VOLUME 19

SHARING Innovative Experiences

Experiences in Addressing Population and Reproductive Health Challenges

Partners in Population and Development
A South-South Initiative

Global South-South Development Academy

The series *Sharing Innovative Experiences* is part of the multidimensional strategy of the UNDP Special Unit for South-South Cooperation (SSC) to promote knowledge-sharing in the South. It presents Southern solutions to Southern challenges through the use of Southern expertise.

Each volume of case studies focuses on a specific topic that is identified by the Special Unit on the basis of its corporate priorities and their links to the Millennium Development Goals. The Special Unit works with partners to identify Southern initiatives that represent successful practices. A technical committee recommends initiatives that can be considered successful in their particular context. Following the methodology of the Global South-South Development Academy, representatives of the selected initiatives are invited to document their experiences in individual case studies and to present them at an international workshop for extensive sharing of information with other practitioners. The case studies are subsequently reworked to meet the criteria for publication.

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ISSN: 1728-4171

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New York, NY 10017 USA

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Design: Alamini Design, 145 West 28th Street, 12th Floor, New York, NY 10001, alaminidesign.com
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UNDP
Global South-South Development Academy
UNFPA
Partners in Population and Development
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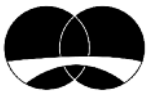
THE UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP) is the UN's global development network, an organization advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. It is on the ground in 166 countries, working with them on their own solutions to global and national development challenges. As they develop local capacity, they draw on the people of UNDP and its wide range of partners.



THE SPECIAL UNIT FOR SOUTH-SOUTH COOPERATION, formerly known as the Special Unit for Technical Cooperation among Developing Countries (TCDC), was established by the United Nations General Assembly within UNDP in 1978. It carries out its United Nations mandate to mobilize international support for sustained South-South cooperation for development. It encourages developing countries to become important providers of multilateral cooperation, fosters broad-based partnerships for supporting South-South initiatives, supports the efforts of the South to pool the vast resources of Southern countries as a way of achieving common development goals, and facilitates South-South policy dialogues.

PARTNERS IN POPULATION AND DEVELOPMENT (PPD) is an intergovernmental initiative created specifically to expand and improve South-to-South collaboration in the fields of reproductive health, population and development. PPD was launched at the 1994 International Conference on Population and Development. Its mission is to assist member countries and other developing countries to address successfully the sexual and reproductive health and rights and population and development challenges through South-South collaboration. PPD carries out its mission by raising a common voice and sharing sustainable, effective, efficient, accessible and acceptable solutions considering the diverse economic, social, political, religious and cultural characteristics of member countries.

THE UNITED NATIONS POPULATION FUND (UNFPA) is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV, and every girl and woman is treated with dignity and respect. UNFPA works in partnership with governments, along with other United Nations agencies, communities, non-governmental organizations, foundations and the private sector, to raise awareness and mobilize the support and resources needed to achieve its mission. It works in some 150 countries, areas and territories and is a field-centred, efficient and strategic partner to the countries it serves.

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Foreword

The year 2011 will be remembered as the year when the world's population reached 7 billion. According to the latest projections by the United Nations, the world population will continue to increase to 9.3 billion by the year 2050. To put these numbers in perspective, the world population did not reach one billion until 1804. It then took 123 years to reach 2 billion in 1927, 33 years to reach 3 billion in 1960, 14 years to reach 4 billion in 1974, 13 years to reach 5 billion in 1987 and 12 years to reach 6 billion by October 1999. Another billion will be added by October 2011. This growth in world population is phenomenal. While on the one hand it reflects mankind's enormous success in reducing mortality and improving quality of life for billions of people, on the other it raises the serious challenge of the social, political, environmental and developmental implications of adding additional billions of people so rapidly.

One crucial feature of the current global demographic situation with significant implications for the future is the fact that more than 3 billion people are under the age of 25, with almost 1.8 billion people between the ages of 10 and 24, the parents of the next generation. How effectively the world helps these cohorts of young people in meeting their development and reproductive health needs will greatly influence the pace and nature of future demographic dynamics in the world.

The International Conference on Population and Development (ICPD) held in Cairo in 1994 was a watershed in the history of the population, reproductive health and family planning movement. It heralded a move away from a past focus on demographic numbers to improving people's quality of life. It redefined the structural antecedents of the population issue and has offered the world a rights-based, gender-sensitive and development-focused approach to its resolution. Central to the new

approach were, among other things, the rights of individuals and couples in deciding the number and spacing of their children; rights for universal access to reproductive health for all, including reproductive rights; the recognition given to inextricable linkages between gender inequality, women's empowerment and reproductive health issues; and the clear implications of population dynamics for sustained economic growth and sustainable development. The ICPD Programme of Action includes a comprehensive set of recommendations to address population issues from these strategic perspectives.

During the last decade and a half, most developing countries have formulated and implemented policy and programmatic measures based on the ICPD Programme of Action. They include efforts aimed at, inter alia, policy formulation, programme development, service delivery, advocacy, training and capacity development, and resource mobilization. The substantive focuses of such successful efforts have included family planning, reproductive health, gender empowerment, adolescent and youth reproductive health, and population and development integration. Although such successes have been important and are common knowledge within national contexts, they are not well known more widely mainly because many successful experiences have not been adequately documented. This publication is an attempt to address this gap.

Recognizing the potential usefulness of such successful experiences to other countries in similar situations, PPD undertook, with the financial support of the United Nations Population Fund (UNFPA) and the Packard Foundation, an exercise to select and document case studies of innovative practices in population, reproductive health and development. This work was undertaken in partnership with the UNDP Special Unit for South-South Cooperation as part of its Global South-South Development Academy, which defines the methodology and standards for the publication of the series, *Sharing Innovative Experiences*. This publication confirms the PPD commitment to help to promote the goals of ICPD through South-South cooperation and to share, in particular, operational experiences in addressing issues in population dynamics and development, family planning and reproductive health among its member and other developing countries.

The case studies cover successful experiences with innovative approaches adopted by PPD member countries in addressing important issues in expanding access to family planning, improving the quality of care in the delivery of family planning services, having national parliamentarians advocate for a reproductive health agenda, tackling the mother-to-child transmission of HIV/AIDS, empowering women and integrating population factors into development planning.

It should be emphasized that these are experiences from the South, Southern solutions to Southern challenges arrived at through the use of Southern expertise. They were selected following a call for nominations by PPD member countries of practices in the population and reproductive health areas that the individual member countries considered to be innovative,

good or successful in their national contexts. From among the more than 80 submissions, 10 were chosen for documentation following an in-country process to ensure that there was consensus in the country on the relevance and usefulness of the practice for wider sharing and replication. An External Review Group comprising international experts, representatives of UNFPA and the Special Unit for South-South Cooperation, and PPD staff reviewed the drafts of the case studies. The authors subsequently presented the experiences for discussion at a workshop held in Bangkok, Thailand, in August 2010, which provided an opportunity for sharing as well as for capacity-building and mutual learning before the finalization of the drafts of the case studies.

The practices included here are important in addressing more effectively the population challenge as the world moves towards the 9 billion mark by the middle of the century. To increase their impact, each case study has been edited into a non-technical version, making it accessible to a wider audience. As with other books in the series, the present volume will be distributed free of charge throughout the South. By providing such a collection of innovative practices and lessons learned, it is hoped that developing countries, with their limited human resources, will be able to select the most appropriate measures and adapt them to their own particular development needs. The present volume is also being made available online (ssc.undp.org) with the hope that the innovative practices that it contains will be able to reach an even wider audience.

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Acknowledgements

The present publication is part of a broader knowledge-sharing process promoted and coordinated by the UNDP Special Unit for South-South Cooperation, which issues the series, *Sharing Innovative Experiences*, in support of South-South learning. It results from a joint initiative of the Special Unit and Partners in Population and Development (PPD) in collaboration with the United Nations Population Fund (UNFPA) and the Packard Foundation.

We wish to express our sincere appreciation to Dr. Thoraya Obaid, the former Executive Director of UNFPA, and to Dr. Babatunde Osotimehin, the current Executive Director, for their continued support of this initiative. We would also like to express our gratitude for the support and guidance provided to this exercise by the Honourable Ghulam Nabi Azad, Union Minister of Health and Family Welfare of India and the Chair of the Governing Board of PPD. This publication would not have become a reality without the support from Mr. Werner Haug, the Director of the UNFPA Technical Division, and Mr. Yiping Zhou, the Director of the Special Unit, and the coordination of Dr. Sethuramiah L. Rao, the Permanent Observer of PPD to the United Nations, and Mr. Francisco Simplicio, the Chief of the Division for Knowledge Management of the Special Unit.

The 10 case studies in this volume were prepared by national government agencies, professional institutions, national experts and practitioners. Without their commitment to share experiences of developments in addressing issues of family planning, reproductive health, and the integration of population, environment and development interrelationships into policies and programmes for sustainable

development, this kind of international review would not be possible and we gratefully acknowledge their contributions to this volume.

The preparation of these case studies also involved a long list of individuals at the country and global levels whose names are too numerous to be mentioned individually. We would, however, like to acknowledge the work done by the members of the External Review Group whose review of an earlier draft was invaluable in improving the quality of the presentations. They are Dr. Michael Hermann and Mr. Rabbi Royan, both of UNFPA; Dr. Denis Nkala of the Special Unit; and Mr. Harry Jooseery, Dr. Jotham Musigunzi, Dr. Sethuramiah Rao and Mr. Jyoti Singh, all of PPD.

Our appreciation also goes to Ms. Lourdes Hermosura-Chang of the UNDP Special Unit for South-South Cooperation, who provided logistical, administrative and technical support to this publication, and to Dr. Barbara Brewka, an independent professional commissioned by the Special Unit to carry out editorial reviews and layout coordination during the publishing phase.

The expertise and commitment of each member of these diverse groups helped to move the project forward efficiently and effectively. We express our thanks to all of them.

Introduction

Background

Partners in Population and Development (PPD) is committed to promoting an exchange of information and experience among the developing countries in general and among its member countries in particular. It recognizes that organizations, countries and communities throughout the world have been implementing programmes for many years in the field of population, reproductive health and development. The focus of these programmes has covered a broad array of concerns, including policy formulation, programme planning and implementation, service delivery, poverty alleviation, social mobilization, advocacy, support communication, capacity-building and institutional development.

Such efforts have frequently been successful, and many innovative, promising, good or best practices have been part of these initiatives by countries or communities. Unfortunately, these successful interventions are often not documented or widely shared. In some cases, documented information may be available but not quickly or easily accessible to programme managers and others as they design and implement programmes. Furthermore, programme managers should be able to have confidence in the credibility of the information available.

To address this critical need, PPD, in close collaboration with the United Nations Population Fund (UNFPA), has undertaken an exercise to help to identify and compile good practices to document the kinds of lessons learned by countries in successfully addressing policy, programmatic or operational issues in the fields of population, poverty and reproductive health in PPD member countries. PPD is convinced that sharing lessons learned from these country experiences with other countries would be beneficial not only to rap-

idly promoting the population and reproductive health agenda in general but also to achieving the Millennium Development Goals and the goals of the International Conference on Population and Development (ICPD) in developing countries.

Experience has shown that many developing countries have indeed succeeded in, among other things, strengthening access to quality family planning services, reducing unmet needs for family planning, slowing the population growth rate, improving women's status and integrating population factors into development planning. It would thus be very timely and useful to document some of these successful approaches for wider circulation and adaptation by other developing countries, given that many developing countries are still facing the population challenge.

Definition of "Innovative Practice"

While there is no universally acceptable definition of a good or innovative or best practice, for the purpose of this publication, PPD has adopted the broad definition of a "good" or "innovative practice" used by UNFPA: *"planning or operational practices that have proven successful in particular circumstances and which are used to demonstrate what works and what does not and to accumulate and apply knowledge about how and why they work in different situations and contexts."*[1]

The Documentation Process

In documenting the innovative practices in population and reproductive health included in this volume, PPD adopted the following steps:

- In early 2009, PPD undertook an informal inquiry, using a simple questionnaire, to collect information among its member countries on practices in the population and reproductive health areas that the individual countries considered to be innovative, good or successful in their national contexts. Based on a preliminary analysis of a large number of submissions, totalling more than 80, PPD discussed the proposed topics with an internal review group and then decided that it should limit itself to focusing on a manageable number of countries. PPD advised the member countries to undertake an in-country validation exercise of the selected individual topic to ensure that the topic enjoys a broad consensus within the country on the relevance and usefulness of the practice for wider sharing and consideration for replication by other countries.
- PPD prepared, with inputs from UNFPA, a set of detailed guidance notes for authors on documenting the practice by largely adapting the Guidelines of the Special Unit for South-South Cooperation.[2] These were made available to the authors of the 10 case studies in November 2009.

[1] UNFPA, Glossary of Evaluation Terms, New York, 2005.

[2] UNDP, Special Unit for South-South Cooperation, Guidelines for Documenting Southern Development Solutions, New York, October 2008.

- A planning meeting of the authors was held in February 2010 in Dhaka, Bangladesh, to review the draft submissions and agree on a common format and approach to documenting the practices.
- Authors were requested to revise their submissions by taking into account comments and suggestions made at the planning meeting and to have an in-country meeting to review the revised draft before submitting it to PPD.
- PPD appointed an External Review Group of international experts, representatives of UNFPA and the Special Unit for South-South Cooperation, and PPD staff to review the revised drafts and to provide a final set of comments and suggestions for revisions by the authors.
- A workshop for the authors with the External Review Group was held in August 2010 in Bangkok to provide comments and suggestions to the authors for the finalization of the country studies.
- An external editor was appointed to undertake copyediting of the 10 submissions.
- Finally, the edited final versions of the country studies were sent to the Special Unit for South-South Cooperation for review and layout.

Relevance of the Case Studies

The International Conference on Population and Development (ICPD) held in 1994 in Cairo, Egypt, was a watershed in the area of population, gender and development. It mandated a new approach to the conceptualization as well as the resolution of the population and family planning issues. Among the many innovations stemming from the Conference, the following three are significant. First, the ICPD laid the foundation for looking at economic growth not only in terms of increases in per capita income but also in the broader context of sustained economic growth and sustainable development. Second, it reconceptualized and accorded a new basis to family planning in the broader context of reproductive health, within a human rights framework. Third, it brought to the forefront the issue of gender equality and women's empowerment and the critical importance of addressing this issue not only in its own right but also as a complementary and necessary strategy to help to resolve the population and sustainable development issue. To help to implement the new vision, the ICPD made a large number of recommendations for implementation at policy, programme, operational and other levels.

Since the adoption of the ICPD recommendations, many developing countries have reformulated their national polices and programmes in the population and family planning field to help to operationalize the new perspectives, and several of these countries have achieved success in implementing specific measures. This publication includes selected examples of such successes from countries in Africa, the Arab States and Asia.

The 10 countries represented here are Bangladesh, China, Ghana, India, Indonesia, Kenya, South Africa, Thailand, Tunisia and Uganda.

Taken together, the case studies substantively represent innovative practices in addressing the long-standing need to expand access to family planning services for the poor and needy as well as to meet concerns arising out the new perspectives on reproductive health and sustainable development mandated in the ICPD Programme of Action. Among the 10 case studies, four deal with improving access to family planning using different approaches; three focus on selected components of reproductive health, i.e., adolescent reproductive health, HIV/AIDS and advocacy for reproductive health; one deals with gender empowerment and reproductive health; and two are studies of training programmes: one on integrating population factors into development planning and the other on the broader issue of population and sustainable development. Several of the case studies are based on a longer time frame and are situated in a historical context (the examples from Bangladesh, China, Indonesia and Tunisia) whereas the six other studies cover more recent and shorter periods of time.

Similarly, the case studies document the experiences of geographically widespread countries: four from sub-Saharan Africa, one from North Africa, two from South Asia, and three from East and Southeast Asia.

Although the total number of case studies in the compilation is relatively small, the composition of the group is broad and represents considerable variability in programme context and cultural diversity. The group includes countries with relatively small populations such as Ghana and Tunisia as well as population giants such as China and India and many mid-sized countries in between. This diversity in geography, culture, programme context and approach contributes to the practical relevance of lessons learned that are identified in the case studies.

Overview of the Case Studies

As already mentioned, the specific topic of the case studies pertains either to family planning, reproductive health, gender or population and development. More than one case study is generally included under each topic, and each case study deals with a complementary theme or a component element of the substantive topic. For example, under the topic of "family planning", case studies concentrate on expanding or extending access to family planning services through different approaches such as the use of domiciliary services, improving the quality of care, strengthening community participation or promoting the greater use of a specific contraceptive method. Likewise, included under the rubric of "reproductive health" are case studies on addressing adolescent sexual and reproductive health, on addressing mother-to-child transmission of HIV within a community framework, and on parliamentarians' advocacy for the reproductive health approach. Similarly, in the category of "population and development", two case studies are included: one dealing with integrating population factors into decentralized development planning and the other with a system

approach to training in population and the broader concept of "sustainable development". Finally, this volume includes a case study on women's empowerment and its ramifications for family planning and reproductive health.

Family Planning

The concept, practice and challenge of family planning have been a central element of population policy and programmes from the very beginning in the 1960s. While the context within which family planning services are provided has undergone fundamental changes over time, the relevance of these services has remained valid. However, there are some indications that the centrality of family planning in population programmes during the last decade or so has been diminished in terms of the proportionate allocation of resources to family planning and, in some cases, political support for it, especially in the context of decentralization and devolution of political power.

Accordingly, there has been a call for renewed effort to put family planning back in a place high on the national and the global agenda. In this context, the four case studies included under this category take on an added significance. All four deal in one way or another with expanding or strengthening the access to family planning services in different national contexts.

The Bangladesh innovation, for example, involves an approach to (a) generate greater demand for family planning services on the one hand, and (b) ensure easy access to services to help bring about changes in the reproductive health behaviour in a population characterized by poor infrastructure, a low literacy level, poor socio-economic conditions, pervasive gender inequality and an overall conservative attitude towards contraception on the other. The focus of the innovation was to successfully introduce the domiciliary (doorstep) service-delivery system rather than depending only on the static service centre approach. As is made clear in the case study, the country succeeded in expanding the practice of family planning, reducing the levels of fertility and decreasing the growth rate of the population. In addition, the approach has, according to the study, led to other benefits for women's empowerment and social mobilization.

The China case study is in many ways an illustration of the basic need to strengthen the quality of care in family planning services, as called for in the Programme of Action of the ICPD. The innovation here lies in the fact that, immediately following the Cairo Conference, China reoriented its family planning programme from a heavy emphasis on demographic targets towards a client orientation and a quality-focused approach to family planning. The case study demonstrates that, by reorienting the focus, upgrading services and improving facilities, the country succeeded not only in attaining low and stable fertility levels but also in generating among the people an improved awareness of reproductive rights and benefits, an improved relationship

between clients and service providers, and an improved image of the family planning programme.

The example from Indonesia is a classic illustration of the importance of involving the community in the promotion and administration of family planning services to meet its needs. The innovation here was the introduction of the Village Family Planning Programme by the Government, with strong central political support. The idea was to use villages as bases for family planning and to decentralize the National Family Planning Programme to the village level and give responsibility for programme implementation to village officials and volunteers. Beginning with successful efforts in Bali, the Programme was expanded to Java and eventually to other islands. According to the study, the approach resulted in a growing and high level of contraceptive practice, a reduced fertility rate, a slowdown in the growth rate of the population, and an associated improvement in family well-being in the population. The study also argues that, with national decentralization, the political and financial support for family planning started to decline and the Programme began showing signs of weakness and instability. To address these new challenges, the country is now addressing the family planning issue through a modified approach, linking family planning with income-generating activities for more prosperous families.

The Kenyan case study documents the Government's successful approach in reintroducing the contraceptive method of the intrauterine device (IUD) into the National Family Planning Programme. The underuse of IUDs and other long-lasting and permanent methods in the National Programme had become a cause for concern to the Government and makers of health policy. According to the case study, overreliance on relatively more expensive methods had burdened the Kenya Family Planning Programme, which was already facing budget cuts as resources were increasingly directed towards the HIV/AIDS programme, and had limited women's access to a full range of contraceptive methods. By adopting an innovative approach consisting of (a) increasing the support for the IUD method among policymakers, service providers and clients, (b) increasing the quality of IUD services, (c) enhancing the demand for IUDs and (d) monitoring and evaluating the Programme performance, Kenya has succeeded in reintroducing the IUD method into the National Family Planning Programme and increasing the uptake of this method.

Reproductive Health

The ICPD was a landmark moment in the history of the population movement since it argued for a different approach to both the conceptualization of the population issue and to its resolution. It introduced the concept of "reproductive health" and advocated for reproductive health care to include, inter alia, family planning, prenatal care, safe delivery and post-natal care, prevention and appropriate treatment of infertility, treat-

ment of reproductive tract infections and sexually transmitted diseases including HIV/AIDS, and human sexuality, reproductive health and responsible parenthood.

In the context of this publication, three recommendations contained in the ICPD Programme of Action[3] are significant: (a) that "[i]nnovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescents";[4] (b) that "Governments should also scale up, where appropriate, education and treatment projects aimed at preventing mother-to-child transmission of HIV";[5] and (c) that "[m]embers of national legislatures can have a major role to play in enacting appropriate domestic legislation for implementing the ICPD Programme of Action, allocating appropriate financial resources, ensuring accountability of expenditures and raising public awareness of population issues".[6] The three case studies of India, Indonesia and Thailand included here deal respectively with the three recommendations cited above.

The Indian case study focuses on addressing the well-being and the reproductive health of youths and adolescents in the country by documenting the experience gained through a multisectoral and integrated approach in selected districts of the State of Haryana. Among the main objectives of the approach were helping to delay marriage and childbearing among adolescents, especially girls, and increasing access by married and unmarried adolescents to information and services regarding modern family planning and reproductive health.

The Government of India adopted an innovative approach by undertaking a mapping exercise to identify issues and problems relating to adolescent reproductive sexual health and combining it with a broad strategy. The strategy comprised: (a) the provision of a comprehensive package of adolescent-friendly reproductive and sexual health services covering promotional, preventive, curative and referral elements; (b) the capacity-building of adolescents by health-care providers and peer-group educators from the community; (c) the creation of an enabling environment by establishing adolescent-friendly reproductive health centres, taking a letter box approach and adopting a frequently-asked-questions modality; (d) the promotion of communication with adolescents by establishing adolescent action groups, implementing a plan of action, organizing youth festivals and/or cultural shows, and arranging for debates or competitions on reproductive health issues; and (e) the carrying out of monitoring and evaluation activities by conducting a household survey and undertaking a quality assessment of adolescent health services using a set of normative standards. By using a classical experimental-and-control-area approach, the study demonstrates the effectiveness of the

[3] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18).

[4] Ibid., para. 7.8.

[5] General Assembly resolution S-21/2, para. 69, Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, 1999.

[6] *Report of the International Conference…*, para. 13.3.

innovative approach implemented in addressing the reproductive health issues of adolescents. Consistently, the levels of awareness and knowledge of reproductive health issues and of the availability of services in the experimental area are higher than in the control area. By involving peer-group educators in particular, the approach was able to overcome the familiar sensitivity of adolescents to discussing reproductive health issues and seeking advice and guidance on them.

The Thailand case study deals with the country's effort in addressing the prevention of the transmission of HIV from mothers to their children. While the national policy promulgated in 2000 was to provide a continuum of care including general care and psychological counselling, with linked services between hospitals and communities, it was not fully implemented owing to a manpower shortage and heavy workload. In 2005, the Government adopted an innovative approach to provide a continuum of care and support to HIV-infected mothers, their children and families through a project implemented by the Department of Health in collaboration and coordination with other related governmental, non-governmental and community-based organizations. By involving the Thai National AIDS Foundation, which brought into its network the peer leaders among the people living with AIDS, these leaders could work closely with the government service providers in clinics for maternal and child health/prevention of mother-to-child transmission of HIV. As the case study clearly demonstrates, it was a successful service model in that it helped HIV-infected women, their children and families to receive a continuum of care and remain within the HIV care programme. Furthermore, there was an increase in the number of diagnosed children born to HIV-infected mothers, permitting the provision of timely and appropriate care to those babies. Also, there was an increase in the number of husbands participating in the HIV care programme.

The issue of involving parliamentarians as advocates for reproductive health is the subject of the case study from Uganda. In accordance with the ICPD recommendation cited earlier and in recognition of the role that parliamentarians can play in promoting the reproductive health agenda, Uganda adopted an innovative approach in using an evidence-based advocacy strategy to draw the attention of parliamentarians to socio-economic realities. The aim was to inform, motivate, persuade and prompt them to take actions that address population and reproductive health issues. By putting in place an implementation plan, developing tools and materials and producing a training-of-trainers manual, the project was able to build capacities of a large number of parliamentarians as advocates for reproductive health and family planning. After ten years of implementation, it has been clearly demonstrated that evidence-based advocacy through parliamentarians has had a great influence on the policy agenda in the country. According to the case study, parliamentarians' messages have been taken on board and have served as the basis for decisions taken in various sectors and at different levels of the Government.

Population and Sustainable Development

The ICPD achieved a major breakthrough in conceptualizing the linkages between population and economic growth. Instead of casting the relevance of population factors in the traditional context of economic growth, the Conference offered a paradigm shift to look at the linkages of population factors with sustained economic growth and sustainable development. By bringing in the concept of "sustainable development", the ICPD has helped development practitioners to look at the significance of population dynamics in the interrelated context of, among other things, natural resources, environment, energy, patterns of consumption and production, technology and successive generations. While this comprehensive conceptualization has made the relevance of population dynamics even more compelling in development dialogue and policy, it has also necessitated more complex methods of analysis to understand better the linkages of population factors with sustained economic growth and sustainable development.

The ICPD made a number of recommendations to address these issues more effectively. Among them, two are noteworthy for this publication: first, "[e]xplicitly integrating population into economic and development strategies will both accelerate the pace of sustainable development and poverty alleviation and contribute to the achievement of population objectives and improved quality of life of the population";[7] and second, "[r]esearch should be undertaken on the linkages among population, consumption and production, the environment, and natural resources, and human health as a guide to effective sustainable development policies".[8] The case studies of Ghana and South Africa describe successful efforts in these two countries to build national capacity of professional staff in order to help to move forward the agenda on population and sustainable development.

The case study of Ghana deals with capacity-building to integrate population factors into development planning, with a view to helping to alleviate poverty. Given that the country has introduced the preparation of District Development Plans as part of the decentralization process in the country, the empowerment of District Assemblies to prepare and implement their own Plans to meet the needs and aspirations of their people is crucial. Recognizing that any effort to help to reduce poverty must take into account, among others, the four major variables of population factors, the development sector, development planning instruments and resources, the National Population Council of Ghana contracted the Department of Planning of the Kwame Nkrumah University of Science and Technology to develop a training course on integrating population factors into development planning.

[7] Ibid., para. 3.3.

[8] Ibid., para. 3.31.

The case study documents the substantive and programmatic aspects of the approach followed by Ghana in formulating and implementing the training programme for capacity-building of mid-level professionals involved in development planning. The course is conceived as an integrated package of fifteen modules, each of which is aimed at building capacity of participants to address the relevance of population factors for a selected component of the development sector. According to the study, a number of innovations have been incorporated into the running of the training programme and the course is considered as successful by all concerned: trainees, District Chief Executives, District Coordinating Directors and the National Population Council.

The South African case study also looks at an exercise in capacity-building but one that is aimed at development policymakers and planners on the broader theme of interrelationships among the three primary fields of population, environment and development. Viewing the multiple interactions among the three fields as a nexus of interrelationships, the training course seeks to build capacity of participants to appreciate the systemic effect of interactions within the nexus and argues for the incorporation of this nexus when crafting development policies, plans and programmes. The training exercise was initially designed as a project with partnership among the Department of Social Development of the Government of South Africa, Leadership for Environment and Development (LEAD) and UNFPA for the development of an integrated approach to population, environment and development issues. According to the case study, the Population, Environment and Development Nexus Training Programme, after several years of implementation and adjustments, is assessed as an innovative practice that is portable, replicable and successful in addressing local development planning and implementation because of the focus and approach of the course: the application of a systemic understanding of the interactions among the key population, environment and development components in sustainable human development.

Gender Empowerment and Reproductive Health

The 1994 International Conference on Population and Development as well as the Fourth World Conference on Women: Action for Equality, Development and Peace held in 1995 has provided a strong rationale for urgently addressing the issue of gender equality and women's empowerment as well as the impetus needed to do so. While some progress on the issue has been noted in many countries, there has not been any consistent progress over a wide range of countries. It is hoped that, with the establishment of UN Women, the pace of progress will quicken around the world.

In this general context, the case study of Tunisia on women's rights and reproductive health is a welcome contribution. It is a compelling narrative of women's empowerment in the national historical context of the country. When it is realized that foundations

for progress on women's rights in the country had been laid long before the Cairo and Beijing Conferences, the Tunisian case study assumes even greater contemporary relevance. As the case study argues, the strategy adopted by Tunisia since its independence in 1956 has, over the years, reinforced the principle of equality between men and women as equal citizens in the society and in the eyes of the law of the land. This has, according to the case study, enabled the country to develop socio-economically, to experience demographic transition and to fully participate in the construction of a modern society. Among the favourable factors identified as facilitating forces for this transition have been the political will and vision of the founding fathers of the nation and the inclusion of the Code of Personal Status (CPS) in the country's Constitution. The case study argues that as a result of that pioneering vision, Tunisia has become a leading country in the field of women's rights among the Arab and Muslim countries. This documentation of the historical evolution of gender and reproductive health achievements in Tunisia is worthy of examination for implications for other contexts.

Conclusion

This compilation of 10 case studies demonstrates, albeit selectively, that the ICPD Programme of Action is being implemented and progress is being achieved in adopting the new perspectives. Almost all of the case studies included in the publication contain elements of innovation either in programme design or implementation and all of them offer lessons learned that are useful for other countries and programme contexts. The authors of the case studies have all commented on the potential of the specific approaches for replication elsewhere.

As we approach the twentieth anniversary of the adoption of the ICPD Programme of Action and the target date for achieving the Millennium Development Goals, it is well recognized that the universal access to reproductive health-care services for all and the promotion of sustainable development have remained an unfinished agenda. Furthermore, the latest projections by the United Nations indicate that the world population will reach 7 billion by October 2011 and will continue to increase to 9.3 billion by 2050. This gives an even greater sense of urgency to addressing the population and sustainable development challenge in the coming decades as many developing countries, especially the least developed countries, continue to face rapid population growth, high maternal mortality, ever-expanding cohorts of young people requiring attention to their development and reproductive health needs, and the challenge of incorporating population factors into development planning and policy. The national experiences captured in the case studies included in this volume offer useful insights into how some of the developing countries have addressed the population and reproductive health issues

during the last decade and a half. It is hoped that other developing countries will find the innovative practices reported here valuable in their own efforts at tackling the population and reproductive health issues in the future.

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1 Bangladesh

Domiciliary Services in Reproductive Health and Family Planning

Mr. Mohammad Abdul Qayyum

Summary

Bangladesh, with an estimated population of 150 million and a corresponding population density of more than 920 people per sq km, is regarded as one of the most densely populated countries in the world (National Institute of Population Research and Training, 2007). Development policies in Bangladesh recognized the pressing need to reduce the population growth rate in order to ease the mounting pressure on the country's finite resources. This sense of urgency was amply expressed in the First Five Year Plan statement that "No civilised measure would be too drastic to keep the population of Bangladesh on the smaller side of 15 crores for the sheer ecological viability of the nation" (Government of Bangladesh, 1973).

Realizing the urgency of the need to contain the rapid population growth, the Government of Bangladesh introduced domiciliary services in 1976 as an innovative approach to provide maternal and child health and family planning services. Family Welfare Assistants were recruited for delivering the domiciliary services nationwide. One Family Welfare Assistant was to serve 500 to 600 eligible couples. All Family Welfare Assistants were women and local residents.

By introducing domiciliary services, the Government wanted to generate demand for family planning through counselling, cater to the people's need for contraception, ensure easy access to services, and bring about changes in reproductive-health behaviour among

Summary (continued)

target groups. Poor infrastructure, the conservative attitude of people towards contraception, a high fertility rate but a low demand for contraceptives, a low literacy rate, the poor economic conditions of the people, and gender inequality were all the background reasons for starting this innovative approach.

With the introduction of the domiciliary service-delivery model, the Family Planning Programme of Bangladesh achieved remarkable results, with a rise in the contraceptive prevalence rate from 7.7 per cent in 1975 to 56 per cent in 2007. The population growth rate came down substantially, the level of knowledge of contraception increased to 100 per cent and maternal mortality was considerably reduced.

Doorstep service delivery provides benefits extending beyond those arising from the receipt of family planning services. Considering their socio-economic situation, hiring young women as providers of family planning services was a milestone in the history of women's empowerment in Bangladesh. In time, Family Welfare Assistants became role models for the other women in the community. This service-delivery system for rural women was introduced in an effort to ensure universal coverage of services upon acknowledging the restricted mobility of village women. With the introduction of this service-delivery strategy, the overall demographic scenario of Bangladesh changed within two decades.

In 1998, the Government introduced a static, centre-based, service-delivery system to replace domiciliary services and Family Welfare Assistants were asked to provide services from fixed sites. As a result, the use of maternal and child health and family planning services decreased and the total fertility rate remained stagnant for a decade (1993-2004). Recognizing this adverse effect, the Government repositioned the domiciliary service-delivery system and the total fertility rate started to decline again.

This service-delivery system is replicable and can be a good option to provide specific priority services in areas with low resource settings, low education levels and poor accessibility to service facilities. Considering the results achieved, this system of service delivery is also cost effective.

Information on the Author

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Introduction and Background

Bangladesh is located in the northeastern part of South Asia and covers an area of 147,570 sq km. The country has a population of about 150 million. With a corresponding population density of 920 persons per sq km, it is the most densely populated country in the world, excluding city states such as Singapore. For the last four decades, the Government has been actively trying to reduce the population growth by adopting various measures.

Family planning was introduced in Bangladesh (erstwhile East Pakistan) in the early 1950s through the voluntary efforts of social and medical workers. During the 1960s, the Government took over the programme, and, after independence, family planning received unanimous, high-level political support. All subsequent Governments that have come into power have identified population control as the priority for Government action.

In the period 1971-1975, women in Bangladesh were having an average of 6.3 children, the contraceptive prevalence rate was 7.7 per cent and the population growth rate was almost 3 per cent. The high total fertility rate with a corresponding low contraceptive prevalence rate was about to cause a population boom; this in turn also adversely affected maternal mortality, child mortality and the nutrition status. During this period, there were very limited services for the people in regards to contraception and reproductive health. Only clinic-based family planning activities were available, which was highly insufficient. Domiciliary services were introduced to generate demand for family planning, to cater to the pressing need for contraception, to ensure easy access to services, and to bring about changes in reproductive health behaviour among the target groups. Poor infrastructure, the conservative attitude of people about contraception, a low literacy rate, the poor economic conditions of the people, low demand for contraceptives and gender inequality were the main reasons for starting this innovative approach.

Fully aware of the importance of family planning services, the Government developed a population policy in 1976, declaring population control as the number one issue, and introduced a broad-based, multisectoral family planning programme. Recognizing the urgency of the need to contain the rapid population growth, it introduced domiciliary services in the same year as an innovative approach to provide maternal and child health and family planning services. Family Welfare Assistants were recruited to deliver the domiciliary services. