITIES in the “GREY AREAS” (20)

In 1993, the State launched a national program aimed at improving the living conditions of people living in the country’s poorest areas. 1,817 so-called “grey zones” were identified with the aim of providing paved roads, building and revamping housing, introducing running drinking water and electricity, and building primary schools and community health centers. The ONFP intervened in 1995 in this project with a specific program, conducted thanks to the UNFPA support in 230 areas spread over 9 priority governorates. The project has two phases: The first includes 100 zones and the second covers the remaining 130 zones.

It aims at reinforcing the existing FP services so as to increase annually, by 10%, the following 3 aspects among the population of reproductive age: a) knowledge of RH. b) use of FP services. c) handling of modern contraception.

The first stage lasted from July 1997 to September 1999.

Facilitators were selected from these areas and received basic training in IEC in line with the FP/RH program. Equipped with educational materials, these staff members, undertook daily home visits to convey the appropriate educational message and direct MWRA (married woman of reproductive age) to the services offered by the MC.

At the end of the first phase of the project, the results were more than obvious and increased steadily:

1. pre-natal consultations by 29.6% (from 60.7 to 90.3%)
2. assisted childbirths of 19.1% (from 70.2 to 89.3%)
3. 39.9% of post-natal consultations (from 46.2 to 86.1%).
4. 20% contraceptive use (from 43.6 to 63.6%)

Results exceeded, by far, the initial 10% targeted by the project, and knowledge improved by 17%. Also, attendance at FP services reached 24% and contraceptive use amounted to 20%.

The second stage, which is also based on the same strategy, was aimed at reproducing the same work in 130 other grey zones. It was equally spread over two years from 1999 to 2001. Figures and statistics show that results were as satisfactory as in the first stage.

The strength of this project was that the work of educating and preparing the ground for the MC visits was not carried out by the MC of the ONFP in the traditional way, but rather, by accredited facilitators who are operating in their area of origin. As a result, the messages sent out to the population were well received.

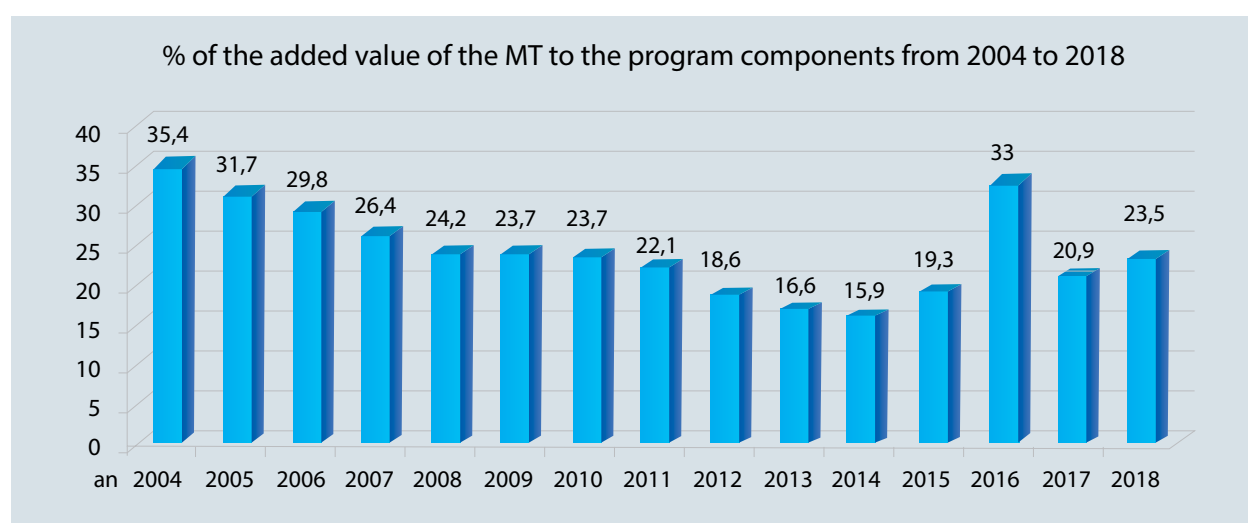
18) CONTRIBUTION of MOBILE SERVICES to the GOOD PERFORMANCE of the ONFP (21).

We propose to present and discuss, here, the contribution of the mobile units (teams and clinics) to the results of the program, in comparison to those recorded at the level of fixed centers. This has been done over the last 14 years (2004 - 2018).

For the sake of comparison, we have retained the total number of the missions undertaken: (FP + SR + pre- and post-natal)

Year	2004	2005	2006	2007	2008	2009	2010	2011
Mobile	208363	210538	188570	167097	155798	156643	172329	136089
Total	289285	664800	632353	633612	644727	659957	728153	616258
%	35.4	31.7	29.8	26.4	24.2	23.7	23.7	22.1

Year	2012	2013	2014	2015	2016	2017	2018	2011
Mobile	199771	105472	102985	132524	157085	142042	154205	136089
Total	644115	634945	645953	688245	714646	6890388	654847	616258
%	18.6	16.6	15.9	19.3	22.0	20.9	23.5	22.1



We notice that this diagram goes through two major phases:

1. The first downward trend reflects the gradual and continuous decrease in the share of mobile units at the level of the results achieved within the framework of the program, that will run from 2004 to 2014. This is explained by the progressive decrease in the number of functional mobile units, following the decommissioning of obsolete and hopeless state of vehicles. State budget restrictions did not allow for the purchase of replacement vehicles either. In 1999, the number of MU (teams and clinics) was 100. This number will witness a noticeable decline to drop to 42 in 2014.
2. In return, the second phase, has witnessed an increasing trend from 2015 onwards. This reflects the particular economic situation that the country is going through with a drop in the profitability of public health units, following the shrinkage in the state budget, the repeated strikes and the departure of several medical staff members to join the private sector or to emigrate. The population, then, fell back on the ONFP units, which are still operational and, above all, free of charge.

With regards to MU, efforts were made to recover and revamp some of these components. This effort was crowned, in 2018, by the recovery of 48 units: 47 MT and only 1 MC.

Despite these annual changes, it can be noted that the MU are still operational and provide about one quarter of the services targeted by the program. This is considered as a good performance, after all.

19) Strengths and Weaknesses of the Program:

An analysis of the MU contribution to the results, recorded by the Tunisian program, reveals the importance of this contribution: in 1985 it accounted for 30% of the activities achieved within the framework of the program (16). In 2018, 33 years later, the share of the same activities was 23.5% (20).

a) Strengths:

The program is characterized by the following strengths:

1. The political will to support the demographic strategy and ensure its integration, right at the outset, within the various development plans.
2. Free services for all social categories.
3. The change in the mindset to shift from a fixed conservative approach towards a better understanding and acceptance of modern-life requirements.
4. The decentralization process to devolve service management to the various regions for more adequate implantation on the ground.
5. Broadening the range of services delivered. Contraceptive activities are further, reinforced, by other measures, related to other maternal and family health services, and subsequently through more actions relevant to reproductive health.

The lessons learned from this experience are focused on the following three main areas:

1. Le management du processus: la gestion des unités mobiles obéit à des règles d'organisation claires et écrites et des étapes de nature à lui assurer la meilleure rentabilité . Ainsi et avant la mise en service de toute UM les préparatifs suivants ont été pris:
 1. Process management: the management of the mobile units is carried out in conformity with clear and written organizational rules and steps to ensure more cost-effectiveness. Thus, and before the commissioning of any MT, the following preparations have been taken:
 - a. Identify the routes according to the proximity of the centers and locations, while taking into account the easiest access of the beneficiaries to the service.
 - b. Take the required measures, beforehand, to inform the population, the staff of the centers to be visited, and notify the local authorities of the dates and times of the MT visit.
 - c. Set up a coherent team of service providers consisting of a midwife (team leader), a nurse or care assistant and educational staff. The driver plays a key role in safeguarding the rolling stock, given the state of the roads and the distances travelled on a daily basis.

- d. Provide services in accordance with a specific written job description for each team member.
2. To adopt an efficient training and recycling strategy to ensure competent and highly qualified technical staff members, in order to offer quality services that meet the needs of the beneficiaries and guarantee the sustainability of the program. This goes through:
 - a. The midwife has a dual competence: in terms of medical knowledge related to SRH/FP and in the field of communication and information.
 - b. The supervising midwife plays a key role in the success of the program, and notably with regards to mobile units. She is both the technical reference and the leader of the regional staff. She ensures the good quality of services that are delivered to the population in accordance with written standards and procedures.
 - c. Educational staff members who perform their duty with full respect of the citizens, while disseminating messages and imparting information that encourage them to make free and voluntary use of the program services. The supervisors of the educational personnel guide the facilitators and help them to perform their work in a proper manner.
3. Monitoring of activities and evaluation of impact.
 - a. A standard medical record is made available to FP / SRH service providers, along with an archiving system that facilitates data collection and analysis.
 - b. A statistical data collection register that allows the evaluation of the profitability and performance of the fixed and mobile consultations as spelled out in the program.
 - c. Regular meetings convened by CREPF staff to discuss the performance and operation of fixed and mobile services.

It should be noted, however, that these procedures are applied by human beings and that incidental or non-technical deviations are not to be excluded. Yet, the role of supervisors consists mainly in avoiding them and helping service providers to comply with the prescribed standards and procedures.

b) Weaknesses

Among the main obstacles that could impede the proper running of the mobile strategy, relevant to the FP/RH program, we can refer to:

1. The temporary or prolonged shutdown of a MT for a few days or weeks for various reasons, and notably due to:
 - (a) The absence of mobile staff due to leave or illness and inability to ensure the takeover,
 - (b) The unavailability of vehicles, for maintenance or repairing reasons, and for an unpredictable period of time,
 - (c) The vagaries of weather conditions, mostly during rainy seasons, where countryside roads would hard to use for vehicles.
1. The contraception stock-outs that might jeopardize the program performance and would often cause unmet demands and exacerbate people's distrust in the program performance.

2. The poor scheduling of itineraries and the working time, allocated to each center visited, that often proves to be insufficient to meet the needs of the population.
3. The replacement of retiring persons by others who do not have the same level of competence as their predecessors, and who require more training in the technical and communication fields.
4. The scarcity of financial resources to be invested in the program in order to preserve an acceptable service quality.

20) Acknowledgments:

The Tunisian skills, acquired over the last 5 decades, through the national FP/RH program, can be shared with countries that face similar demographic and family health problems, as those experienced by Tunisia. Given the similar nature of the program, it would be safe to adapt to the socio-sanitary, demographic and cultural environments of the countries of the South. The achievements of the FP/RH program, and notably the strategy underlying the FP/RH mobile services, have been welcomed by international organizations that are active in the field. Furthermore, some of these organizations have rewarded the ONFP for its outstanding performance in terms of population and health policy. Here, we propose to quote the following testimonials:

1. In 1994, and in recognition of the achievements performed by the ONFP program, and notably the CFR, the UNFPA designated Tunisia as a centre of excellence in population for Africa and the Arab world.
2. In 1999, JAICA selected Tunisia as a provider of expertise in the field of RH for French-speaking African countries.
3. In 2009, the WHO included the ONFP training and research center to the list of Collaborating Centers for Training and Research in the field of Reproductive Health.
4. In 2008, the UNDP awarded the ONFP a prize for the success of the project implemented, jointly with the ONFP experts, in KOLO, Niger.
5. In 2008, JICA awarded its 1st prize to the ONFP for the exemplary nature of its bilateral and multilateral cooperation.

21) MOBILITY and TRANSFER of EXPERIENCES among COUNTRIES of the SOUTH

Before talking about the collaboration between the countries of the South, it is important to underscore the key role played by Tunisia in the promotion of South-South cooperation. This move consists in the transfer, of the training program, geared toward the French-speaking African executives in the field of population and FP, from the ULB in Brussels to the International Training Centre (CEFIR) of the ONFP in Tunis, as agreed with the ULB.1990-1993. Subsequently, and after an evaluation of this experience, the CEFIR was designated as a centre of excellence.

Some African countries have benefited from the collaboration of ONFP experts within the framework of a triangular cooperation (Tunisia - Donor - Beneficiary country) (22). In this context, we can cite the following examples:

1. Niger has benefited from a 3-year project entitled “Project to support south-south cooperation in the field of reproductive health” with the support of the French Cooperation, in the KOLLO district which accommodates 350,000 inhabitants. It is a mobile FP/RH project that is focused on the development of local skills, the establishment of a network of mobile teams to serve isolated populations living far from health centers, the implementation of a management system with supervision and evaluation of project activities. The aim of the project was, first and foremost, to improve access to RH services and in particular: the rate of contraceptive coverage - pre- and post-natal - assisted childbirth.

The results of the project were very positive, and where success rates have reached 126% for contraception, 190% for vaccinations and 403.6 for prenatal and 323% for postnatal care.

This success has motivated the WB, UNFPA and JICA to support the promotion of FP/RH services in several areas of Niger such as Niamey, Dosso and Zinder.

