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# Improving Maternal and Newborn Health – The Role of Family Planning

*Report of a Regional Consultation  
Chiang Mai, Thailand, 19–21 November 2003*

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## ACRONYMS USED

BCC	Behaviour Change Communication
CPR	Contraceptive Prevalence Rate
CST	Country Support Team
GNP	Gross National Product
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
NGO	Non–Government Organization
PRSPs	Poverty Reduction Strategy Papers
RCH	Reproductive and Child Health
SEAR	South–East Asia Region
TRF	Total Fertility Rate
UNFPA	United Nations Population Fund
WHO/SEARO	World Health Organization/South–East Asia Regional Office

## 1. INAUGURATION

The inauguration of the Regional Consultation on ***Improving Maternal and Newborn Health: the Role of Family Planning*** began with Dr Monir Islam, Director, Family and Community Health, reading the inaugural address of Dr Uton Muchtar Rafei, WHO Regional Director, South-East Asia Region. In his address the Regional Director noted that pregnancy related mortality and morbidity were highest among the world's poorest communities. The majority of the half a million maternal deaths occurred in developing countries, of which South-East Asia Region accounted for more than 30%. Eight out of the eleven SEAR countries viz., Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal and Timor-Leste had a maternal mortality ratio, that was of particular concern. India, Indonesia, Bangladesh and Nepal alone accounted for 98.3% of all maternal deaths that occurred in the Region. The *Making Pregnancy Safer Initiative* was a health sector strategy for reducing maternal and newborn morbidity and mortality. The first of its three key messages was to ensure that every pregnancy was wanted, linking it directly with family planning. Adequate focusing on family planning would contribute to improving maternal and newborn health.

Key issues in family planning that needed to be addressed included unintended pregnancies, too many pregnancies, quality of family planning services and access to services. Special attention needed to be paid when working on these issues to ensure meeting the specific needs of adolescents.

While significant progress had been achieved in the use of modern contraceptive methods, with contraceptive prevalence rates increasing significantly in some countries, other countries in the Region still lagged behind. Unfortunately, progress on family planning had become static in some countries. Furthermore, while it had been demonstrated that a reduction in population growth positively impacted social, economic, and political development, and other social sectors, including education and health service delivery, family planning was no longer a priority in the international agenda.

The Regional Director hoped that the consultation would address these issues, identify the specific problems of Member Countries, and suggest how the Regional Office could support their work in addressing family planning.

Besides introducing the country participants to evidence-based norms and standards for family planning services. The Regional Director urged that partnership with NGOs and other institutions, and integrated efforts at regional and country levels be maintained. Finally, he stressed that the sharing of individual country experiences could help in strengthening family planning services throughout the SEA Region.

Dr Prasanna Gunasekera, UNFPA Country Support Team Adviser, Reproductive Health Services, Kathmandu, highlighted the importance of the meeting, emphasizing that maternal mortality and population growth continued to be serious problems in the Region. He also pointed out that the 2002 World Health Report found that unsafe sex was the second most important aspect that contributed to the global burden of diseases, underscoring the importance of the meeting.

Dr Gunasekera said that UNFPA had a three-pronged approach to reduce maternal mortality and reduce neonatal deaths, which included increased the use of family planning. In addition, UNFPA had committed to providing support in implementing the plan of action from the 1994 International Conference on Population and Development (ICPD) in Cairo. The implementation of the ICPD plan of action would also contribute to the achievement of the Millennium Development Goals (MDGs) focusing on maternal mortality and under-five mortality. UNFPA had a fruitful collaborative relationship with WHO on many programmes, including family planning. At the country level, this collaboration translated into providing technical and programme guidance, making more effective the formulation of strategies, sector-wide approaches, and the development of common country assessments and the United Nations Development Assistance Framework (UNDAF). Dr Gunasekera hoped that through these joint efforts and in cooperation with country representatives, MDGs could be achieved and sustainable development of communities reached.

Dr Wipada Kunaviktikul, Dean, Faculty of Nursing, Chiang Mai University, welcoming the other experts in family planning, hoped that the meeting would foster the sharing of experiences and explore solutions to problems.

Dr Islam said that the meeting was a historic event because it was for the first time that the Regional Office had organized a meeting to specifically discuss family planning issues in the Member Countries. He said that the Regional office needed to understand better the needs of its Member

Countries with respect to family planning, and that only through such a dialogue would the Regional Office be able to help address these needs and support their efforts.

The List of participants and the Programme are at Annexes 1 and 2 respectively.

## **2. OBJECTIVES AND OUTCOMES**

Dr Ardi Kaptiningsih, Regional Adviser, Reproductive Health and Research, WHO/SEARO, explained that the general objective of the meeting was to assist and facilitate Member Countries in improving maternal and newborn health by addressing key family planning issues.

Based on this, the three specific objectives were:

- (1) To identify key issues relating to family planning and country needs for improving maternal and newborn health;
- (2) To introduce evidence-based norms and standards for family planning services in order to improve maternal and newborn health, and
- (3) To develop a framework for country plans of action for improving key issues of family planning services in order to improve maternal and newborn health.

The expected outcome of the meeting was to develop a framework for country plans of action for improving key issues of family planning services in order to improve maternal and newborn health.

## **3. BACKGROUND INFORMATION AND DISCUSSION**

### **3.1 The Role of Family Planning in Improving Maternal and Newborn Health: Key Issues**

Dr Islam presented the role of family planning within reproductive health, and maternal and child health. He stressed that family planning should not focus on controlling populations and meeting targets; rather it should be seen as a way to save and improve lives while meeting women's existing needs through increasing their reproductive options. He explained that family planning included both modern and traditional methods.

Statistics based on the global situation suggested that family planning could play a critical role in improving the outcomes of pregnancy and childbirth. Out of 180–200 million pregnancies every year, 75 million were unwanted. More specifically, more than half of all pregnancies in the developing world were unintended. This was the result of method failure or the lack of use of any contraceptive. Out of the 50 million induced abortions in the world, 20 million abortions were unsafe. The consequences from unsafe abortions included undesired fertility, morbidity and mortality. Furthermore, 20 million women worldwide suffered from maternal morbidity, and 600 000 died annually from pregnancy and childbirth complications. In other words, the absence of family planning put women's lives in danger.

Barriers to family planning existed at the national, district, service provider, community, family, and individual levels. These included forbidding the use of certain methods in a country, provider bias in the form of denying certain or all methods to some groups, such as adolescents or nulliparous women, and client discontinuation of a method due to partner disapproval. Where family planning needs had been met and population growth reduced, family planning had had the active support of politicians, development workers, health care providers, and communities.

Unmet need for family planning referred to sexually active women of reproductive age who were not using contraception but who wanted to limit or space their births, and pregnant women whose pregnancies were unwanted or mistimed. Among women of reproductive age, unmet need for family planning was 15% in Bangladesh and India, and almost 30% in Nepal. Interestingly, while the contraceptive prevalence rate (CPR) had been increasing, the total fertility rate (TFR) had not been declining proportionately. This was in part due to incorrect use or discontinuation of methods.

Dr Islam explained how unmet need also contributed to the problem of early pregnancy. This could result in more births over a life-time, and poor maternal and infant health. While there were laws in some countries of the Region prohibiting marriage of women before the age of 18, they were often not enforced. Also, there was strong social and economic pressure for women to get married while young, and it was often expected that young brides prove their fertility immediately or soon after marriage. Most young women and men lacked access to sufficient contraceptive information and methods while pre-marital sex and its consequences were still inadequately addressed among youth. By the age of 19, almost 60% of Bangladeshi women, about

40% of Indian and Nepalese women, and 30% of Indonesian women were already mothers or pregnant.

Bias among health care providers at all levels regarding family planning method mix continued to be a problem. Some methods took more time to explain, to follow-up with, or required discussions with clients, which might make providers uncomfortable. At other times, newly introduced methods might not be fully understood or trusted by some providers and, as a result, not offered to women as an option. This meant women's contraceptive choices were limited based on provider bias. Client dissatisfaction with a contraceptive method could lead to its discontinuation, and if the client's remaining choices were limited, this could result in pregnancy, morbidity or mortality.

