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Strengthening Family Planning Programme in South-East Asia

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Summary

In collaboration with the Department of Reproductive Health and Research, WHO-HQ, the WHO Regional Office for South-East Asia (SEARO) organized a Regional Workshop on Strengthening Family Planning (FP) Programmes in South-East Asia (SEA) from 22-25 September 2008 in Bekasi, Indonesia. The objectives of the workshop were to: (1) review the progress of the family planning programmes and the implementation of the Strategic Partnership Programme (SPP) in the SEA Region; (b) discuss challenges and opportunities in accelerating family planning programmes and possible ways to strengthen the programmes and their linkage with other reproductive health services; and (3) develop a framework for country-specific actions for strengthening family planning programmes according to the country situation and needs.

More than 40 participants attended the workshop including national counterparts from 10 countries of the Region (except for DPR Korea), development partners (UNFPA, JHPEIGO) and WHO staff from HQ, regional and country offices. The WHO Representative for Indonesia, Dr S.R. Salunke delivered the opening remarks on behalf of the Regional Director. During the workshop the participants discussed the common problems and lessons learned in promoting FP programmes. As the main outcome of the meeting, the country teams identified the gaps and priority areas in the implementation of their FP programmes and developed action plans for strengthening and accelerating country FP programmes towards achieving MDG 5 targets.

1. Introduction

During the last three decades, all countries in the Region have shown a significant decline in the total fertility rate, (TFR - average number of births per woman), except in Timor-Leste which has the highest TFR of 7.8 in the world. While the global total fertility declined from an average of 4.5 births per woman in 1970-1975 to 2.6 births in 2000-2005, six countries in the South-East Asia Region, had a TFR higher than 2.6 in 2005, despite the significant decline achieved during the last three decades, i.e. Bangladesh (3.2), Bhutan (4.4), India (3.1), Maldives (4.3), Nepal (3.7) and Timor-Leste (7.8).

Also, adolescent fertility (births to women under 20 years of age) is a challenge, as early childbearing entails a much greater risk of maternal, neonatal and infant morbidities and mortalities. The age-specific fertility rate (ASFR) amongst adolescents (childbearing per 1,000 women aged 15-19 years) is high in Timor-Leste, Bangladesh and Indonesia and the percentage of births to women under age 20 is also high in Bangladesh, Timor-Leste, Nepal and India.

The unmet need for FP is high, especially amongst adolescents and may lead to unwanted pregnancies, insufficient spacing between pregnancies and, as a consequence, increased risks for the development of maternal and newborn complications and unsafe abortions. In countries with a high maternal mortality ratio (MMR), complications of unsafe abortion contribute to approximately 13% of maternal deaths. More complex than the above issue is the challenge of low demand for family planning in some countries with a high TFR and a low contraceptive prevalence rate.

Most countries in the South East Asia Region have improved access to modern contraceptive methods by providing direct support through government-run facilities and through indirect support to nongovernmental activities. However, the contraceptive prevalence rate (CPR) in some countries of the Region has been stagnant for the last few years. Among its causes are poor quality of family planning service, limited contraceptive

choice and access to low cost, safe and effective contraceptives; poor contraceptive commodity security system; poor management of FP programme, including its monitoring and evaluation; gender imbalance in the use of contraceptive methods (especially for sterilization) and inadequate knowledge about FP services. Moreover, the delegation of authority to the primary care level in some countries of the Region has created new challenges in managing the family planning programme locally.

Evidence-based programme guidelines that play a crucial role in ensuring quality of FP services and the programme performance are worth mentioning. The collaborative efforts between WHO and UNFPA under the Strategic Partnership Programme (SPP) have been in place to assist countries in the Region in the adaptation and utilization of FP and STI guidelines and tools since 2004-2005.

2. Objectives

The overall objective of the workshop was to facilitate countries in the South East Asia Region in strengthening the family planning programme to contribute to achieving universal access to reproductive health. The workshop focused on the following specific objectives:

- To review the progress of the family planning programmes and the implementation of the Strategic Partnership Programme in the South-East Asia Region.
- To discuss challenges and opportunities in accelerating family planning programmes and possible ways to strengthen the programmes and their linkage with other reproductive health services.
- To develop a framework for country-specific actions for strengthening family planning programmes according to the country situation and needs.

3. Highlights of the Workshop

3.1 Panel 1: Setting the Scene

Dr. Katherine Ba-Thike, RHR Department, WHO-HQ, briefed participants on the implementation of the WHO Global Reproductive Health Strategy, which was adopted at the World Health Assembly in 2004. It emphasizes the five core aspects of reproductive health services: i) improving antenatal, perinatal, postpartum and newborn care; ii) high-quality services for family planning, including infertility services; iii) eliminating unsafe abortion; iv) combating sexually transmitted infections including HIV, reproductive tract infections, and cervical cancer and v) promoting sexual health. The strategy calls for actions in five areas:

- Strengthening health systems capacity.
- Improving information base for priority-setting.
- Mobilizing political will.
- Creating supportive legislative and regulatory frameworks.
- Strengthening monitoring, evaluation and accountability.