2. Chad has conducted a project entitled “Mobile strategy in reproductive health and family planning in the rural region of Mayo Kebbi”. The project was carried out with the support of the World Bank and the PPLS2. The overall objective of this project was the implementation of a mobile strategy for the promotion of FP/RH services in the area mentioned above. Here too, the results far exceeded the set objectives, as the following achievement rates show: Prenatal care at a rate of 419% - Postnatal care at a rate of 242.8% - Contraceptive methods at 118% - Vaccination at 183% and population coverage at 133.3%. At the end of the project, the health officials planned to extend the same strategy to all other health centers.
3. Djibouti benefited from a project in partnership with UNFPA entitled “Support for the establishment and management of a reproductive health centre in Djibouti”. The two Tunisian experts were entrusted with the organizing of RH services, training providers and producing working documents as well as monitoring the activities and ensuring the supervision work.
4. Mali carried out a project entitled: “Support for the implementation of the reproductive health policy in the Kayes region” in partnership with the “Spanish Agency for International Development Cooperation”. The objective of this objective was to contribute to the reduction of maternal and neonatal mortality by improving the use of RH educational and medical services. The Tunisian technical support, provided in this field, allowed the authorities in Mali to focus on the areas of communication and information, training delivery and supervision techniques.
5. Mauritania carried a project entitled: “Support for a national health and reproduction program”. This project is supported by the Spanish Agency for International Development Cooperation and covers the capital Nouakchott and the Trarza region. It is scheduled for a period of 5 years (2007 - 2011). The organizers of this project have pledged to reduce maternal mortality by 25% and to support the components of reproductive health, ensure the upgrading of the technical platform and boost the competencies of program managers.

The experiences cited above demonstrate the wide opportunities that exist for the promotion of the health status of populations through collaboration and transfer of know-how among the countries of the South. Hence, the PPD is in a good position to give further impetus to this strategy. Development in the fields of population and reproductive health will continue to depend essentially on the political choices of high-level country officials, the motivation of service providers, the means being deployed and the degree of acceptability of the target populations.

CONCLUSION

More than five decades since the inception of the national FP program, and after going through several stages, it can be stated that the population policy, coupled from the outset with the socio-economic development of the country, has proven to be a relevant and cost-effective approach.

THE MOBILE STRATEGY, underlying service delivery, was not a simple choice but a duty, given the lack of qualified personnel and the limited coverage of the national territory in terms of fixed health units.

Starting from the principle, calling for the need to bring activities closer to the target populations, mobile services made it possible to cover front-line health centers and provide the underprivileged rural areas with health facilities.

By mobilizing substantial material resources and employing qualified personnel, this approach has proven to be worthwhile: fertility has fallen to levels compatible with the country's means; population growth, once described as explosive, is now under control; and lastly, the small size of households has largely contributed to the improvement of family living conditions.

However, it is worth taking into account the cost of this program in an environment where budgetary resources are becoming increasingly scarce. A cost-effectiveness study of the mobile strategy would be conducive to a better understanding of this issue.

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CONTRIBUTOR

Dr. Farouk ben Mansour

Dr. Farouk ben Mansour, Tunisian. 73 years. Retired public health physician. Perfect command Arabic and French languages, written/spoken English. Worked at ONFP for 27 years in RH, as field national supervisor then national medical director then head of the 1st pilot RH center (17 year). Holder of “the National RH Award” in 2006. National Consultant at WHO office/Tunis (2 years). Independent consultant to national and international organizations in RH”

CHAPTER 12

THE POPULATION AND FAMILY PLANNING PROGRAM OF VIETNAM SUCCESS AND LESSONS LEARNED 1992-2019

Luong Quang Dang, Phuong Thu Huong, Dr. Bui Minh Tien and Dr. Le Thi Mai

1. Overview

Viet Nam is one of the first countries in Asia that launched the population and family planning (PFP) program. On 26 December 1961, the Government issued the Resolution 216-CP on guided birth marking the beginning of the PFP program in Viet Nam. After various periods, especially since 1992, the PFP work has gained important achievements. Viet Nam has gotten Population Award of United Nation in 1999 and other Awards of the Government of Viet Nam. Viet Nam is one of a few countries has achieved MDGs by 2015 and Viet Nam is striving to achieve the SDGs by 2030.

However, before 1992, the fertility rate of Viet Nam was very high: The annual population growth rate was more than 2% per year, the total fertility rate (TFR) was 3-4 children per woman at reproductive age (15-49 years). Maternal and child mortality was high, and the life expectancy at birth was low. People's lives still face many difficulties and are always in poverty and hunger. The targets of the PFP programs set by the government have not been achieved.

Facing that situation, it was seriously requirement that the government of Viet Nam have appropriate PFP programs. The Government has set a target of achieving replacement fertility (TFR: 2.1) by 2015; the population growth rate was too fast to be controlled, reducing maternal and child mortality and improving the life expectancy at birth.

In 2005, Viet Nam achieved the replacement fertility rate (TFR: 2.1), 10 years earlier than the set target (by 2015). The growth rate of population was 1.17%/year. The contraceptive prevalence rate reached 76.8% in which modern method was 65.7%. The infant mortality rate of children under 1 year (IMR) has decreased to 17.8%. The maternal mortality rate (MMR) fell to 80 per 100 thousand live births. The life expectancy at birth increased 72.2 years. The success of reducing the fertility has brought Viet Nam enter the dividend population/ bonus demographic period with huge numbers of people at working age since 2007. It was advantages for so-economic programs in Viet Nam. By the Housing and Population census 2019, the replacement fertility has been maintained since 2005 (TFR: 2.09). The IMR dropped to 14.0%, the under-five mortality rate of children (U5MR) reduced to 21‰ and the MMR dropped to 46 per 100 thousand live births. The life expectancy at birth increased to 73.6 years, in which men are 71.0 years and women are 76.3 years. The achievements of the PFP program have made important contributions to improving people's health, improving education status, implementing gender-based equality issues, and successfully implementing the poverty reduction program, increasing GDP per capita and improveing the quality of life of the people in Viet Nam.

At present, after nearly six decades, especially since 1992 up to now, the PFP program of Viet Nam has achieved many important achievements in reducing the fertility with suitable structure of population and improving health population. The standards of people lives is increasing day by

day. Viet Nam has shifted its focus on population policy from family planning to population and development, placing population in close relationship between population and socio-economic programs, defense-public security sectors and ensures the rapid and sustainable development of the country.

What has made the PFP program success over the past decades, especially the period 1992 up to now in Viet Nam? What are the lessons learned including successes and failures that Viet Nam found out in the past periods? The Viet Nam's successes could be applied appropriately and creatively in other countries specially with countries have not yet reached replacement fertility level? How the Viet Nam case could be applied for South-South cooperation framework or triangle cooperation initiative?

The information below may meet or satisfies those key questions.



The success of the PFP program has made an important contribution to the poverty reduction program in Viet Nam, improving the quality of life for people, including ethnic minorities. Viet Nam is one of the largest rice exporters in the world.

Implementing Institutions

The whole political system (party and government bodies, political and social organization in Viet Nam) involve in the PFP program. The Party has a leading role, and government agencies, political and social organizations, NGOs, communities, families have a coordinating role in implementing PFP.

The National Committee on Population and Family Planning (NCPFP) is responsible organization.

In 1991, the NCPFP, the first PFP institution, was established. From this time, the PFP system from

central to local level was set up and step-by-step strengthened and improved.

In 2002, the National Committee for Population, Family and Children was established on the basis of merging the NCPFP with the Committee on Protection of Children. The National Committee for Population, Family and Children has functions on state managements of PFP, family and children sectors.