Birth spacing through family planning could help reduce maternal and infant mortality, but it had not been promoted as strongly as it could be. Evidence showed that when the birth interval was less than two years, there was an increased risk of infant mortality. Recent evidence showed that a birth interval of three years was even more beneficial. In addition, saving the life of a mother reduced under-five deaths, especially among daughters.

Dr Islam emphasized that efforts needed to be made to educate community leaders, especially among minority groups, regarding demographic transition. Policy-makers and providers needed to be sensitized to better understand the root causes for the resistance to family planning.

Family planning saved the lives of women and children by helping to avoid unsafe abortion, limiting the risk of pregnancy and childbirth, reducing the number of births, and limiting pregnancy to the healthiest ages and desired points in time. It offered more choices to women, could address gender-based inequities, and encourage adoption of safer sexual behaviour. In turn, slower population growth helped protect the environment, and contributed to better socio-economic development not only for individuals, but also for society. Population growth was directly associated with education, economic development, women's rights, quality improvement, and access to services. Currently, population growth outpaced the ability of health services to meet its demands.

WHO, Dr Islam concluded, had a key role to play in addressing family planning needs. This effort would be in collaboration with governments, UNFPA, and NGOs. By working on family planning in the SEAR countries,

WHO could contribute to achieving the goals set at the 1994 International Conference on Population and Development (ICPD), support the millennium development goals, and improve development. While WHO was not a donor or implementing agency, it could provide technical assistance, advocacy and guidance for the implementation of up-to-date family planning standards and norms, and share lessons learned and best practices.

Dr Islam's presentation was followed by a discussion. The discussion points had been incorporated into the group work sections of the report since they were also addressed at that stage. Dr Islam summed up the discussion by reiterating that more needed to be done and called for increased investment for stabilizing population growth. The fatigue of family planning that some governments and donors were experiencing was politically risky; leading to conclusions such as "we have been successful so we do not need to work on this any more." As the population grows, so do the demands on the health and other sectors. In fact, even while fertility declined the population continues to grow because of the demographic transition, until replacement fertility was reached. Unfortunately, the demands of the existing population were not being met, and until there was replacement fertility, services would continue to fall short of the needs of the population. WHO's role could be in part to remind people that family planning was a health, economic, social, and political investment, that it was linked to overall development and that it needed to be given sufficient emphasis.

### **3.2 Overview of Population and Family Planning Policies and Programmes in the SEA Region**

Dr Prasanna Gunasekera made a presentation on the policies and programmes in the Region that affect fertility and family planning. He pointed out that family planning and MCH are sometimes conceptualized and carried out separately, as is the case in Bangladesh. He gave the example of Sri Lanka, however, where family planning and MCH have been integrated. With the expansion of health infrastructure and population demands, governments faced the dilemma of whether or not to integrate these two types of programmes.

A number of countries in the Region have population policies in place that address population growth concerns. Revisions made by Bangladesh on their population policy in 2002 need to be approved, while Bhutan's 9<sup>th</sup> five-year plan sets goals for 2020. India's latest policy demonstrates a shift from

population control and a focus on demographics to a Reproductive and Child Health (RCH) approach, and some states have formulated their own specific policies. Maldives has a draft population policy and Nepal aims to formulate and implement a long-term Population Perspective Plan with a special focus on relating population dynamics to poverty alleviation.

Dr Gunasekera pointed out that high fertility and population growth mutually reinforce poverty. High population growth slows economic growth and poverty reduction, while poverty supports high fertility and intergenerational continuation of poverty. With the exception of Maldives, the countries of the Region that have a TFR of 2.1 or above, have a Gross National Product (GNP) per capita of \$1000 or less. On the other hand, Thailand, which has achieved replacement fertility, has a GNP per capita of \$2000.

While population policies will soon be in place in all SEAR countries, factors hindering the achievement of replacement fertility are still present. These include poor economic growth, low female literacy, especially when compared to male literacy, high infant mortality, early marriage, lack of access to affordable and effective quality family planning services, and societal preference for large families. Conflicts also affect TFR. The conflict in North-eastern Sri Lanka has resulted in that area not only having a higher total fertility rate but also half the national contraceptive prevalence rate, double the national infant mortality rate, and more than triple the national maternal mortality ratio (MMR).

Total fertility rates are directly correlated with positive socioeconomic development indicators as well, such as education. As literacy rates have risen in SEAR countries, TFR has declined. In Bangladesh, better schooling for girls has led to improved population and reproductive health outcomes. For example, the more schooling a woman has the later she has her first birth, and she has fewer children over her life time. In comparison, where there has been little or no schooling for girls childbirth begins younger, the contraceptive prevalence rate is lower, and fertility and infant mortality rate are higher.

Dr Gunasekera discussed the experience of Bangladesh with family planning in greater detail. He pointed out a rural-urban discrepancy, where TFR in urban areas was 2.5 while in rural settings it was 3.5; there was even a slight increase in the TFR in rural areas recently. While the contraceptive prevalence has slightly improved since the mid-90s, it has declined among

the poorest in Bangladesh. There is also a high discontinuation rate in Bangladesh. This is partly due to socioeconomic reasons such as societal pressure for large families, often pushed by the mother-in-law, and sex preference for males. Alarming, fertility among women 15–19 years old steadily increased through the mid-1990s, at which point it began to decrease. While overall adolescent fertility has slightly decreased, it has increased among the poor. He suggested that policies and norms need to take into account that adolescents are not a homogenous group: for example, some are married while others not. In Bangladesh, as CPR has increased IMR has decreased, demonstrating that maternal and child health and family planning are directly related. This is mutually beneficial as each can help achieve the goals of both types of programmes.

There is a wide range of unmet need for family planning among the SEAR countries. In Sri Lanka 8% of married women have an unmet need, in India and Bangladesh it is about 15%, in Nepal it is 28% and in Maldives it is 42%. There are numerous factors that contribute to this unmet need, including the following:

- Provider bias remains a problem in the Region. In a study done in India, significant discrepancies were found between user preferences for contraception versus doctor preference.
- Knowledge does not equal behaviour change. There are also differences when comparing knowledge of methods and actual use. While knowledge is almost 100% in Sri Lanka, Bangladesh and Nepal, CPR is at 70.8%, 53.8%, and 39.3% respectively.
- There is a need to involve men in family planning. With the exception of Bhutan, the male methods is low in the Region. Research on the reasons for discontinuation of the method in Bangladesh showed that the highest rate of disapproval among husbands was for condoms the method with the least side effects, and in the second place was withdrawal. Programme planners and service providers need to have a better understanding of men's reproductive health needs and emphasize partner communication. Working with men has been shown to lead to greater support of women's reproductive rights.
- Traditional methods are not addressed although they are used in the Region to varying degrees. However, providers tend not to discuss these with clients and they are sometimes used incorrectly, resulting in undesired pregnancies.

- Unsafe abortions lead to maternal morbidity and mortality. In Sri Lanka 11% of maternal deaths are due to complications from abortions, in Indonesia it is 25–30% and in Myanmar it is 50%. Family planning could prevent these unintended pregnancies in the first place.
- There is a lack of security in the provision of commodities, as stock-outs and irregularities are not rare. There is also a gap between donors financing for commodities compared to the projected need. If the demand for contraception is raised, then there needs to be a supply ready to meet it.

In order to achieve family planning and other MCH or reproductive health goals, quality of care also must be improved. There is currently limited contraceptive method mix, lack of secure availability of commodities, and ineffective distribution of contraception. The family planning landscape in the Region is also characterized by service providers with low technical and managerial skills, lack of counselling based on informed choice and client rights, and lack of equity in access to services when comparing urban–rural areas or different socioeconomic sectors.