The RHR Department, WHO-HQ, developed policy briefs to assist the countries in implementing the Global Reproductive Health Strategy to address issues of financing, integrating service provision, creating a supportive legislative and regulatory framework and promoting sexual and reproductive health needs of adolescents. Inclusion of reproductive health within National Development Plans/PRSPs, integrating reproductive health needs in the proposals to the Global Fund for AIDS, TB and Malaria, increasing budgetary allocation and availability of free or subsidized health care for the poor were cited as examples of on-going efforts in implementing the WHO Global Strategy in countries of the Region.

Dr Ardi Kaptiningsih, WHO/SEARO provided an update on the progress, issues and challenges of FP programmes in the Region. She presented data and trends on the main MDG 5 indicators including: the overall declining trends in TFR (except for Timor-Leste), contraceptive method mix in SEAR in the 2000s, trends in CPR in countries of the Region, 1990-2008; unmet needs for family planning in countries of the Region; trends in teenage fertility rate; contraceptive failure and unwanted

pregnancies and challenges in managing FP programmes. Most countries in the Region have improved access to modern contraceptive methods with increasing use of these methods and a decreasing unmet need for FP, although a limited contraceptive choice is a challenge in some countries.

Dr Saramma Mathai of UNFPA presented opportunities for strengthening the family planning programme in the Region and the WHO-UNFPA Strategic Partnership Programme (SPP). Dr Mathai noted that all countries in the Region were signatories to ICPD and its Programme of Action. Assessing the current situation, she highlighted the issue of insufficient access to family planning services and information especially among unmarried adolescents, including policy and programme challenges related to it. The latter included decreased financing of FP programmes due to competing for funding with other health priorities and the low priority given to FP programmes in some countries in the decentralized setting. Widening contraceptive choice, satisfying unmet need, helping couples achieve desired fertility size, helping countries achieve replacement fertility levels and helping countries achieve MDG and ICPD goals are the five goals of successful FP programmes. Dr Mathai emphasized the need for quality FP services and recommended strengthening advocacy for FP, re-shaping service delivery and creating a demand for and sustainability of the programmes.

The Panel 1 discussants raised the issues of quality of FP services, especially ensuring quality of services provided by the private sector. The need to involve religious leaders for ensuring a favourable policy and programme environment for provision of comprehensive choice of modern FP methods to the clients was also emphasized. It was mentioned that strengthening family planning programmes required concerted efforts and continuous monitoring.

3.2 Panel 2: Quality improvement in family planning

Dr Loshan Moonesinghe shared in his presentation Sri Lanka's experience in improving quality of care for FP services. The goal of Sri Lanka's FP programme is to "enable all couples to have a desired number of children with optimal spacing". Contraceptive prevalence during 1975-2007 showed a steady increase from 34.4% in 1975 to 70% in 2000 and a slight decrease to 68% according to the 2007 Demographic Health Survey (DHS).

The increase in the contraceptive usage included increase in the use of modern temporary methods, such as IUD, OCP, DMPA and condoms.

Family Planning services are delivered as part of the integrated MCH/FP package which is seen as a prerequisite for success of the programme in Sri Lanka. Based on the WHO FP guidelines, *Medical Eligibility Criteria* and *Selected Practice Recommendations for Contraceptive Use*, the national guidelines on provision of oral contraceptive pill (OCP), injectable DMPA and IUD along with visual aids for providers were finalized through a series of technical consultations. During discussions, it was clarified that in general the Government of Sri Lanka provides 40%-50% of the market share for contraceptive supplies, with 60% of injectable contraceptives and 90% of IUDs and the remaining being available at the private sector clinics and pharmacies.

Dr Djoko Soetikno presented JHPIEGO's Standard-based Management and Recognition in FP (SBM-R), an innovative approach to improving performance and quality at facility level in low-resource settings. This approach is based on the following quality improvement cycle: i) setting standards of performance and care; ii) measuring current performance (setting baseline indicators); iii) identifying gaps; iv) designing interventions to improve performance and address the gaps; v) implementing and measuring interventions and performance; and vi) recognition of performance improvements. He presented tools used in this approach and the results of the quality improvement processes in 22 health facilities in Indonesia where the approach was applied. Those results demonstrated that health providers perform better if they clearly understand the task, know how to complete the task, are empowered to perform the task, acknowledged for their success and are supported to improve further.

Dr Melania Hidayat introduced UNFPA's country programme actions on monitoring quality of care in family planning in Indonesia. UNFPA is supporting the national FP programme in at least 63 health centres of 21 districts of selected six provinces. The monitoring tools and instruments range from those used for self assessment by health providers, regular observations and routine data reporting. Low capacity of staff in understanding the monitoring tools, high staff turn-over and inflexibility of the programme to respond to immediate needs were cited among the challenges.

3.3 Panel 3: Improving Access to FP Service

Dr Keerti Malaviya of the Ministry of Health and Family Welfare, India, made a presentation on the expanding contraceptive choice and addressing gender issues in accessing FP services in India. The National Population Policy, 2000, targeted TFR at 2.1 by 2010 with the aim of population stabilization by 2045 at 1.4 billion. Dr Malaviya shared the achievements of India's national population policy and the FP programme performance resulting in unmet needs in FP services decreasing from 16% in 1998-1999 to 13% in 2005-2006 and decreasing TFR dropped to 2.7 in 2005-06 (NFHS III) from 3.4 in 1992-93 (NFHS-I). The following were mentioned as areas of concern: unmet needs for contraception especially for underserved populations; low use of modern contraceptive methods; low male participation; young age at marriage and childbearing; weak quality and coverage of family planning services; complacence among service providers; and weak commitment. It was stated that strong son preference resulted in female foeticide and posed challenges to the population structure.