In 2007, the National Committee for Population, Family and Children was separated again. In which the function of state management on family is assigned to the Ministry of Culture, Sports and Tourism, the function of state management of children is assigned to the Ministry of Labor, Invalids and Social Affairs. The function of state management of PFP is assigned to the Ministry of Health and the establishment of the General Department of Population and Family Planning (GOPFP). The GOPFP was established by the Prime Minister and working today.

PFP organizational apparatus from central to local level:

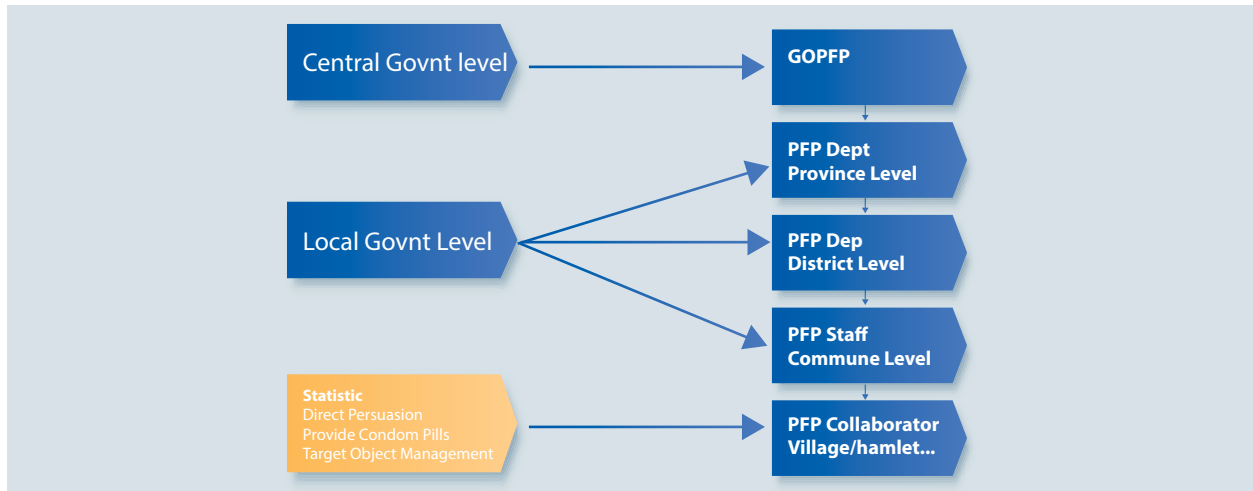
Central level: General Office for Population and Family Planning (GOPFP), Ministry of Health

Provincial level: Provincial PFP Office

District level: PFP department

Communed level: full-time officer, village population motivators/ PFP collaborators.

The network of population motivators was formed at all villages, streets, hamlets. Population motivators were provided with professional training on communication, advocacy and provision of family planning services. They are the core persons who make the PFP program successful. Different and qualified PFP intervention programs were implemented, including communication and education programs, behavior change communication programs, reproductive health/family planning (RH/FP) services, training courses, improving quality of the labour force, strengthening scientific research, promoting socialization and cross-sectoral cooperation, improving service quality and management, and finalizing the PFP mechanism from central to local level. Not only women of reproductive ages and eligible couples but also adolescents/youth, specific ethnic groups and older people get benefits from the program.



The PFP Organization system

Party commissions: Central Propaganda and Training Commission, Central Commission for Mass Mobilization, Central Economic Commission...

The Party agencies also participated with leading role in the PFP programs at all local levels

Related ministries: Ministry of Labour, War-Invalid and Social, Ministry of Public Security, Ministry of Planning and Investment, Ministry of Finance, Ministry of Education and Training, Ministry of Culture, Sport and Tourism, Ministry of Justice, Ministry of Agriculture and Rural Development, Ministry of Home Affairs, Ministry of Science and Technology, Ministry of Information and Communication, Ministry of Foreign Affairs, Committee of Ethnic Affairs...

The related sectors also participated in the PFP programs at all local levels.

- **Political and social organization:** Viet Nam Father Front, Viet Nam General Confederation of Labour, Viet Nam Farmer's Union, Viet Nam Women's Union, Ho Chi Minh Communist Youth Union, Viet Nam Family Planning Association...

The related political and social organization also participated in the PFP programs at all local levels.

NGOs, community and family in the whole of Viet Nam.



Reproductive health counseling for people in Bong Khe commune, Con Cuong district, Nghe An province. (Photo: Bich Hue / VNA)

2. SUMMARY: BACKGROUND, OBJECTIVES AND RESULTS

2.1. Background and Justification:

The Doi Moi (Renovation since 1986) in Viet Nam with many so-economic development policies has been issued and has been initially effective. However, the so-economic situation of Viet Nam faced many difficulties; especially the economic growth rate was low while the population growth rate was too fast. Viet Nam's PFP program has not been particularly successful in previous decades. In 1991, Viet Nam's population was 67.2 million people, TFR: 3.8, the annual population growth rate was over 2%. If the annual population growth rate and TFR continued the population size of Viet Nam will double in 30 years late.

The population growth rate rapidly increases is one of the most important reasons hindering so-economic development, causing great difficulties for improving life, limiting intellectual and cultural development conditions and the Vietnamese fitness. Reducing the rapid population growth rate was one of the most priority national policies of Viet Nam at that time. It must become a large, strong and profound movement in the whole country, the Party said. The Central Committee of the Communist Party of Vietnam has issued Resolution No. 04-NQ/HNTW on population-family planning sector.

2.2. Objective: to ensure small size family with healthy children to achieve happy and well-off life.

Specific objectives: By 2000, the population growth rate is 1.8%, by 2015, in the whole country, each family has two children. The total population did not exceed 82 million by 2000.

2.3. Solutions: In order to institutionalize the directions and objective given by the Party, the Prime Minister has approved the Strategy for Population-Family Planning of Viet Nam by 2000. The strategy emphasizes "lowering the population growth rate requires doing well in family planning program, having a family with few children, healthy, civilized and wealthy"

A comprehensive solution system was deployed, in which:

- Leadership and organization was the prerequisite solutions;
- Information, education, communication (IEC), family planning/reproductive health services and policies/programs are the basic solutions;
- Finance-logistics, training-research and management are the conditional solutions.

2.4. Outcomes: Major indicators were achieved ahead of schedule. The TFR reduced from 3.8 (1991) to 2.9 (2000). Viet Nam has gotten the replacement level fertility since 2005, earlier 10 years as compared with objective (2015). The fertility keeps constant until now (2019: 2.09).

The population growth rate reduced from over 2%/year to 1.28% (2000), exceed the set targets (1.8%) and 1.17% in 2005 and now 1.14% (2019).

The total population increased from 67.24 million (1991) to 77.6 million in 2000, smaller 4.36 million compared with objective (82 million by 2000) and was 86.92million 2005 and now 96.2 million (2019).