Dr Gunasekera explained that the fifth MDG aims to improve maternal health by reducing by three quarters the maternal mortality ratio between 1990 and 2015. UNFPA's strategy for the reduction of maternal mortality and morbidity involves working on family planning, as MMR and total fertility are directly correlated. Countries that have reached replacement level fertility, such as Sri Lanka and Thailand, have an MMR that is substantially lower than that in the countries that have a TFR higher than 2.1. The UNFPA strategy also involves working towards having skilled attendance at all births, and the provision of emergency obstetric care. UNFPA's approach to ensuring reproductive health commodities security at the global level involves advocacy, resource mobilization, technical cooperation, and coordination. At the national level, UNFPA conducts advocacy and capacity building activities, and works on sustainability and coordination issues. Finally, UNFPA recognizes that family planning has become a vehicle for STI and HIV/AIDS work, which should be regarded as a mutually beneficial opportunity.

Dr Gunasekera concluded by pointing out areas for cooperation between WHO and UNFPA:

- Adopt common strategies for making health, including reproductive health, a priority.
- MDGs and Poverty Reduction Strategy Papers (PRSPs) provide WHO/UNFPA with the opportunity to strengthen country-level partnerships to leverage additional resources for population, gender and reproductive health programmes targeting the poor.
- Knowledge sharing in the provision of youth-friendly reproductive health services, especially in HIV prevention.
- WHO/UNFPA Strategic Partnership Programme: This is a collaboration in the introduction, adaptation and adoption of evidence-based practice guides developed by WHO to promote sexual and reproductive health at national and sub-national levels, and contribute towards ensuring high-quality care for family planning and prevention and management of sexually transmitted infections (STIs) suited to the country situation.

A lively discussion followed the presentation. The discussion points that were raised have been incorporated into the group work sections of the report, as they were also addressed at that stage.

### **3.3 Priority USAID Programme Themes**

Dr Jim Shelton, USAID, discussed the family planning-related priority theme areas at USAID. These include:

- Best practices – quality and access: There is a lot of evidence of what works and what does not. While there is no recipe for achieving family planning goals, there are similar threads that run through successful programmes.
- Private sector – social marketing
- Contraceptive security
- Contraceptive technology – Broadening Choice: he warned that those at all levels need to take into consideration what individual clients may be interested in, and what would attract new users
- Systems and people strengthening
- Linkages with other reproductive health programmes

Functional elements of programme support:

- Training (learning – performance improvement): the classic approach of a one-time training is not very effective. It has been shown that job aids, support, follow-up, refresher courses, and establishing links with other ongoing work improve performance
- Behaviour change communication
- Policy
- Research (programme research)
- Surveys and evaluation
- Contraceptives and logistics
- Technical collaboration
- Management and leadership
- Knowledge management: this focuses on how to take the knowledge that already exists and make it useful and available to others

The Implementing Best Practices Consortium<sup>1</sup> promotes a cycle, which includes generating evidence, synthesizing it and developing norms, disseminating and applying these norms, and evaluating the progress made. In order to ensure this cycle, evidence should continuously be collected and shared. These best practices should answer the question: “What options do I have to make this programme better?” Country partners, programmes and communities are key to best practices without which evidence would not be collected, disseminated or applied. Dr Shelton emphasized that there must be an understanding of what is really happening at the service delivery level in order to have an effective policy. As a result, it is important to consider the operational issues.

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<sup>1</sup> The Implementing Best Practices (IBP) is an initiative begun in 1999 to enhance the ability of countries to identify and apply evidence-based and other demonstrated practices that improve the quality and delivery of reproductive health services. WHO Department of Reproductive Health initiated the programme and includes partner organizations and agencies such as USAID, UNFAP, IPPF, and 14 other organizations. The IBP Initiative helps identify and facilitate synergies that can improve value for money spent in the effort to improve reproductive health services. Focus is placed on helping local governments enhance programmes and maximize available resources through participation in a network operating at country, regional, and global levels, promoting harmonized approaches and sharing experiences, tools, and lessons learned. An important priority of the IBP Initiative is to engage reproductive health professionals with interactive mechanisms that will facilitate multi-level exchange of information and knowledge.

Dr Shelton cautioned that integration has to be a selective process. If a programme tries to integrate too much, it may not work because it may no longer be practical or may not even be possible. He also suggested that addressing HIV should emphasize behaviour change, and that a clinical setting may not be the most effective way to work on this issue. Policy-makers and programme planners should be careful to take into account the reality and needs of health care providers and issues of practicality when considering integration.

Dr Shelton suggested that the most important question each participant can ask him or herself at this meeting is "What can WHO do for me?" A lively discussion followed Dr Shelton's presentation. The points that were raised have been incorporated into the group work sections of the report as they were also addressed at that stage.

### **3.4 Medical Eligibility Criteria for Contraceptive Use**

Dr Richard Guidotti, Consultant, WHO/SEARO, discussed WHO's approach to improving access to quality family planning. He defined this as ensuring:

- information for clients on consistent and correct use of a contraceptive;
- technical competence, counselling and ongoing support by providers;
- accessibility, acceptability and affordability, and
- contraceptive counselling and service delivery based on eligibility criteria supported by a scientific rationale.

The four cornerstones of WHO's family planning guideline are:

- The Medical Eligibility Criteria for Contraceptive Use. This book helps providers decide which clients can use which contraceptives based on their clinically relevant background.
- Selected Practice Recommendations for Contraceptive Use.
- Decision Making Tool for Family Planning Clients and Providers.
- Handbook for Family Planning Providers.

The Medical Eligibility Criteria document was first published in 1996 and revised in 2000. It provides recommendations for appropriate medical eligibility criteria based on the latest scientific evidence. It is intended to be

used by policy-makers, managers and the scientific community. It is a practical document, meant to assist in the preparation of national guidelines and be used as a reference guide. It is also a document, which is regularly updated based on new evidence collected.

Dr Guidotti explained that scientific evidence was reviewed regarding the safety of using different contraceptive methods for particular “conditions,” and then the condition was categorized from 1 to 4.

- Category 1: A condition for which there is no restriction on the use of a contraceptive method.
- Category 2: A condition where the advantages of using the method generally outweigh theoretical or proven risks.
- Category 3: A condition where theoretical or proven risks usually outweigh the advantages of using the method.
- Category 4: A condition which represents an unacceptable health risk if the contraceptive method is used.

He went on to explain that where clinical judgment resources are limited, a simpler form of the categorization may be used. If the categorization is 1 or 2, the method should be used. If the categorization is 3 or 4, the method should not be used. Furthermore, there may be different categories based on whether the method is being introduced or continued.

Dr Guidotti ended his presentation by giving examples of several case scenarios and discussing why a particular categorization was chosen for each. A lively discussion followed the presentation, which helped participants clarify the categorization of relevant scenarios.

### **3.5 Selected Practice Recommendations for Contraceptive Use**

Dr Guidotti made a follow-up presentation on the second of the four WHO cornerstones for family planning guidance, the *Selected Practice Recommendations for Contraceptive Use*. He explained that this document provides guidance on how to use contraceptive methods safely and effectively once they are deemed to be medically appropriate. These guidelines are intended for use by policymakers, programme managers, and the scientific community. They were designed to help guide national family planning/reproductive health programmes in the preparation of guidelines for contraceptive service delivery. This document is updated through the

identification of new issues or questions, which undergo a review process, based on which best practices are recommended.

The guidelines are based on the review of evidence to answer 23 questions related to common clinical challenges in providing family planning services. Of these 23 questions, there are five questions on oral contraceptives, five on injectable contraceptives, one on emergency contraceptive pills, two on implant contraception, five on IUDs, one on standard days method, and the remaining four questions are on programmatic issues. Dr Guidotti presented case scenarios for this document as well.

He pointed out that among key programmatic issues are informed consent, elements of quality of care, essential screening procedures for administering the methods, provider training skills, and referral and follow-up for contraceptive use. Dr Guidotti also gave examples of key unresolved issues.