Ms Isabelle Gomez in her presentation highlighted the commitment of the government of Timor-Leste in improving maternal health by addressing high TFR and low demand for FP services. Religious leaders have also demonstrated support to the national family planning programme. The government efforts include focussed training on FP services and counselling for midwives and nurses, tracking information using HMIS and improving the Logistics Management Information System (LMIS) for effective projection, storage and distribution of reproductive health commodities. She pointed that 80% of health posts in Timor-Leste were able to provide at least three modern FP methods.

Dr Aragar Putri reviewed the improvement in the FP programme management at district level and below in Indonesia in the era of decentralization. The change in the organizational structures due to decentralization when authority and responsibilities are shared between central and local government have presented challenges to FP service delivery. Since 2004, as per the policy established by the National Family Planning Coordinating Board, free contraceptives are provided only to the poor (approximately 30%), while other clients have to pay. The role of the MoH in revitalizing the national FP programme was seen in ensuring a better quality of contraceptive services for all at all level of service facilities including public and private.

3.4 Panel 4: Addressing unwanted pregnancy

The panel focused on the issues of addressing unwanted pregnancy. Mr Abdullah Al Mohshin Chowhdury brought up the issues of improving access to FP services in Bangladesh for underserved population groups, especially adolescents. Early pregnancy and childbearing are common in Bangladesh: 23% of all births are to women before they are 20 and 55% during their twenties. The overall unmet need for FP increased from 11% of currently married women in 2004 to 18% in 2007. The unmet need for family planning among women aged 15-19 years is even higher (20%). Most unwanted pregnancies – their numbers are largely underestimated – end in abortions, often in unsafe conditions. Concerted efforts of the government and partners that include recent initiatives on improving availability of and access to comprehensive reproductive health services are expected to reduce unsafe abortions and their complications. These include quality FP services, information and services for adolescents and menstrual regulation (MR).

Issues and challenges in addressing contraceptive failure were discussed by Dr Akjemal Magtymova. Efficacy of contraceptive methods measured under ideal circumstances (perfect use) vis-à-vis their effectiveness under real circumstances (typical use) were differentiated. Use of less effective methods, side effects, high parity, poor knowledge and availability of different contraceptive methods, short duration of contraceptive use, inadequate counseling and non-compliance are among the major factors predisposing to contraceptive failure.

Expanding contraceptive choices and providing adequate counseling to woman would lead to greater user satisfaction. This would also improve compliance that would, in turn, reduce contraceptive failure, enhance acceptance of the resulting pregnancy and minimize the chances of negative psychological sequelae. However, women who seek options to terminate unwanted pregnancies should be offered safe service alternatives, such as emergency contraception, medical abortion and menstrual regulation early in pregnancy in order to prevent unsafe practices and negative health outcomes.

Discussion points included the use of emergency contraception in the Indian FP programme, which was available through the public services but its use was rather patchy; while emergency contraceptive pills were widely available in the pharmacies there was anecdotal evidence of misuse. The

problems related to contraceptive supplies in Bangladesh were related to the supply shortages at the district level but not at the national level. It was suggested that operational research be carried out with a focus on countries in the Region with stagnant or low CPR with possible support from WHO/HRP.

3.5 Panel 5: Contraceptive commodity security

Key issues and challenges with regard to commodity security and financing of FP programmes were discussed by Dr Saramma Mathai, UNFPA Regional Office, Bangkok. The presentation highlighted the definition of Reproductive Health Commodity Security (RHCS); issues and challenges; RHCS situations in countries of the South East Asia Region and UNFPA actions to support RHCS in countries. Dr Mathai spoke of the increasing gap globally between the costs of increasing needs and the available resources for contraceptive commodities and the decreasing donor support to FP programmes and RHCS in developing countries. The Global RHCS Strategy calls for sustainable commitment, advocacy, national capacity building and coordination among partners to meet the contraceptive needs.

Ms Ambar Rahayu of the National FP Coordinating Board (BKKBN) shared experiences in managing commodity security in Indonesia. Dr Rahayu presented trends of contraceptive prevalence rate (CPR), FP unmet needs, and total fertility rate (TFR) in the country and the latest distribution by provinces, as per the latest Indonesia DHS 2007. The contraceptives commodity security strategy in Indonesia focuses on the following five key components: (i) policy component, which allows decisions at central and local level (including districts) in support to contraceptive security; (ii) improvement of clinical skills of FP providers and facilities and distribution of supplies; (iii) diversifying financing/funding sources from central and local governments, donor agencies, the private sector and community; (iv) supply of services and commodities with the involvement of private suppliers, NGOs, social marketing and commercial sectors; and (v) logistic management for planning the needs, procurement, storing, distribution, recording, reporting, monitoring and evaluation. The provision of supplies is diversified according to the ability-to-pay: free contraceptives for the poor (except for IUDs and condoms which are free for all) and the blue-circle contraceptives for those who can afford to pay. More than 60% of the people get contraceptives from the private sector.

The discussion points included an information update from Myanmar on the initiation of RHCS strategy. In view of the decentralization process in the country, the Timor-Leste participants expressed the desire to learn more from Indonesia on the management of FP programme at the district level in the decentralization era and experience of managing the public-private partnership in delivering FP commodities and services. In Indonesia, in order to ensure that district level development plans incorporate the national agenda, the government has endorsed regulations encouraging district government to prioritize FP. At the beginning of the decentralization process, FP in Indonesia was not included as one of the mandatory services at the district level; however, later, the FP programme was assigned to the Women's Empowerment Institution, which boosted prioritization of the FP programme at the community level.

With a few exceptions, provision of contraceptives in the countries of the Region is ensured through the public and private sectors, as in India with free provision of contraceptives through the public sector, while they are also available through pharmacies and the social marketing network. In Nepal, the policy of the government is to provide free contraceptives for all. However, while the contraceptive stock is sufficient, due to logistics problems rural populations may be restrained from accessing free contraceptives, so they have to incur out-of-pocket expenditures to pay for the contraceptives provided by NGOs. Bhutan provides an example of countries where the government has taken full responsibility for contraceptive supply in the absence of a private sector.

3.6 Panel 6: Maximizing FP service through service linkage

Dr Katherine Ba-Thike highlighted linkages between FP and RTI/STI/HIV programmes, as both programmes serve the same target population of sexually active men, women and young people. The rationale for integration include: minimizing missed opportunities, increasing access and coverage for vulnerable and high-risk groups, building on existing programmes, structures and institutions and promoting universal access to both, potential for cost savings, providing tailored sexual and reproductive health services for people living with HIV, reducing Mother to Child Transmission and stigma against people with HIV/AIDS, potential to increasing dual protection and condom use and likelihood to increasing impact on prevention. The WHO comprehensive four-pronged approach to Prevention of Mother to Child Transmission of HIV was emphasized

which aims at preventing women from becoming infected, preventing unwanted pregnancies among HIV-infected women, providing ARV, safe delivery practices and infant feeding options to reduce MTCT, providing care and support for HIV-infected mothers, children and families. Programme planners should try to expand entry points for accessing HIV prevention and care, increase efficiency and cost-effectiveness of programmes.

Ms Suzanne Reier presented experiences in Africa in integrating FP services in post-abortion care (PAC) and showed strong evidence to include FP counseling and service delivery in the PAC model. She also highlighted experiences in Kazakhstan and Nigeria showing that FP proved to be less costly than post-abortion care or abortion services.

Dr. Salwa Bitar, Regional Technical Adviser for FP and Maternal, Newborn and Child Health, USAID Expanding Service Delivery Project, shared country experiences of Jordan, Egypt and Yemen on integration of FP and post-partum services. She elaborated on the major gaps and challenges with regard to integration and on post-partum contraceptives choices. She also emphasized that each country should have a tailored approach that utilizes the strength of its health system and services as well as social norms and service seeking behaviour for integrating services.

During the discussion session, the participants shared their country experiences in integrating FP services with other programmes. In India for example, FP services are integrated in the HIV/AIDS programme for high-risk groups. It was noted that counseling is the most important element of FP programmes; however, its actual provision and maintaining its quality yet to receive due attention. Bhutan is adopting the family health care approach in its health system that includes FP; however, post-abortion care was not included until 2004. In Myanmar, the health service clinics do not have a separate FP department and thus all FP services are integrated in post-partum care and prevention and care of HIV/AIDS.

It was mentioned that recent reviews of country experiences in relation to abortion laws showed no strong correlation between abortion rate and the different government policies on abortion. There was no evidence of increasing or lowering abortion rates in the countries that have legalized abortion; however, the legalization of abortion could lay the ground for safer abortion services – thus decreasing the risks of complications and deaths due to unsafe practices.

Abortion is legal in Nepal and FP is incorporated in post-abortion care (PAC). Clients mostly select short-acting contraceptives and the discontinuation rate is quite high. Apart from antenatal care and PAC, the government has started the integration of FP in post-partum care. This is also the case in Sri Lanka; however, PAC has not been formalized but the government is currently developing a policy to integrate FP into PAC.

In Timor-Leste, FP is integrated in the post-partum and PAC; a guide has been developed but there are problems in implementation. Not all providers are trained on the above. Abortion is illegal, except for life-threatening medical reasons. In Bangladesh, abortion is also illegal, although MR services are legal since the 1970s as a back-up service for contraceptive failure.

3.7 Panel 7: Role of advocacy and community involvement in strengthening FP programme

Experiences on advocacy for FP in Thailand were outlined by Dr. Kittipong Saejeng, MOH Thailand. Dr Saejeng highlighted the cornerstones of Thailand's national population policy that includes the FP programme. He shared the data on the country's CPR and TFR over the last 30 years showing increasing CPR trends and reduction of TFR below the replacement level since 2000. Among the key factors for the rapid expansion of contraceptive use he highlighted the role of advocacy and awareness-raising in the community. However, current challenges relate to adolescent reproductive health: earlier age of first sex; increased prevalence of STIs, teenage pregnancies and induced abortion among adolescents. Ms Suzanne Reier contributed to the discussion on the role of advocacy by presenting experiences from Africa in advocacy for FP programme using the "toolkit" that contains nine advocacy briefs prepared by WHO.