Providing family planning / health care services for the people is getting better, including ethnic minorities.

3. MAIN ACTIVITIES, ACHIEVEMENTS AND IMPACT

3.1. Main activities: As above mentions that a comprehensive solution system was deployed, in which leadership and organization was the prerequisite solutions; IEC, family planning/reproductive health services and policies/programs are the basic solutions; finance-logistics, training-research and management were the conditional solutions.

3.1.1. Population Policy:

As above mentioned, the Party has issued Resolution No. 04-NQ/HNTW and other related documents every 5 years. The National Assembly of Viet Nam also issued annual and 5-years fertility reduction targets. The Prime Minister has issued the Strategy for Population-Family Planning of Viet Nam by 2000. The Government issued an Action plan for 5-years, 1991-1995, issued improving three programs: management capacity, efficiency of family planning services and IEC programs.

The strategy is implemented in the whole country but focuses on rural areas, especially three key areas with high population density (Red river delta, Central coast and Mekong river delta).

Some policies to encourage people to implement family planning such as loan support, poverty reduction, job creation, health insurance, and support for planning service providers, PFP commune staffs, PFP collaborators. Emulation and commendation policies and programs have also been widely deployed across the country.

Likewise, in the following periods, the Prime Minister issued the Strategy for Population of Viet Nam period 2001-2010; the Strategy for Population and Reproductive Health of Viet Nam period 2011-2020. Currently, the Strategy for Population of Viet Nam by 2030 has been issued by the Prime Minister.

3.1.2. Organization:

In order to achieve the objectives that issued by Party and National Assembly, the Government established the National Committee on Population and Family Planning (NCPFP) in 1991 (previous periods, the MOH has responsible for PFP).

NCPFP is established from central to local levels (including 3 levels: province, district and commune). The PFP collaborators were working at the villages/streets/hamlets. The commune PFP staff and PFP collaborators work as method of “door-by-door”, “mouth to mouth” for providing information, advocacy and non-clinical contraception. They were key human resources for the success of the PFP program in Viet Nam. In 2002, the National Committee for Population, Family and Children was established on the basis of merging the NCPFP with the Committee on Protection of Children. In 2007, the National Committee for Population, Family and Children was separated again. The function of state management of PFP is assigned to the Ministry of Health and the establishment of the General Department of Population and Family Planning (GOPFP).

Currently, at the central level is GOPFP that was established by the Prime Minister. At the local level: 63 PFP agencies of 63 provinces/cities; more than 700 PFP district agencies, more than 10 thousand PFP staffs at commune level and 140 thousands PFP collaborators in villages/streets/hamlets. Beside the PFP system, Viet Nam also establishes a PFP Committee at all levels from central to local. The Chairperson of the Committee is the leader of the Government (Prime Minister or Deputy Prime Minister at central level), President or Vice President of the People’s Committee at all levels in the locality. Members of the Committee are leaders of relevant agencies such as health, education, labor, society, investment planning, finance, women’s union, youth, labor unions, farmers... The Committee is advisable for the leaders of Government, People’s Committees at all levels to implement the PFP sector and integrate population objectives/targets and indicators into the socio-economic sectors.

3.1.3. IEC:

IEC is promoted, comprehensively implemented on mass media, expanding in scope and object; improve quality, innovate methods to raise awareness, create consensus of the whole society on PFP and increase the number of users.

IEC is implemented through all mass media channels from the central to local levels such as the Viet Nam National Television, the Voice of Viet Nam, etc. In addition, there are entertainment programs, theater, advertising, and questions and answers program... The IEC of PFP is also integrated into the educational programs, extracurricular activities and clubs of universities, high schools and secondary schools.

IEC has mobilized the participation of all related sectors such as the youth, farmers, farm workers and at all levels in the whole country. The content of IEC on family planning, the benefits of family planning, giving birth at health facilities, care during pregnancy...IEC documents are produced and distributed to all people, focusing on couples of childbearing age, adolescents, and young people.

Nowadays, the digital communication methods via smart phones and social networks are also using in Viet Nam.

3.1.4. Family Planning/Reproductive health Services:

The reproductive health/family planning service delivery network has been expanded and improved service quality from central to local levels. The services are provided to each family and users with convenient, close to the people, safe and effective.

The services have been invested and upgraded equipment, diversified family planning measures and contraceptive to meet the increasingly choice opportunities and demand of users. The providers have been enhanced knowledge and skills to meet the increasing needs of users.

Non-clinical methods of contraception are provided to users at their houses by PFP collaborators. The preventive contraceptive storage system is established at all levels from the central to local levels. Every commune has health centers in which have a doctor and midwife. At the village where the mother could not give a baby at health center, the health worker will support services for the mother at their house. The annual campaigns to strengthen both of communication and service by qualified health workers at district level to support commune level for providing high quality reproductive health/family planning services to users. Currently, Viet Nam is providing a comprehensive services packet in the life cycle approach from prenatal to old age at the commune level, including counseling and pre-marriage health check-ups, health care services for pregnancy, screening and prenatal diagnosis, neonatal, free medical services for children under 7 years old; cervical cancer, breast cancer screening for women in some places, occupational disease health care, and health care for the elderly.

3.1.5. Resources:

Since 1993, the national PFP program has a separate budget from central to local and higher by yearly. The national budget is approved by the National Assembly. Local authorities also added more budgets to the PFP program. The state budget used for contraception, family planning services, IEC, incentive, training, management, research and administrative expenses of the PFP system from the central to local government level including for PFP collaborators. Currently, contraception and family planning services are provided free for the poor.

3.1.6. Training and Research

Since 1990, NCPFP has cooperated with the Ha Noi National Economics University and the University of Economics Ho Chi Minh City to open basic population training courses (3 months) for the PFP staffs from central to local. The TOT training is also applied to provide basic knowledge about PFP for all staffs, especially at the communes, villages and hamlets.

Postgraduate training programs are also focused. Many officials are trained abroad; hundreds of employees are allowed to abroad for short terms or sharing/learning experiences. In order to ensure the scientific and practical basis for the management of the PFP program, the research is

strengthened with state-level and ministerial-level research projects. Research results contribute to making policies and programs based-evidences. The Scientific Council established at NCPFP (currently is GOPFP)

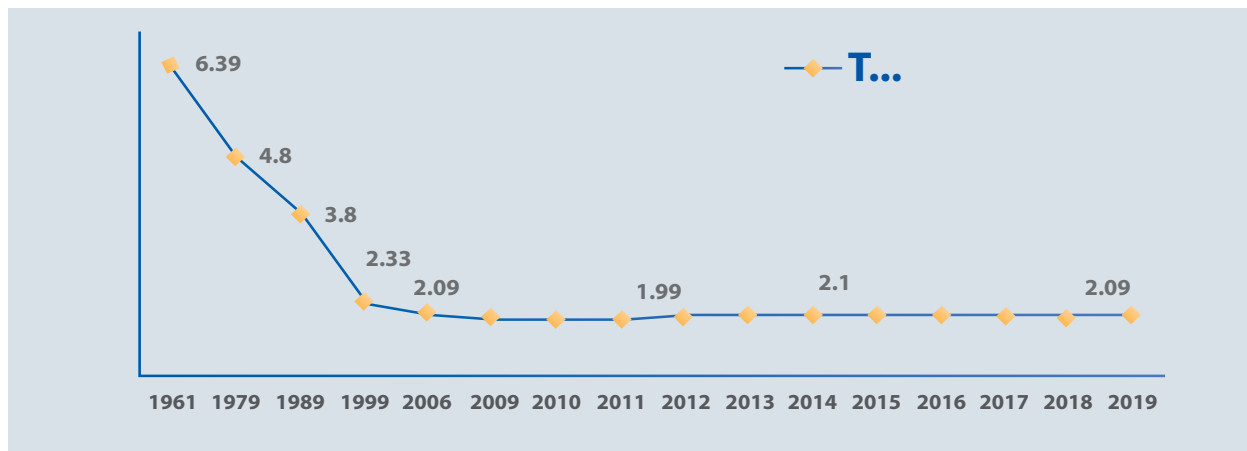
3.1.7. Cooperation:

The involvement of relevant agencies and sectors in the PFP program is very important. As mentioned in the organization item, beside the PFP system, which has function of state management in population sector, in Vietnam there are also PFP Committees at all levels where the Committee's members are relevant ministries, socio-political organizations. These member organizations all implement PFP programs in their systems. For example, the Viet Nam Women's Union has a movement for women who do not have a third child; The Youth Union has a movement of 3 goals (no early marriage, no early birth, no thick birth), the Viet Nam Farmers Association implements the male involvement in family planning; The Ministry of Culture implements the movement of cultured family, including family planning indicator. Agencies such as the Voice of Viet Nam, The National Television of Viet Nam, Viet Nam News Agency and local press agencies implement the IEC for PFP program. The participation of all ministries, sectors in PFP program created a great movement in the whole society to implement family planning and its consensus and success.

3.2. Achievements and Impacts:

With the main activities above, the PFP program of Viet Nam has achieved impressive results. The TFR reduced from 3.8 (1991) to 2.9 (2000). Viet Nam has gotten the replacement level fertility since 2005, earlier 10 years as compared with objective (2015). The fertility keeps constant until now (2019: 2.09).

TFR Viet Nam, 1961-2019

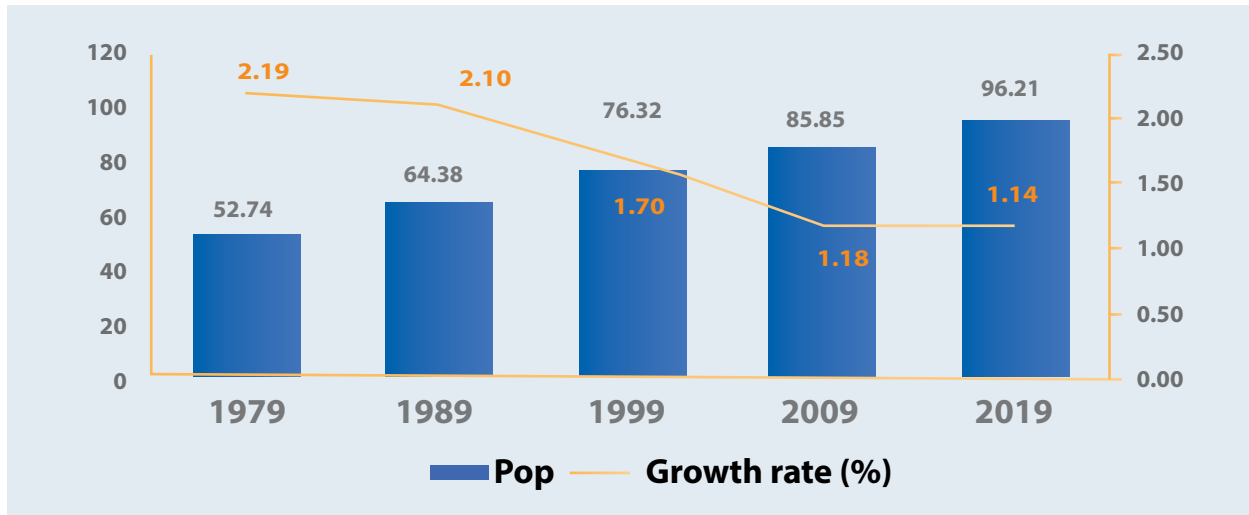


Source: GSO, Census (1979,1989,1999, 2009, 2019), Annual sample survey

IMR greatly decreased from 36.7‰ (1999) to 14.5‰ (2016), and 14‰ (2019). In 2019, U5MR was 21%, declining by over a half compared to 1999 (56.9‰). MMR was 46 deaths per 100.000 live births, a reduction of 223 deaths compared to 1999.

The total population of Viet Nam is increasing by census from 64.38 million persons (1989) to 85.85 million persons (2009) and reached 96.2 million persons (2019). However, the growth rate reduced from 2.1% (1989) to 1.7% (2009) and 1.14 (2019).

The population and growth rate, Viet Nam 1979-2019



Source: GSO, Census 1979, 1989, 1999, 2009, 2019

The declining fertility and mortality rate has made Viet Nam's population enter a dividend period since 2007 with the number of population at working age is increasing. The proportion of population at working aged (15-64 years) increased from 53% (1979) to 69% (2007) and 68% (2019). Viet Nam is an emerging destination for foreign direct investment in the world. Because of advantaged factors such as stable political environment, favorable infrastructure for waterways, airways, roads, the labor force is large, hard-working, higher technical level and cheap labor cost...The success of the PFP program has made a success in reducing poverty program, enhancing the education and health care for the people, improving gender issues as well as women empowerment, promoting migration and urbanization, increasing the GDP per capital in Viet Nam. The life expectancy at birth also increased from 65.2 years (1989) to 68.3 years (1999) and reached 73.6 (2019). Viet Nam was one of a few countries has achieved MDGs by 2015.

The successes of the PFP program over the past decades have helped Viet Nam to issued new policies for the phase towards in which improving health population quality, life quality, taking advantage of the dividend period and strongly integrate population dynamic into development program to achieve the SDGs by 2030.



The corner of Ha Noi capital, Viet Nam
Photo: VOV

4. LESSON LEARNED

The successes of the PFP program in Viet Nam have been recognized by the international community. In 1999, the United Nations awarded Viet Nam the Population Prize. In Viet Nam, the NCPFP (GOPFP) also receives great awards from the Party and Government of Viet Nam. Viet Nam also assesses the results achieved in population work and found out important lessons learned as the following:

4.1. PFP policy must be closely linked with socio-economic policy, consistent with the aspirations of the majority of people.

Viet Nam has early recognized the role and impacts of the population on economic development, social security, health, education, food security, hunger and poverty reduction programs... In 1986, Viet Nam officially implemented Doi Moi (Renovation) and has been really effective today. At that time, Viet Nam realized that if the population growth rate was too fast, even if the economic growth was high, the socio-economic will not success. Viet Nam was an agricultural poor and backward country. The vicious cycle of a large population, high fertility, low education, low health care, poverty, backwardness, and high birth again... Therefore, Viet Nam determined that the PFP program must be successfully implemented as soon as possible. The results of the PFP program will have a positive impact on the socio-economic development program.

On the other hand, the PFP program cannot be successful if it is separated from the socio-economic development program. Socio-economic development will facilitate the success of the PFP program. For example, the government provides free contraception, family planning services, and free medical care for children under 7 years old... To do this, the economy must develop to be able to free payments for users and people. When the level of education is raised, people are also more proactive in implementing family planning programs. Advancement in the health sector has also helped reduce maternal and child mortality. IMR, MMR decrease, fertility also decreases.

The program must be built in accordance with the aspirations and interests of the people. The PFP program is developed entirely from the interests of the people, by people and for the people. Viet Nam does not have the two-child policy, it is a major campaign in the whole society through IEC so that people understand the benefits of family planning and voluntarily implement it. Up to the present time, Viet Nam has no punishment for people having the third child.

4.2. The political commitment is strong by the Party and authorities at all levels.

Political commitment is the most importance to the PFP program. In Viet Nam, the PFP program only really changed when the Party issued Resolution 04-NQ / HNTW (since 1993). In 2005, the Politburo of the Communist Party of Vietnam issued Resolution No. 47-NQ/TW on continuing to implement the PFP program. In 2017, the Central Committee of the Communist Party of Viet Nam issued Resolution No. 21-NQ / TW on population sector in the new situation, with emphasis on population and development.

The National Assembly of Viet Nam issued the Ordinance of Population in 2003, the Ordinance Amended of Population in 2008. Under the leadership of the Party and the National Assembly, the Government issued specific policies, strategies and 5-year action plans, and assigning targets/

indicators and budget allocations from central to local levels. Each party member, state employee also exemplifies the implementation of the PFP program.

Under the leadership of the Party, socio-political organizations also participate in the PFP program. The evaluation of the program implementation results, comparison of indicators is done seriously at all Party agencies and authorities at all levels.

4.3. The strong organization from central to local levels

In order to effectively implement the PFP program, it is necessary to have a separate and strong organization established from the central to local levels. Before 1991, the PFP agency was under the Ministry of Health and from 1992 to 2007 was an independent agency of the Government. Currently it is GOPFP belong Ministry of Health.

The PFP system has been established at all levels including central, provincial, district and commune levels. In the villages, streets, and hamlets, there is also a team of collaborators even it is not the administrative management level.

With this system has helped making, implementing, monitoring and evaluating the PFP program to be unified and seriously. The coordination among stakeholders and integrated population indicators with health, labor, social security, rural development... is also more favorable. Beside the PFP system, Viet Nam also establishes a PFP Committee at all levels from central to local. Members of the Committee are leaders of relevant agencies such as health, education, labor, society, investment planning, finance, women's union, youth, labor unions, farmers...

4.4. The network of PFP collaborators/ motivators is developed in the whole country.

One of the most important success lessons of the PFP program in Viet Nam is the development of population collaborators/ motivators at all villages, hamlets and streets in the whole country. These staff was formed since 1992 and has been maintained up to now (although the numbers and specific person have changed). The PFP collaborators who were born and raised in their own villages, hamlets and streets. They are trained regularly, provided with the basic knowledge about population and specially family planning. They go to house to house to collect population data and propagate and mobilize people (mouth to mouth method) to implement population policies, especially using contraceptives. They also offer non-clinical contraception such as condoms and pills. They know clearly the number of people in the village, who will get married, the number of married women of reproductive age, the number of pregnancies, the number of mother will give a birth and the number of babies born... the PFP collaborators do not get a salary but just only a small amount of remuneration. Therefore, they work with all their hearts and live by hearts with great contribute to their community. The measures of encouragement and praise should be especially focused. Normally, the PFP collaborators are women.

4.5. Adequate investment for PFP Program

Viet Nam recognizes that the state budget is inadequate to meet financial requirements for action in PFP programs. The State continues to prioritize resource allocations to develop basic human capital through education and training, preventive medicine and subsidizing health insurance to

improve access to health services for disadvantaged groups, with emphasis on achieving equity goals and overcoming market failures.

To deal with resource shortfalls, Viet Nam has resorted to social mobilization strategies, namely mobilizing additional resources through fee collection in public facilities from better off individuals in society who can afford to pay. As Viet Nam develops, external assistance is less readily available, but donors are still investing in disadvantaged areas, for public health and disaster preparedness. Despite the large amount of resources spent on human development, accountability for use of these resources is inadequate, primarily due to lack of data on actual government spending and on measurement of its impact.

4.6 Integrated IEC and reproductive health/family planning services ensure convenience, proximity, safety and efficiency.

IEC and service provision go hand in hand. IEC is the mobilization of all stakeholders involved and creates a great movement in the society for people to understand the benefits of family planning and voluntary implementation.

When people accept to use family planning, services must be diverse for people to choose. Services must be provided conveniently, safely and effectively to people's homes. A number of non-clinical contraception is delivered at home to users through PFP collaborators. The provision of reproductive health/family planning services does not only focus on married women but also to adolescents. The services are expanding such as pre-marital care, baby care, postpartum, safe motherhood program (give baby at health facilities), mother-baby package, midwifery program, etc.

IEC and services are increasingly improved in quality, in accordance with the development of society, of science and technology to meet the increasing needs of the people by lifecycle approach.

IEC and service delivery are not only by the government but also need to mobilize the participation of the whole society, socialization is especially important and the participation of the private sector in provision of reproductive health/planning services with high standard for the people.

4.7. Training, research and program management.

Training and capacity building to create high-quality human resources is an important item. Training methods of TOT, training on jobs are widely applied to meet the needs of improving the knowledge, expertise and skills of the team of more than 150 thousand PFP staffs in the whole country. Making evidence-based policies and programs need focus on research. Research, survey, evaluation of the program, lessons learned from the locality are regularly held and shared throughout the country. Making evidence-based policies and programs need to focus on research. Research, survey, evaluation of the program, lessons learned from the locality are regularly held and shared throughout the country.

Training and research are not only done domestically but also with the support of international partners. Viet Nam has sent many PFP delegations to attend short-term overseas training courses.

One of the reasons that make the PFP program successes in Viet Nam is the program management by the national target program that approved by the National Assembly. PFP program is one of the most important and prioritized objectives to invest in resources and be determined to succeed. State budget was assigned to NCPFP and NCPFP signed responsibility contracts, including budget

with provinces and ministries to implement the PFP program. Monitoring and evaluation activities are implemented by agencies including the Party, National Assembly, the government, socio-political organizations, depending on the functions of each of these agencies.

4.8 International cooperation is expanded.

International cooperation is indispensable in the success of Viet Nam's PFP program. The effective support of the international community, especially UNFPA, has led to the rapid success of the PFP program in Vietnam. UNFPA has provided technical and financial support including contraceptive for Viet Nam. Many experts of the UN, other countries and international organizations have come to Viet Nam to provide technical assistance to the Vietnamese government and are ready to assist Viet Nam in sending delegations to join the other countries like China, Indonesia, Egypt, India, Thailand, Denmark, Sweden, Norway

Viet Nam joined ICPD 1994. Since ICPD, Viet Nam is more aware of population and development, and applies to policy and program development in a creative, flexible way in accordance with conditions of Viet Nam. In 2009, Viet Nam officially became a member of PPD family. With the support of the international community and the efforts of Viet Nam, Viet Nam was one of the few countries in the world to successfully implement the MDGs in 2015. Viet Nam has been consulted for SDGs by 2030.

The success of the PFP program has helped with the success of socio-economic development programs in Viet Nam. Viet Nam is one of the most attractive destinations for foreign investment in the world. Viet Nam is also increasingly integrating deeply and wirely with the region and the world community.



Celebrates Viet Nam's Population Day (26/12) in Da Nang

Source: Baodanang.vn

5. FUTURE PLANS: EXTENSIONS THAT ARE CURRENTLY BEING IMPLEMENTED.

FUTURE PLANS

The successes of the PFP program over the past decades have changed the overall picture of population work in Viet Nam. The population size of Viet Nam is 15th largest in the world, 8th in Asia and 3rd in the ASEAN community. The replacement fertility rate (TFR = 2.1), which has been maintained for the past 15 (many countries quickly drop to very low fertility, after reaching replacement fertility). Viet Nam is in the period of a golden population structure, the quality of human resources and the quality of the population are increasingly improved. These brings Viet Nam have a chance to succeed in economic development.

However, Viet Nam is also facing many challenges in population work such as some provinces and cities of Viet Nam with low fertility (TFR = 1.5-1.8); imbalanced sex ratio at birth; the need of reproductive health care/family planning continues to increase due to birth cohort. Viet Nam is aging country with the proportion of people at aged 65+ accounting for 7.7% of the total population. The number of people aged 80+ is 2 million. Viet Nam is one of the countries with the fastest aging population in the world. Internal and international migration is increasingly in the context of Viet Nam is increasingly integrating with the region and the world.

To guide Vietnam's population policy by 2030, in 2017, the Central Committee of the Communist Party of Viet Nam issued Resolution No. 21-NQ/TW on population sector in the new situation in which focus of the population policy continues to move from family planning to population and development. Comprehensive attention should be paid on the size, structure, distribution, specifically the well-being of the population that are integrated in economic, social, defense, security issues to ensure rapid and sustainable development.

Sustainably maintaining replacement level fertility; making efforts to achieve natural sex ratio at birth; taking advantage of the population dividend; responding the population ageing, reasonable population distribution; improving the population's well-being

Some indicators by 2030

Population: 104 million; Urban population: 45%; maintain replacement fertility (TFR: 2.1). SRB: 109 boys/100 girls. Life expectancy at birth: 75 years; healthy life expectancy at birth: 68 years; 100% older persons have health insurance and is provided health care.



6. REPLICABILITY AND SCALABILITY TO PROMOTE SOUTH-SOUTH COOPERATION

In 2009, Viet Nam officially became a member of PPD. Since then, Viet Nam has always been an active and responsible member of the PPD family.

The success of Viet Nam's PFP program as well as that of PPD is a good example to the success of ICPD since 1994. Viet Nam is willing and happy to share the lessons of Viet Nam in the PFP program with PPD members and other countries, especially countries that have not yet reached replacement fertility. Sharing Viet Nam's lessons learned through this small book is an example.

Under the financial support of UN, UNFPA or a third party, a triangle cooperation model in which Viet Nam has technical support if it is possible. It could be good example for the triangle cooperation or promote South-South cooperation.

CONTACTS

Implementing institutions:

General Office for Population and Family Planning (GOPFP), Ministry of Health

Add: 8, Ton That Thuyet, Nam Tu Liem, Ha Noi, Viet Nam

E-mail: lgdangvn@gmail.com

Website: <http://www.gopfp.gov.vn>

CONTRIBUTORS

Bui Minh Tien

Bui Minh Tien, Head of Obstetric and Gynecology Department, Thai Binh University of Medicine and Pharmacy, Viet Nam. He received his Medical Degree in 1998, Master Degree of Gynecology in 2005 and PhD Degree in 2012. He is a Vice Head of Nursing Department, a lecturer in Obstetric and Gynecology Department, a member of Medical Curriculum Development and Reform Committee in Thai Binh University of Medicine and Pharmacy.

Luong Quang Dang

Luong Quang Dang, Director of Personnel department, GOPFP, Ministry of Health, Viet Nam. He has gotten a BA of Law, BA of Politics (in Viet Nam) and MA of Population science (in India). Dang has been working for 15 years in the population sector. He is a member of the Scientific Council of the GOPFP, a visiting lecturer at Hanoi Medical University. He is a PCCs of PPD.

Phuong Thi Thu Huong

Phuong Thi Thu Huong, Consultant to the Centre for Population Studies, Information and Database, GOPFP, MOH, Viet Nam. She has almost 30-year experiences in the field of information and documentation. She got her Master in Population Education in 1999 and a number of certificates on population information and documentation, communication, data analysis. She had good collaboration with some International Organizations. She's now involving in other activities relating to research, survey and evaluation.

Le Thi Mai

Le Thi Mai, Staff of GOPFP, Ministry of Health, Viet Nam. She has gotten her Degree of Doctor of Preventive Medicine in Hanoi Medical University. She has been working for VNM9P01 project - the cooperation between UNFPA and MOH (Viet Nam) for 2 years.



PPD SECRETARIAT

Partners in Population and Development (PPD)
PPD Secretariat Building Complex
Block-F, Plot 17/B&C, Sher-E-Bangla Nagar
Administrative Zone, Agargaon, Dhaka-1207
Tel: +88-02 9117842, 9117845
Fax: +88-02 9117817
Email: partners@ppdsec.org
Web: www.partners-popdev.org

PPD AFRICA REGIONAL OFFICE

Statistics House, Third Floor, Room 3.2
9 Colville Street, P.O. Box 2666
Kampala, Uganda
Telephone: (+256) 414-705-446
Fax line: (+256) 414-705-454
Email: aro@ppdsec.org
Web: www.partners-popdev.org/aro

CHINA PROGRAM OFFICE

No.30 Rd. Dong Xianfu, Taicang,
Jiangsu, 215400, China,
Tel: +8651253719188, Fax: +8651253719126