### **3.6 The Role of Clients in Quality of Family Planning Service: The Indonesian Experience**

Dr Gary Lewis, Indonesia–STARH Programme /USAID, highlighted some of the myths that exist among providers regarding quality of family planning. He explained that Indonesia’s approach to empowering clients includes “smart client job-aids”, the Sahabat Campaign (“Provider is a Caring Friend”), and provider job-aids such as a decision-making tool/ flipchart and point of service materials. Dr Lewis then highlighted Indonesia’s experience with the “smart patient” intervention and the decision-making tool/flip chart.

The “smart patient” intervention consisted of a 20-minute discussion with clients on their rights to seek information, ask questions, express concerns or opinions, and ask for clarification. It was found that the smart patient intervention encouraged higher client participation in two out of three indicators as compared to those who had not received the intervention. Clients who had smart patient coaching asked two more questions than those who did not receive the intervention, an increase of 57%. Clients who had smart patient coaching expressed one more concern, or opinion, in comparison to those who did not undergo the intervention.

The Decision-Making Tool for Family Planning Counselling was developed by WHO and JHU/CCP and reviewed by international experts. It contains best practices in client-provider interaction, and WHO’s technical

standards for family planning which are evidence-based best practices. This tool focuses on clients' reproductive rights and responsibilities, through the promotion of equal communication between clients and providers. It is based on the premise that a client can make an informed choice, and that this meets the needs of both the client and the provider. It uses a flip chart to assist in client-provider interaction.

Key findings from the pilot study in Indonesia were analysed based on the following categories: format and usability, how the provider gave information on family planning to clients and what was covered, provider counselling skills, client participation and satisfaction, and decision-making. Based on these findings, the flip chart was revised so that it would flow better and address the concerns or issues that were raised during the pilot phase. After it was revised, basic adaptations were made to make it relevant to the Indonesian context. These included making the tool consistent with new Indonesian family planning guidelines, including methods based on use, simplification of method content and/or decision-making process, use of local terminology, and the modification of drawings and pictures. Indonesia is currently considering more adaptations. These would be based on different outcomes based on provider and client actions, different types of providers, addressing dual protection, including referral procedures and more annexes, expanding on reproductive health issues, adding a kit of materials to accompany the tool, and linking the tool to other family planning projects and programmes.

Currently, dissemination issues are being considered. For example, should the dissemination be piloted and focused or simply carried out at the national level? Should the tool be disseminated inclusive of all components or by method based on provider needs? And should the client side of the flipchart be translated into local languages?

Training needs are also important to consider in order to use this tool appropriately and effectively. Dr Lewis explained that training decisions affected adaptation. As a result, a balance must be reached between training costs and effective use of the tool. This tool necessitates training on counselling and communication skills, practical use of the tool, and technical guidance. There are different possible training interventions, including an individualized training programme, mentorship, training videos, and pre-service training.

Dr Lewis concluded that the following were needed in order to empower the client in regard to quality of family planning service delivery:

- Adaptation process: basic or advanced
- Coordination of implementation process
- Dissemination strategy
- Dissemination with family planning guidelines
- Training strategy
- Training curriculum production process

A lively discussion regarding quality improvement and the role of the client in service delivery followed the presentation. The points that were raised have been incorporated into the group work sections of the report, since they were also addressed at that stage.

### **3.7 Technical Updates on Contraceptives**

Dr Shelton gave a technical update on contraceptives with emphasis on emergency contraceptive pills and IUD.

Emergency contraceptive pills are a safe and effective method of contraception as they prevent pregnancy by stopping ovulation and fertilization, do not affect an existing pregnancy, cannot terminate a pregnancy, and women who have used this method report high levels of satisfaction. Dr Shelton explained that emergency contraceptive pills prevent about 80% of pregnancies that might otherwise occur. Emergency contraceptive pills contain hormones and are taken in two doses, 12 hours apart. They can reduce the risk of pregnancy if started within 120 hours (five days) after unprotected vaginal intercourse. They work best when the first dose is taken within 72 hours – during this time they can reduce the risk of pregnancy by 75–89%. Dr Shelton added that emergency contraceptive pills do not replace regular contraception, but are useful in preventing pregnancy after intercourse when no contraceptive was used, when there was a contraceptive failure or misuse, and in cases of sexual assault.

An operational research study on emergency contraceptive pills in Bangladesh found that after a two day training, providers were knowledgeable and had favourable opinions towards the method. It was found that many clients also had favourable opinions and were willing to pay for the method.

Finally, the study showed that emergency contraceptive pills seem to support "regular" contraceptive use.

Dr Shelton went on to describe recent findings regarding IUD use and STIs. In a hypothetical high STI setting, there is a very low increased risk of clinical pelvic inflammatory disease (PID) attributable to IUD. Moreover, in a recent case control study with nulligravid women, copper IUDs were not associated with tubal infertility, but tubal infertility was associated with *chlamydial trachomatis* infection. Where a woman may have or be exposed to gonorrhoea or chlamydia, the WHO Medical Eligibility Criteria category is 2, "generally use the method." However, if a woman has a very high individual likelihood of exposure to gonorrhoea or chlamydia, the condition is a category 3, "use of method not usually recommended."

Women who are HIV-positive is a category 2 for copper-bearing IUDs, according to WHO. The only exception is if a woman has clinical AIDS which is not responding to antiretroviral therapy and she wants **to start** using an IUD, in which case it is a category 3. There is no increase in risk of HIV acquisition among IUD users, and no increased risk of complications in HIV-positive women using an IUD was found. Furthermore, there is no increase in HIV genital shedding after as compared with before IUD insertion. Dr Shelton acknowledged, however, that there is a debate among providers on whether HIV-positive women should be given IUDs, fearing that this may discourage consistent condom use. While he recognized that some providers do not see IUD as a valid option for HIV-positive women, he reiterated that there is no evidence that supports that position.

Dr Shelton also described how insufficient time, training, and resources, as well as provider bias, lead to low IUD use. Several studies have found that providers do not insert IUDs because it requires more work, extra supplies and equipment, and additional training which providers do not feel they have. Some also fear personal risk from potential exposure to HIV and other infections, have misconceptions about IUDs, and feel socially distant from the method. He pointed out that there is a new upscale strategy for IUDs. The old strategy aimed at training numerous health workers, especially at lower levels, to insert IUDs has been replaced by one that focuses on a smaller number of higher-level providers, such as physicians or skilled midwives and nurses.

Dr Shelton discussed recent evidence, which shows that there are more benefits to having three-year birth intervals, not just two years. In a recent multi-country study, it was found that 61% of births in India and 36% in

Indonesia are less than 36 months apart. Dr Shelton explained that women are not necessarily just worried about death, but rather they want to take some rest between births. There is a high unmet need for birth spacing among postpartum women. In addition, men and mothers-in-law, key actors in decision-making, are not as aware of the advantages of birth spacing as they could be. While birth spacing may be used as a synonym for family planning, it is not directly addressed as much as it could be. More can be done in terms of information, education, communication (IEC) and counselling training.

In response to a participant's inquiry regarding STIs, Dr Shelton cautioned that one needs to consider STIs separately since they are very different from each other. He added that it is important to know the prevalence of a particular STI before it is assumed that there is an overall high prevalence of STIs in a given population. He warned that most women who present with vaginal discharge symptoms do not have an STI but other conditions such as bacterial vaginosis, which may call for different medical treatments.

A lively discussion followed the presentation. The points that were raised have been incorporated into the group work sections of the report since they were also addressed at that stage.

## **4. GROUP WORK AND DISCUSSION**

### **4.1 Introduction to Group Work**

Dr Ardi Kaptiningsih, Regional Adviser, Reproductive Health and Research, WHO/SEARO, recapitulated some of the links between family planning and MCH, and outlined the causes of unintended pregnancy.

Participants were made to work in groups and discuss the following key questions:

- What is the present situation of family planning programming and services in countries, and how do they relate to maternal and newborn health, and beyond?
- What is the population policy and how is this policy being implemented?
- What are the bottlenecks in implementing family planning programming and services?

- How can access and quality of family planning services be improved? What are the available family planning programme and service guidelines, and when were they updated? What kind of technical support is needed?
- How could integrated services of family planning and other reproductive health components be optimized?

Groups:

- Bangladesh, India and Nepal
- DPR Korea, Indonesia, Myanmar and Thailand
- Bhutan, Maldives and Sri Lanka

## **4.2 Needs Assessment: Group Presentations and Discussion**

### **Bangladesh, India and Nepal**

#### ***Present situation***

These three countries are similar in terms of their family planning situation. Although TFR was on the decline, it seems to have stagnated. Sterilization and long-term family planning methods are not increasing. The young structure of the population adds to the population momentum, and early marriage and pregnancy are a problem. Son preference continues to be a critical issue in what type of contraception is used, when, and for how long. Desired or ideal family size is currently around 2.5 children per couple, which is higher than replacement-level fertility. Furthermore, there is an unmet need for family planning, between desired family size and actual TFR, because the socially acceptable family size is larger than that which women desire. Minority and marginalized groups, such as hill tribes, urban slum dwellers, and the rural poor, are least likely to have access to contraception.

CPR has been increasing over the past decade, but not at the same rate as population growth. The knowledge of contraception has been increasing and it is widespread: 99% of currently married women in all three countries know of at least one modern method of contraception. About 98% of women know of female sterilization and around 89% of women know about male sterilization. In addition, roughly half of currently married women are aware of the traditional rhythm/safe period method or withdrawal methods. However, only 44–48% of married women are using any contraceptive method. Furthermore, there is a rural–urban divide in knowledge and use of

contraception. There is a lower level of knowledge regarding female sterilization, oral contraception, IUD and condoms in rural areas, and IEC activities there are minimal. As a result, CPR is higher in urban areas. In Nepal, the unmet need is twice as high among women in rural areas in comparison to those in urban areas.

In Bangladesh and India, there has been a decline in the unmet need over the past decade, with rates falling from 20% to 15%. However, there is still substantial scope for improvements to meet the needs of women who wish to space or limit their births. In Nepal, the current unmet need is 28%; for this gap to be bridged, CPR would have to increase from 39% to 67%.

Unsafe abortion continues to be a matter of concern in all three countries. The issue of “the missing girl child” is a problem in India. Sex preference for boys due to social pressures, and the desire to limit the size of the family as a result of economic reasons, has led to infanticide and drastically skewed child male–female ratios in some parts of India. This is an issue that must be dealt with within the family planning programme.

Early motherhood remains high. Mothers in the age group 15–19 contribute to about 20% of total fertility in these three countries. In India, IMR for this age group is 93/1000 live births, in comparison to 66/1000 live births for all age groups. The situation is no different in Nepal and Bangladesh.

Quality of family planning services is an important parameter to assess the success of family planning programmes, including the assessment of follow-up services received by the family planning recipient. Unfortunately, family planning information and counselling are not based on the principles of informed choice and are influenced by provider bias. Furthermore, family planning programmes continue to not adequately address male involvement. In all three countries, male condom use is less than 5% of all methods used and male sterilization is less than 1%.

In Bangladesh, family welfare volunteers are not permitted to work with long-term family planning methods. In Nepal there is a need for more nurses and paramedics as there are not enough qualified staff to meet the demand.

Better family planning would save women’s and children’s lives in Bangladesh, India, and Nepal. Avoiding unintended pregnancies through the use of contraception and bridging the gap of unmet need would prevent about one fourth of all maternal deaths, help prevent unsafe abortion, and enable women to limit births to their healthiest childbearing years. While

there has been a decline in IMR and MMR, this has been relatively static since 1995. In India, IMR is almost three times as high for children born in a birth space of less than 24 months in comparison to those with a birth interval of 48 months or more. In Bangladesh it is 2.5 times higher. There is limited information on abortion-related maternal deaths in India. Largely due to unmet need, there are four million unsafe abortions per year in India, and as a result a conservative estimate places the number of abortion-related deaths in a year at 15000–20000. In addition, more than 130000 Indian women die every year of causes related to pregnancy and childbirth.

### ***Population policies***

Bangladesh has a population policy that has been formulated but not yet approved by the government. The main feature of the draft policy is to achieve replacement level fertility by the year 2010.

India's population policy was ratified in 2000 and some states have also created their own state policy. Strategies for achieving goals have been operationalized, and National Population Commission has been created in order to oversee and review the implementation of the policies.

Nepal's policy endorses reaching replacement level fertility by 2020, and focuses on reproductive health. In all three countries, family planning guidelines are available but need to be updated.

### ***Bottlenecks***

The family planning programme in all three countries is characterized by a lack of effective coordination between health and family planning departments. As is the case in other countries, donor funding is gradually declining. There is a need to improve health care infrastructure, and a need for additional and better-trained doctors and paramedics. There is also a general lack of skilled human resources at the service delivery level. The supply of contraceptives is insecure, and there is a limited ability to introduce new or other contraceptive options to enhance the choices offered to women. Male dominance and son preference are the norm. Furthermore, poor quality of services contributes to poor access to services. There is insufficient behaviour change communication (BCC) and IEC activities, and in India and Nepal social marketing of contraception is poor. While there is strong political commitment to family planning, it is not reflected in implementation plans.

In India, health is separate from family planning and efforts to limit family size. In addition, family planning and MCH are dealt with separately from primary health care. Yet without a concrete programme to limit the size of families and stem population growth, RCH cannot effectively meet its other objectives. Furthermore, even when funding is not an issue, family planning is not a political priority, so it does not become a programmatic priority. The absence of family planning, and the risks involved with numerous pregnancies and births and continued population growth is not something that is addressed publicly as a problem that must be dealt with urgently in India.

### ***Improving the quality of family planning services***

This group explained that there are several key things that would improve access to and the quality of family planning services. It is necessary to mobilize communities in order to increase demand for services. Also, capacity building is needed for service providing institutions as well as service providers. Urban health infrastructure needs to be improved in order to meet the needs of the population living in the periphery of cities and towns. Furthermore, an effective adolescent health programme needs to be created. Unless there are sufficient and adequate inputs, quality of care cannot improve. This includes human resources, infrastructure and supplies. These basic elements must be addressed in conjunction with family planning programmes.

Participants from this group felt that two types of technical support are needed in order to improve family planning programmes:

- Guidelines: updating of existing guidelines, development of additional guidelines where there are gaps, and dissemination of these.
- Advocacy: support to generate political will to prioritize family planning as key to improving the standard of living.

In order to optimize integrated services of family planning and other reproductive health components, the group made four suggestions:

- Mainstream family planning services within the broad perspective of reproductive and child health programme.
- Strengthen coordination between health and family planning programmes.
- Effectively involve NGOs and the private sector in family planning and reproductive health programmes.

- Apply an integrated approach for all participating agencies in the formulation and implementation of family planning and other elements of reproductive health programme.
- Strengthen antenatal on family planning counselling for increased birth intervals, and provision of postpartum family planning services.

It was suggested that WHO could help advocate for the integration of family planning and MCH into primary health care in India in particular. Integration could raise demand for family planning services because it would increase access to the services in a more convenient way for clients.

## **Bhutan, Maldives and Sri Lanka**

### ***Present situation***

In all three countries there is family planning policy, strategy and implementation with partners at different levels. Coverage includes married and unmarried individuals and high-risk groups. However, method mix and counselling needs more attention.

In Sri Lanka, over three-fourths of the women using contraception either use injectables or oral contraceptives. In Maldives, there is a relatively even split between injectables and oral contraceptives and tubal ligation. In Bhutan, vasectomies account for almost 45% of the method mix, injectables account for almost 20%, and the remainder is a relatively even split between IUD, oral contraceptives and tubal ligation. While in Bhutan the contraceptive method mix consists almost entirely of modern methods, in Maldives and Sri Lanka, traditional methods contribute to the method mix. In Sri Lanka there is a lack of sterilization services. More research is needed to better understand if these differences in method mix are due to user preferences, provider bias, or unavailability of methods.

Unintended pregnancies are a problem in all three countries. In Bhutan, there are fewer induced abortions, and there is no abortion data for Maldives. In Sri Lanka, there is a relatively high CPR along with a relatively high abortion rate as 4.5 out of every 100 women of reproductive age have an induced abortion. Furthermore, 13% of maternal deaths are due to septic abortion. Data show that 94% of abortions are among married women who either wish to limit births or extend birth intervals but do not have access to methods. Abortion is illegal in Sri Lanka and although it is a rather open practice, it is not regulated and safety is an issue. The integration of family planning

counselling into post-abortion care would help limit repeat abortions among women who want to delay or space their births, and additional, quality sterilization services would address the needs of women who do not want to have additional children.

### ***Population policy***

All three countries have policies addressing demographic and health perspectives. Governments are committed to family planning and incentives are given in Sri Lanka and Bhutan, while indirect incentives are given in Maldives at the community level. Strategies addressing family planning in all three countries are integrated with primary health care services, are based on a cafeteria approach and include counselling. These services however are not functioning at all levels and there is an unbalanced method mix. These programmes are implemented mainly through the government health system. In Bhutan, implementation is exclusively carried out by the government, whereas in Maldives one NGO is also involved. In Maldives, there is an effort to get the fishing and tourism ministries involved in facilitating family planning programmes. In Sri Lanka, the majority of the programmes are government-implemented although there are numerous NGOs also implementing strategies, especially for permanent methods.

While awareness of contraception is high, knowledge is not adequate. Linked to this is inadequate counselling, as staff are in need of training. Lastly, youth needs have not been addressed by the existing family planning programmes.

### ***Bottlenecks***

There are numerous bottlenecks in implementing family planning programmes in Bhutan, Maldives and Sri Lanka. In all three countries, it is difficult for those who are unmarried to get access to information and methods. There is also a scarcity of adequately-trained providers, coupled with a high turnover rate. Poor staff knowledge and skills in technology and counselling, along with inadequate supervision is a problem in all three countries. Additionally, infrastructure needs improvement, and funds and supply of commodities are insecure with a particularly inadequate supply of permanent methods. It is also difficult to involve males due to temporary migration. Integration however, is not a bottleneck.

Access varies in all three countries. Geographical limitations in Bhutan and Maldives result in follow-up only with some methods. While user fees are not a problem, economic limitations hinder access to transportation. There are also socio-cultural obstacles such as religion and ethnicity. In the case of Bhutan, there is a need for assistance in working with minority ethnic groups. Participants explained that these groups argue that if they use contraception they will become extinct. In Maldives, the provider's sex is sometimes a barrier, as is the law. Also, men migrate for work in tourism as well as fisheries increasing the need for family planning in these areas. Finally, family planning services are limited by terrain and the availability of service providers.

### ***Improving the quality of family planning services***

The presenters pointed out that there are numerous ways to improve access and quality of family planning programmes. These include:

- Training in counselling for service providers
- Training for IUD and vasectomy
- Conducting operational research
- Increasing client knowledge
- Expanding services to those who are not married
- Ensuring proper follow up
- Strengthening family planning programme by including post-natal care and post abortion care
- Improving male involvement
- Focus on the identification and provision of services for those with unmet need
- Improve access to education, especially for girls
- Try to integrate family planning with poverty reduction strategies
- Improve collaboration between fisheries and tourism sector in Maldives
- Strengthen partnerships between donors and NGOs

## **DPR Korea, Indonesia, Myanmar and Thailand**

### ***Present situation***

This group is not homogeneous in its population indicators. The countries have a population growth rate that ranges from 0.9 in Thailand to 2.02 in Myanmar. TFR ranges from 1.7 in Thailand to 3.7 in Myanmar, and CPR ranges from 43.7 in Myanmar to 70.2 in Thailand. There is quite a contrast in MMR, where Thailand is at 36.5 and Indonesia is at 315. IMR in DPR Korea is 23.5 while it is 50 in Indonesia. There are no data for pregnancies for women between 15 and 19 years in North Korea or Myanmar, but in Indonesia and Thailand it is around 12%.

Contraceptive method mix also varies in each country. In Thailand, over 70% of those using a contraceptive are taking the oral contraceptives, injectables, or have had tubal ligation. In Indonesia, over a quarter of the method mix is the use of injectables, and 13% is due to oral contraceptives. Over a third of those using contraception in Myanmar are using the oral contraceptives and 15% are using injectables. In DPR Korea 43% of the method mix is the result of IUD use. Condom use is highest in DPR Korea, making up 5.8% of the method mix. In Thailand it is 1.7% in Indonesia it is 0.9% while in Myanmar it is .3%. In Indonesia, about 70% of contraception is provided by midwives. Unintended pregnancies continue to be a serious problem in all four countries. In Myanmar illegal abortion is a problem.

In DPR Korea, health indicators have been deteriorating over the last 10 years, but there has been an upward trend since 2001. While IUD is the most widely used method, many women experience complications and side effects and discontinue its use. As a result, greater efforts must be made to diversify the contraceptive method mix. While in general there is a lack of resources, UNFPA supported programming has been successful. Abortion has decreased considerably since 1997 in the areas where UNFPA is working. In DPR Korea abortion is legal and provided in health centres.

In Indonesia, the private sector has compensated for government budget cuts. While public facilities are free, they are not easily accessible due to distance and long waiting periods. There is a debate regarding the provision of contraception free of charge to those who cannot afford it, as a result of the economic crisis, but as of right now this has not changed. There is also a system of private midwives.

While these four countries vary in their indicators and family planning programmes, they share some positive and negative key issues. These include:

- Strong political commitment
- Good infrastructure
- Family planning is not based on demographic targets, and is based on a health and human rights approach.
- Quality of care is a problem
- High risk and unintended pregnancies are a problem

### ***Population policy***

In Thailand, family planning is fully integrated in MCH programming, and the programme is already decentralized.

In Indonesia, there has been a shift from demographic to reproductive health approach with a client focus. There has also been a shift from public to private service delivery. These changes have also brought a focus on quality of services. There is a decentralized programme, and family planning is integrated into MCH service delivery.

In DPR Korea, there is a strong political commitment by the government for MCH. Family planning is not seen as a way to reduce population growth; rather, it is a tool to improve maternal and child health.

In Myanmar, there has also been a shift in policy, from demographic targets to birth-spacing goals. While there is a shortage of funds, NGOs are playing a larger role in family planning than before.