On community empowerment and involvement in FP: NGO perspective, Mr Adrianus Tanjung, a representative from the Indonesian Planned Parenthood Association (IPPA) shared his experience of working with the community for its empowerment through the FP Community Based Distribution (CBD) Project and the Income Generating Project. He highlighted that the CBD Project has improved the distribution of contraceptives to meet the demand by improving community participation

and supply of contraceptives through provision of availing micro-credit to community distributors.

During the discussion session, Dr Saejeng clarified the following points: (a) the southern area of Thailand is mostly populated by muslims and the concept of FP would be considered as limiting births – for this reason the government decided to use the term "birth spacing"; (b) voluntary FP means that all FP clients are given information and knowledge through counseling services and it is up to the client to decide whether to accept FP and to choose the method; (c) it is a combination of many efforts that leads to programme success in reducing the TFR and increasing the CPR, in which quality IEC is one of the most crucial components, including person-to-person communication; (d) to improve quality of care a set of interventions were carried out, i.e. the development and introduction of guidelines for services, training and supervision of auxiliary midwives; (e) many youth centres have been established for provision of information and improving awareness on Adolescent Reproductive Health among youth and promotion of 100% condom use is continuing; (f) contraceptives are free for migrants.

NGOs have been playing an important role in delivering services and information on FP and reaching the communities. The objective of the Family Planning Association in Nepal is to improve RH services to the community. It has a strong network of 651 service delivery points, 450 professional staff, and 700 community health workers. The programme delivers through four key components: (1) advocacy; (2) adolescent and youth; (3) safe abortion; and (4) HIV/AIDS. The programme covers 20%-25% of the total population (nine million out of 23 million population) working in 23 of the 75 districts. The Myanmar Medical Association provides IEC for the community related to birth spacing services. Many international NGOs also provide birth spacing services.

In India, there are three big national NGOs that have been working for the past 30 years under the overall strategy and policy of the government on comprehensive RH services including FP, antenatal care and immunization. These NGOs contribute nearly 10% of CPR by delivering educational training programme to increase community awareness, supporting social marketing for pills and condoms that are in line with the government's strategy.

3.8 Group Work: Identifying priorities and defining gaps

The participants were divided into four mixed groups: Group 1 with members from Bangladesh, Bhutan, and Nepal; Group 2 had members from Timor-Leste, Myanmar and India; Group 3 had members from Sri Lanka, Thailand, Maldives and Indonesia; and Group 4 had members from India and Timor Leste. All groups presented policies and strategies of their countries, including the level of the implementation status, lessons learnt, constraints and implications for countries. The groups also focused on the various activities related to the quality of care provided. A discussion followed after the group work presentations.

3.9 Panel 8: Universal access to RH within the primary health Care Approach

Universal Access to Reproductive Health was presented by Dr Katherine Ba-Thike. She highlighted the difficulties in measuring maternal mortality ratio (MMR) and emphasized that pregnancy and delivery care alone is not sufficient to reduce MMR as all components of sexual and reproductive health had a direct impact on achieving MDG 5. Family planning, prevention and treatment of complications of unsafe abortion and prevention and treatment of STIs, including HIV and AIDS, are important. The newly-agreed MDG 5B target *"to achieve universal access to reproductive health by 2015"* was discussed with an explanation of new targets and four indicators for global monitoring of MDG 5 in addition to MMR and the proportion of births attended by skilled health personnel. The four additional indicators were *antenatal care coverage; contraceptive prevalence rate; adolescent birth rate;* and *unmet need for family planning*. The presentation concluded with an emphasis on the importance of developing a national framework of indicators for monitoring and evaluation of reproductive health programmes and strengthening linkages between sexual and reproductive health and HIV/AIDS.

Key issues in revitalizing primary health care and its implications for reproductive health programmes in the South East Asia Region were presented by Dr Ardi Kaptiningsih. Dr Ardi informed the participants that the commemoration of 30 years of Primary Health Care (Alma-Ata, 1978), will be held in Almaty, Kazakhstan simultaneously with the launch of the World Health Report 2008 (WHR 2008) dedicated to PHC. She stressed on

the importance of revitalizing PHC at all three levels (primary, secondary and tertiary). It was outlined that PHC is the approach that has the potential to address the current challenges in health including the shift in the burden of diseases from communicable to non-communicable diseases, inequity in health and escalating health care costs, and inadequate performance of the health system.

3.10 Panel 9: Implementation of FP guidelines and new research evidence

The overview of the "WHO Four Cornerstones of Family Planning" and new research evidence was presented by Dr Katherine Ba-Thike. She informed the participants about the *Continuous Identification of Research Evidence* (CIRE), a global monitoring system which allows monitoring of new evidence and ensures that WHO guidelines are kept up-to-date. The WHO Four Cornerstones of FP include two guidelines– *Medical Eligibility Criteria for Contraceptive Use* (MEC) and *Selected Practice Recommendations* (SPR) and a tool for providers and clients: *Decision Making Tool for FP Clients* and a technical guideline for providers, *FP: a Global Handbook for Providers*. Dr Ba-Thike also provided an update on the *FP Wheel* derived from the above guidelines.

Dr Bal Krishna Suvedi, Director, Family Health Division, Nepal, and Ms Nazeera Najeeb, Department of Public Health, Republic of Maldives, presented their experiences in adaptation and utilization of WHO FP guidelines in their respective countries carried out under the UNFPA-WHO Strategic Partnership Programme. In Nepal, the revision of the national FP guidelines took place in 2006-2007 with the aim to improve the quality of family planning and RT/STI services through adaptation and implementation of WHO's evidence-based guidelines. Maldives undertook the revision of their National Standards for FP Services in 2005 based on the WHO MEC and SPR with technical inputs from national programme managers, technical experts and service providers incorporated through the transparent consultative process.

3.11 Panel 10: Promoting best practices and partnerships

Implementing the Best Practices (IBP) Initiative, a partnership for improving quality and for scaling up, was presented by Ms Suzane Reier from the

Reproductive Health and Research Department, WHO/HQ. The importance of creating the IBP Initiative and detailed information regarding the IBP Knowledge Gateway were shared.

Dr Salwa Bitar, Senior Regional Adviser, Extending Service Delivery (ESD) Project, USAID, gave an overview of the Family Planning Best Practices presented in September 2007 at the Asia Near-East (ANE) Best Practices Meeting in Bangkok and its follow-up. The meeting was attended by 450 participants from 18 countries of the ANE Region to share state-of-the-art information, materials, skills and strategies in FP and maternal, newborn and child health (MNCH) areas. Thirteen country teams trained in scaling-up methodology developed plans for scaling-up FP-MNCH best practices and eight countries initiated plans with different progress levels. Dr Bitar announced a new ESD invitation for FP-MNCH proposals from ANE countries and discussed current and potential collaboration with partners. Five countries from the South East Asia Region: Bangladesh, India, Indonesia, Nepal and Thailand are among the 13 ANE countries identified by USAID eligible for ESD project grants.

The overall objective of the UNFPA-WHO Strategic Partnership Programme (SPP) is to improve the quality of sexual and reproductive health services through adaptation and application of evidence-based guidelines. SPP is an example of successful partnerships that provides an opportunity for enhancing synergy and complementarity within the UN system and between international and national partners towards improving sexual and reproductive health. Dr Katherine Ba-Thike highlighted country experiences in the development and revision of national FP guidelines based on the WHO Four FP Cornerstones, as well as guidelines on maternal and newborn health and RTI/STI guidelines carried out within the framework of the WHO-UNFPA SPP.

Dr Chawalit Natpratan from Family Health International, Indonesia, stated that contraception was the "best-kept secret" in prevention of HIV/AIDS. He provided evidence of the correlation of high rates of HIV with high unmet need for contraception, involving a high level of unintended pregnancies to HIV-positive women who are likely to deliver HIV-positive infants. Preventing these unintended pregnancies with effective FP methods could dramatically reduce transmission of HIV to infants.

Healthy Images of Manhood (HIM) was presented by Dr. Salwa Bitar. It is a community-based approach for improving men's roles in postpartum and FP. It promotes responsible sexual and reproductive health behaviour, specifically among men in various settings (schools, refugee settings, workplace) by changing gender norms related to traditional notions of masculinity that impact negatively on health. HIM promotes positive sexual and RH/FP behaviours and outcomes among men and women. Intended positive changes include, among others, responsible sexual behaviour among men, supportive, caring and involved partners/husbands and fathers as well as healthy and non-violent responses to conflict resolution. The presentation provided an overview of HIM and the process and procedures of application of HIM in different countries.

3.12 Group Work: Development of country action plans

Participants worked in their country teams to develop country action plans to address priority issues in FP programmes. As a result, the country teams presented plans with priority gaps and challenges to be addressed and the proposed actions with timeframes. Some country teams were able to develop concrete and actionable points with a back-up of the approved national plans; while other proposals were in draft form which had to be further refined in consultation with respective ministries of health.

The following are the highlights of the country action plans.

Bangladesh. The country team prioritized the issue of discontinuation of contraceptive use. A set of actions proposed over a two-year period included conducting operational research to understand the reasons for discontinuation, strengthening of FP counseling and follow-up through training of FP providers, updating of FP tool for counseling (Decision Making Tool/DMT) and strengthening supportive supervision. Actions to meet the needs of the undeserved urban poor and those in hard-to-reach rural areas were also considered as a priority. The activities include initiation of door-to-door services in slum areas in collaboration with NGOs and increase recruitment of community workers in rural areas through the development of special programmes.

Bhutan. The action plan highlighted the development and implementation of the comprehensive Reproductive Health Commodity Security Strategy (RHCSS) to improve RHCSS management and revisiting

medical contraceptive standards, adaptation of DMT and training of FP staff to improve quality of FP services. Bhutan requested funding support for a number of activities related to a client satisfaction survey to study high discontinuation rates, training of health counselors in schools and institutions on sexual and reproductive health of adolescents and awareness creation and sensitization of young people and their communities to address the increase in teenage pregnancy rates.

India. The plan covered a four-year period and included periodic advocacy to generate high-level awareness of reproductive health and family planning issues, training of peripheral workers in FP counseling, expanding contraceptive choices by making a wider contraceptive mix available, reaching communities through outreach and fixed-day clinics, involving private sector/NGOs in service delivery and social marketing of contraceptives up to the peripheral level. Filling up existing vacant sanctioned posts was put as a priority along with the development of supervision guidelines and tools.

Indonesia. Advocacy on FP both at the central and local (district) levels was prioritized for securing necessary resources including staff and commodities. Information, education and behaviour change communication activities were emphasized at the demand creation side, especially for young people to promote reproductive health and rights for informed choice. Operational research to pilot a programme for improving access for FP information and services in urban slum areas was planned. Indonesia's plan includes an adaptation of DMT for use in settings with a generalized HIV epidemic. Strengthening and expanding commodity security along with the development of a national commodity security strategy 2009-2014 and improving logistic management for contraceptives at district level was emphasized. Improvement of FP counseling was also emphasized. It was suggested to integrate FP counseling and services in the pre-service training curricula for doctors, midwives and nurses.

Maldives. The action plan aimed at achieving two goals: i) improving men's understanding of their own and partner's RH needs, choices and rights and ii) ensuring easy access to safe, affordable and effective methods of FP services and information. The former enlisted the development of tools/protocols for public health providers, NGOs and the community to involve boys and men in health-related issues, while conducting a survey to assess the unmet needs for contraception and reasons for discontinuation rates were stipulated in the latter.

Myanmar. A detailed two-year action plan was developed aimed at addressing the following two main objectives: i) ensuring universal access to quality birth spacing services through the primary health care system in 112 project townships through strengthening the leadership, supervisory and monitoring role of lady health visitors (LHVs) and ii) ensuring utilization of DMT by medical officers and primary health care providers for healthy timing and spacing of pregnancy.

Nepal. As part of the concerted efforts to address high unmet needs for FP and high discontinuation rate, the action plan had very concrete actions focused on strengthening quality of family planning services through focused counseling at the community level using the local adaptation of the Decision Making Tool. Support was requested from SEARO for the piloting of DMT for use in settings with generalized HIV epidemic that was recently developed by RHR Department/HQs.

Sri Lanka. The action plan highlighted strategies to address four main issues: i) ensuring availability and accessibility to quality FP services for temporary contraceptives by developing guidelines and establishing FP clinics (1 per 10,000 population), improving contraceptive method mix and choices (offering a choice of at least four methods); ii) ensuring the availability of male and female sterilization services in institutions; iii) addressing the unmet need for contraception to reduce teenage pregnancies and abortions through staff training on counseling and collaborating with NGOs for provision of services to adolescents; and iv) commodity security through a computerized information system and improving the forecasting and supply chain capacity (including in emergencies/conflict situations).

Thailand. The action plan emphasized the need for an integrated RH services model, improving quality of FP services and addressing the unmet need for contraception and unwanted pregnancy, especially among adolescents and minority population groups (hill tribes, southern muslims, out-of-school adolescents, urban poor, construction workers) and involving men in accessing RH services. Financial support was requested from SEARO for making DMT and other FP guidelines available at the FP clinics.

Timor-Leste. The actions for improving awareness and FP services included: advocacy at the national and district level; improving quality of FP services; strengthening logistics management information system and routine recording and reporting; and building community awareness and

participation. A study tour for programme managers at the central and district levels to Indonesia to see the FP services and for monitoring the MNH programme was also planned in collaboration with development partners.

All action plans reflected broad participation of various key stakeholders and donor support under the national leadership and the need to further strengthen private-public partnerships to reach the poor and underserved populations. The array of interventions for strengthening logistics management information systems proposed by country teams ranged from the development and implementation of comprehensive national RH commodity security strategies to in-service training on forecasting and procurement and actions to improve a supply chain. Improving quality of care was cited as a priority issue across the country action plans and the quality improvement steps included updating standards of care, adaptation and implementation of DMT, training for supervisors and providers with an emphasis on counseling skills and diversifying availability and choices of modern contraceptive methods to the client. Male participation was also highlighted in the action plans involving pilot centres for male services and educational activities to increase their participation in FP and RH issues.

4. Next steps and closing

At the closing session, Dr Katherine Ba-Thike summarized the key issues discussed and the diverse reproductive health and programmatic situation in the countries of the Region that call for action at all levels with special focus on vulnerable groups.

The participants agreed on the following next steps:

(1) The country teams: i) to follow-up with the ministries of health, respective stakeholders and WHO on the draft country action plans developed during the workshop; ii) those countries where the action plan included concrete actions – follow-up with its implementation by contacting UNFPA, WHO and other donors and to explore channels for supporting the planned activities. WHO-SEARO will be able to provide support within the current fiscal year subject to availability of seed funds.

(2) WHO Country Offices and SEARO: to provide further technical assistance for implementing FP programmes in countries of the Region.

(3) WHO-HQs: to provide support for country action plans through WHO-UNFPA Strategic Partnership Programme and HRP.

Dr Ba-Thike, Dr Saramma Mathai and Dr Ardi Kaptiningsih thanked the participants and the partners for attending the workshop and for producing action plans for revitalization of FP in the countries.

Annex 1

Programme

Monday, 22 Sep 2008

	Subject	Facilitator/Speaker
08:30 – 09:00	Registration	
09:00 – 09:45	**Inaugural Session**	WR Indonesia
	• Message from the Regional Director, SEARO	UNFPA Regional Office
	• UNFPA remarks	RA-MPS/RHR-SEARO
	• Objectives of the Workshop	Secretariat
	• MOH Opening Remarks	RA-MPS/RHR-SEARO
	• Introduction of Participants	MO-RHR/SEARO
	• Group photograph	
	• Announcements	
	• Appointment of Chairperson and Rapporteur	
	• Introduction to the Programme of the workshop	
09:45 – 10:30	**Panel 1: Setting the scene**	
	• Global Reproductive Health Strategy	Dr Katherine Ba-Thike
	• Progress, issues and challenges of Family Planning Programme in SEAR	Dr Ardi Kaptiningsih
	• Opportunities for strengthening Family Planning Programme in SEAR and the *Strategic Partnership Programme*	Dr Saramma Mathai
11:00 – 12:00	**Panel 2: Quality improvement in Family Planning**	
	• Improving quality of care for Family Planning service in Sri Lanka	MoH, Sri Lanka
	• Standard-based management and recognition in Family Planning	Dr Djoko Soetikno
	• Monitoring quality of care in Family Planning (FP)	Dr Melania Hidayat

12:00 – 12:30	**Panel 3: Improving access to Family Planning service**	
	• Expanding contraceptive choice and addressing gender issues in accessing Family Planning service in India	MOHFW, India
13:30 – 14:10	**Panel 3 (continued)**	
	• Addressing low demand for FP service in Timor-Leste	MoH, Timor-Leste
	• Improvement of FP Programme management at district level and below in the decentralization era in Indonesia	MoH, Indonesia
14:10 – 14:20	Questions/clarifications	
14:20 – 14:50	**Panel 4: Addressing unwanted pregnancy**	
	• Improving access to FP service for adolescents and managing contraceptive failure in Bangladesh	MoH, Bangladesh
	• Issues and challenges in addressing contraceptive failure	Dr Akjemal Magtymova
14:50 – 15:30	**Group discussions**	All participants
16:00 – 16:20	Group discussion (continued)	
16:20 – 17:00	Presentation of key discussion points by 3 groups	Presented by group reporters
17:00 – 17:30	Meeting of facilitators	WHO, UNFPA and other facilitators

Tuesday, 23 Sep 2008

08:30 – 09:00	**Panel 5: Contraceptive/Commodity security**	
	• Key issues and challenges on commodity security and financing of FP Programme	Dr Saramma Mathai
	• Experiences in managing commodity security in Indonesia	NFPCB Indonesia
09:00 – 09:30	Discussion	
09:30 – 10:30	**Panel 6: Maximizing FP service through service linkage**	
	• Linkages between FP and RTI/STI/HIV programmes	Dr Katherine Ba-Thike
	• Linkages between FP and post-partum services	Dr Salwa Bitar
	• Linkages between FP and post-abortion care	Ms Suzanne Reier

11:00 – 11:30	Discussion	
11:30 – 12:30	**Panel 7: Role of advocacy and community involvement in strengthening FP Programme**	
	• Experiences on advocacy for FP in Thailand	MoH, Thailand
	• Advocacy approaches for FP in other regions	Ms Suzanne Reier
	• Community empowerment and involvement in FP: NGO perspectives	PKBI
13:30 – 13:50	Discussion	
13:50 – 14:00	Introduction to Group Work (*on lessons learned, constraints and implications for countries*)	Dr Akjemal Magtymova
14:00 – 15:30	Group Work	All participants
16:00 – 16:30	Group Work (continued)	

Wednesday, 24 Sep 2008

08:30 – 09:15	Presentation of Group Work	By group reporters
09:15 – 09:45	Discussion	
09:45 – 10:15	**Panel 8: Universal access to Reproductive Health within Primary Health Care approach**	
	• MDG 5B, concepts and indicators	Dr Katherine Ba-Thike
	• Key issues in Revitalizing Primary Health Care in SEAR	Dr Ardi Kaptiningsih
10:15 – 10:30	Discussion	
11:00 – 12:00	**Panel 9: Implementation of FP guidelines and new research evidence**	
	• Overview of the "WHO Four Cornerstones of Family Planning" and new research evidence	Dr Katherine Ba-Thike
	• Experiences in adaptation and utilization of WHO FP guidelines in Nepal	MoH, Nepal
	• Experiences in adaptation and utilization of WHO FP guidelines in Maldives	MoH, Maldives
12:00 – 12:30	Discussion	

13:30 – 14:30	**Panel 10: Promoting best practices and partnership**	
	• IBP Initiative and approaches to improving quality of services and scaling up	Ms Suzanne Reier
	• Review of the Asia Near-East Best Practices Meeting and its follow-up actions in countries	Dr Salwa Bitar
	• Progress of the WHO-UNFPA Strategic Partnership Programme	Dr Katherine Ba-Thike
14:30 – 15:00	Discussion	
15:00 – 15:30	Partners' initiatives in Family Planning:	
	• FP among HIV positive people	FHI Indonesia
	• Healthy Images of Manhood	Dr Salwa Bitar
16:00 – 16:10	Introduction to Country Group Work (*development of a framework for country actions for strengthening FP Programme*)	Dr Akjemal Magtymova
16:10 – 16:30	Country Group Work	All participants

Thursday, 25 Sep 2008

08:30 – 10:30	Country Group Work	
11:00 – 12:30	Country Group Work (continued)	
13:30 – 14:30	Presentation of Group Work	By group reporters
14:30 – 15:00	Discussion	
15:00 – 15:30	Next steps, conclusion and recommendations	WHO, UNFPA
	Closing	

Annex 2

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