### ***Improving the quality of family planning services***

In order to improve access to and quality of family planning services, this group suggested the following:

- Greater choice and information on contraceptive commodities
- Increase community awareness
- Provide or update standards and guidelines
- Facilitate continuing medical education

- Develop post-partum and post-abortion family planning services programme
- Conduct advocacy on abortion policy

The group concluded that support is needed in carrying out the following:

- Research for capacity building and evaluation
- Training for performance improvement
- IEC to improve awareness of the links between family planning and MCH
- Supplies and materials, including contraceptives, and medical supplies and equipment
- Development of post abortion and post partum family planning services
- Guidance in integrating family planning with HIV/AIDS programming (especially in Myanmar)
- Emergency contraception

## 5. SUMMARY

Dr Islam summarized the problems identified by the groups. He invited participants to outline solutions and discuss WHO's possible role in supporting their work. The following is the outcome of the discussion:

### **Problems identified**

#### ***Reproductive health problems related to family planning***

- Unintended pregnancies and its consequences
- Early marriage and pregnancies
- Poor staff knowledge
- Poor knowledge of the community
- Rapid population growth
- Poor male involvement
- Lack of community awareness

**Policy**

- Divided responsibilities between health and family planning
- Insufficient decentralization
- Insufficient private/public/NGO mix
- Demographic versus reproductive health approach

**Health system**

- Poor quality of care
- Lack of skilled human resources
- Poor management and supervision
- Poor infrastructure
- Insecure logistics and supplies
- Inadequate contraceptive mix
- Lack of services for poor and marginalized populations
- Poor utilization of public sector services
- Inadequate pre-service/in-service training

**Proposed solutions**

**Policy**

- Integration of services
- More emphasis on rapid population growth and its implication on development and the environment
- Improve access to poor and marginalized groups, such as adolescents
- Appropriate public/private/NGO mix of providing family planning services
- Expand services:
  - Urban service delivery
  - Introduction of new methods
- Increase commitment from local government
- Effective and coordinated partnership with NGOs and donors

### **Health system**

- Improve health information system
- Training
- Update guidelines and incorporate evidence-based norms and standards
- Provide family planning in postpartum and post-abortion care
- Improve quality of care and performance
- Pre and in-service education and training
- Improve logistics and supplies; ensure contraceptive security
- Mainstream family planning in overall health services

### **Community participation**

- Male involvement
- Improve community awareness
- Women's empowerment and improve the status of women

### **Operational research**

#### **Suggested areas for WHO's support**

##### **Advocacy**

- Decentralization and its implication on family planning services
- Integration of health and family planning services
- Appropriate investment
- Demographic versus reproductive health approach
- Increased or continuing donor support
- Policies to include and address needs of marginalized and poor populations
- Policy change and policy dialogue/poverty reduction strategy papers

### ***Improve quality***

- Promote best practices among public and private sectors, and NGOs
- Update policy and service delivery guidelines
- Facilitate appropriate human resource development and deployment
- Improve providers' skills and performance
- Improve client–provider communication
- Improve counselling in skills and content
- Monitor progress

### ***Strategic approach for introduction of technology/methods***

#### ***Operational research***

#### ***Networking***

Collaboration between institutions within SEAR countries

### **Country-specific implementation: Potential activities and possible partnerships**

The following is the result of country teamwork. Teams were asked to make a list of how WHO/SEARO could support their country's efforts in family planning. This is the requested support from WHO/SEARO in family planning, based on each country's needs assessment. Top two priority areas have been highlighted. Also, there is a commitment statement from each country team describing how they will support family planning upon their return.

#### ***Bangladesh***

##### **(1) Advocacy**

- to bridge gap between health and family planning directorates
- for increasing utilization of public sector facilities
- for continued donor support in the procurement of reproductive health commodities, and in the expansion, updating and equipping of existing and newly– constructed service delivery facilities.

- (2) Quality improvement
  - Technical assistance in supervising and monitoring reproductive health facilities
  - Technical assistance for the development of health sector adolescent strategy
  - Technical assistance for skills development training on emergency contraception, VSC, and IUD, and for skilled birth attendants (SBA)
  - Update policies and make service delivery guidelines uniform and available at all service delivery levels, including NGO sector
  - Development of IEC/BCC materials
- (3) Strategic approach for the introduction of technology/ methods
  - Dissemination of research findings
  - Awareness raising among communities, service providers, managers, and clients
  - Create, print, and disseminate skills development guidelines for service providers and managers
- (4) Study tour and fellowship
- (5) Networking

Government, NGO and private sector partnerships/ collaboration

Commitment: Participants from Bangladesh committed themselves to ensuring that all skilled attendants currently being trained will also be trained in family planning services.

### **Bhutan**

- (1) Advocacy
  - Continue financial and technical support in order to sustain the programme
  - Increase financial and technical support
- (2) Quality Improvement
  - Inadequate human resources is the main constraint in the implementation of the family planning programme. WHO is

requested to facilitate and support the development of human resources.

- Improve provider skills and performance
- Improve client–provider communication
- Improve counselling

(3) Strategic approach for the introduction of technology/methods

(4) Operational Research

Commitment: Participants from Bhutan assured that they would brief the rest of their departments upon their return, and identify candidates for funding.

### **DPR Korea**

(1) Advocacy

- WHO should approach family planning in DPRK not as a demographic issue, but in terms of improving MCH and decreasing MMR and IMR
- WHO should highlight family planning needs in WHO's collaborative programmes and sensitize government policy-makers and programme managers
- Since MCH has been incorporated as a priority area in WHO CCS–DPRK and WHO work plans 2002–2003, 2004–2005, family planning can be addressed as a critical part of reaching these goals.
- WHO should advocate for resources to improve family planning services and programmes in partnership with UNFPA, NGOs, and other donors. Here, WHO should take a leading role in bringing this to the attention of the donor community.

(2) Improving quality

- Focus should be given to the diversification of various contraceptives, enhancing the contraceptive method mix, other than IUD and emergency contraceptive services.
- WHO should make available at the country level, updated policies and service delivery guidelines. These could be the basis for orientation of providers and in-service training of skills and performance.

- WHO should support increasing awareness of various contraceptive methods, particularly among men. IEC specific materials are needed for this effort.

(3) Research

- WHO should support clinical research on contraceptives, operational research, and situation analysis.
- WHO's technical input is requested in establishing research methodology, standards and indicators for research activities.

(4) Strategic Approach

- WHO should stress the importance of family planning services among its country representatives
- WHO should ensure sustained availability of updated policies and guidelines
- WHO should include in collaborative programmes activities for improvement in family planning through local training, guideline distribution, research, fellowships, etc.

Commitment:

- To meet with policy-makers, technical experts, and programme officers because although there is a strong commitment in MCH, there needs to be sensitization in family planning
- Update guidelines based on latest reports
- Support UNFPA-WHO discussions to establish a stronger relationship in DPR Korea.

**India**

(1) Advocacy

- Community mobilization for creating awareness among people of family planning programme and interventions, and relate it to health and family welfare so that the community effectively buys into the programme.
- Policy change and policy dialogue/Poverty Reduction Strategy Papers for mainstreaming family planning issues in overall RCH programme.
- Decentralization and its implications on family planning services

- Support policies to include and address needs of marginalized and poor populations
- Support adolescent specific needs
- Support needs of urban poor
- (2) Improve quality through counselling
  - Promote best practices
  - Facilitate the sharing of information and experiences from the public and private sector, and NGOs
  - Update service delivery guidelines
  - Facilitate appropriate human resource development
  - Improve provider skills and performance
  - Improve client–provider communication
- (3) Strategic approach for the introduction of technology: IUD
- (4) Operational research, study tour
- (5) Networking:
  - Establish resource centres of research at the national (in the Ministry of Health) and regional levels, and assist in the dissemination of information
  - Collaboration between institutions within SEAR countries.

Commitment: Participants from India committed themselves to working on making the system more decentralized up on their return.

### **Indonesia**

- (1) Advocacy
  - Promote national dialogue to generate political support from local government on the importance of family planning to improve reproductive health status
  - Development of material/guidelines for local government
  - Development of materials for marginalized groups, including poor, adolescents, high risk groups
  - Disseminate four WHO guidelines and tools on Family Planning and materials on HIV/AIDS and post–abortion care

- Development of guidelines on the role of family planning in public health for policy makers
  - Advocate against barriers in accessing family planning
  - Develop family planning management tools for local health managers
- (2) Quality Improvement
- Improve quality of family planning services by training and skill building, maintain up-to-date national standards and guidelines, improve standard curriculum in pre- and in-service training, develop post-abortion and post-partum family planning programme.
  - Introduce standards and guidelines to medical teachers, midwives, nurses, and doctors
  - Develop tools on improving provider compliance to standard of services
  - Technical support to improve quality assurance system
- (3) Strategic approach for the Introduction of Technology/Methods
- Develop strategy on emergency contraception services in the private sector.
- (4) Operational research and study tour
- Tour for national officials in family planning management
- Commitment: Participants from Indonesia committed themselves to formally discussing the meeting's findings and conclusions with government representatives.

### **Maldives**

- (1) Advocacy for integration of health and family planning services
- (2) Quality improvement:
- Capacity building for reproductive health management at the regional level.
  - Training to improve provider's skills and performance, for example in Norplant, and No Scalpel Vasectomy (NSV).
  - Provision of training in counselling to improve service provider counselling skills, and support for leveraging funds in order to conduct training.
  - Refresher training in supervisory skills for regional supervisors.

(3) Strategic approach for the introduction of technology/methods

Technical support for updating standard medical guidelines for family planning, NSV, and IUD insertion.

(4) Operational research and study tour

Support for individual country reproductive health and family planning programmes to conduct operations research in order to train people regularly, and carry out research.

(5) Networking between Collaborating Centres in SEAR countries.

Commitment: To discuss findings and conclusions from this meeting with other government officials in order to help raise support for family planning.

**Myanmar**

(1) Advocacy for integration of health and family planning services

(2) Improve Quality

- Improve skills of health staff at all levels through training and creation, promotion and dissemination of IEC materials.
- Promote best practices between public and private sector, and NGOs.
- Improve client–provider communication, especially in marginalized areas.
- Improve overall family planning coverage.

(3) Research

- Technical support on research methodologies
- Support monitoring, evaluation, research, and collection of data and statistics.

Commitment: To report findings and conclusions from this meeting back to different departments in order to raise support for family planning.

**Nepal**

(1) Advocacy

- Mainstreaming family planning in overall health services

- Advocacy materials targeting policy-makers, programme managers, medical professionals, members of the society of OB/GYNs, community leaders, and others.
- Pre-service medical and nursing education
- (2) Quality improvement
  - Promote best practices.
  - Facilitate appropriate human resources.
  - Update policy and service delivery guidelines.
- (3) Strategic Approach for technical support:
  - Strengthen birth spacing efforts and enhance contraceptive method mix.
  - Strengthen use of IUD and Norplant.
- (4) Research
  - Operational research on acceptability of IUD

Commitment: Participants from Nepal committed themselves to advocate for family planning in their work.

### **Sri Lanka**

- (1) Advocacy
  - Family planning service for marginalized populations: while Sri Lanka has favourable fertility indicators, certain groups such as those who are not married, the urban poor, those in remote rural areas, and those affected by the conflict have less access to the family planning programme.
  - Preventative health care approach: currently, the main emphasis is on providing curative care, and advocacy is needed to make policy makers aware of the need to focus on preventative care, such as family planning.
  - Policy: policies need to be reviewed in relation to abortion law and demographic transition.
  - Decentralization: priorities of decentralized policy makers do not support family planning
  - Investment: WHO can advocate that donors and governments continue to invest in family planning

Sri Lanka has a large percentage of people in reproductive age. About 200 million rupees is needed to procure contraceptive commodities. Currently, about 60% of funding is from international donors. Since the government is experiencing a financial crisis, it is important to have continued donor support.

- Demographic versus reproductive health approach: in Sri Lanka, the family planning programme began with demographic goals. As a result of the ethnic conflict, the majority population has become sensitive to the issue. Advocacy for a reproductive health approach is important.
- Management and supervision: some areas that have adequate resources still have poor performance. The main reason identified is poor supervision. This needs to be emphasized.

(2) Quality improvement

- Human resources development: The health care worker at all levels needs development. This includes those involved in programme planning, staff training, logistics management, coordinating and providing support to MoH, at the central or national level.

At the district level, medical officers of MCH are coordinating the implementation activity.

At the local level, PHC staff is implementing the programme.

- Guidelines: Most of the available guidelines were developed in the early 1998 and need updating. WHO could support this effort.
- Promoting best practices: The majority of the family planning services is carried out by the government, but the private sector and NGOs also play an important role. However, there has been little sharing of lessons learned and knowledge of best practices in family planning between these actors. WHO can help provide technical support in this area.
- Improving communication/IEC: while DHS 2000 showed satisfactory awareness levels of family planning, the specific knowledge of clients on family planning is found to be insufficient. In order to improve this, considerable amount of IEC inputs is needed.
- Counselling: Even though family planning counselling has been introduced, health care providers are still not well experienced in providing counselling. WHO has supported the training of providers

in two out of 25 districts last year. Continued support, evaluation and expansion of this programme were requested.

(3) Strategic approach

- Training in counselling: family planning training was introduced some years back but it has failed to show a significant impact. From 2000, the counselling training programme has been revised, and refocused in a more strategic manner.
- IEC dissemination.

(4) Research

Very little research has been carried out on family planning. WHO's support is needed in carrying out operational research in family planning programme.

**Thailand**

(1) Advocacy

- Decentralization and its implications on family planning services.
- Support policies to include and address needs of marginalized and poor populations.

(2) Quality improvement

- Update policy and service delivery guidelines
- Facilitate appropriate human resource development
- Improve provider skill and performance in counselling
- Monitor progress
- Provide training in family planning services

(3) Strategic approach for introducing technology/methods

New technology/methods.

(4) Operational research and study tour

Operational research for evaluation of decentralization of system.

(5) Networking

To enhance in-country collaboration, and networking between government and academics/Obstetrics and Gynaecology society.

## **6. CONCLUSION AND CLOSING**

Dr Islam was pleased to note the importance accorded by the participants to the issue of family planning. However, he pointed out, sufficient progress could only be achieved with the full support of all those involved in the family planning programme, including different government ministries, donors, NGOs and other institutions.

He thanked the Faculty of Nursing, Chiang Mai University, for hosting this important consultation. He also expressed his appreciation for the contributions made by Dr Gunasekera, Dr Shelton, Dr Guidotti, and Dr Lewis. He stated that Ms Antigoni Koumpounis would be following up on the findings of the meeting over the next two years. Dr Islam stated that participants showed interest and enthusiasm throughout the consultation, leading to its success in meeting its objectives. He also thanked the hotel staff for the excellent arrangements made by them for the smooth conduct of the meeting. Dr Islam concluded that the work had only begun, and that it would need to be taken forward through collective and persistent efforts. He assured full WHO support to the countries in this regard.

## Annex 1

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## **Annex 2**

### **PROGRAMME**

#### **Wednesday, 19 November 2003**

0830 – 0900 hrs	Registration of participants
0900 – 0945 hrs	Inaugural session
0945 – 1015 hrs	Regional key issues on the role of family planning in improving maternal and newborn health Dr Monir Islam, Director, Family and Community Health, WHO/SEARO
1045 – 1145 hrs	Regional situation and overview of the population and family planning policy and programme Dr Prasana Gunasekara, CST Adviser, RH Services – Kathmandu UNFPA
1145 – 1245 hrs	USAID's priority areas and supported programmes in family planning in SEAR countries Dr Jim Shelton, USAID
1345 – 1400 hrs	Introduction for Group Work Dr Ardi Kaptiningsih, Regional Adviser Reproductive Health and Research, WHO/SEARO
1400 – 1630 hrs	Group work
1700 – 1730 hrs	Meeting for facilitators

#### **Thursday, 20 November 2003**

0900 – 1000 hrs	Group work (continued)
1030 – 1130 hrs	Group presentations and discussions
1130 – 1230 hrs	Medical eligibility criteria Dr Richard J Guidotti, Consultant, WHO/SEARO
1400 – 1445 hrs	Selected practice recommendations for contraceptive use Dr Richard J Guidotti
1445 – 1530 hrs	Client empowerment for quality family planning services Dr Gary Lewis, Indonesia–STARH Program/USAID
1600 – 1630 hrs	Technical updates on contraceptives Dr Jim Shelton

**Friday, 21 November 2003**

0900 – 1200 hrs	Country team: Implementation in countries: Potential activities and possible partnership
1200 – 1215 hrs	Conclusion and Closing Dr Monir Islam, Director, Family and Community Health, WHO/SEARO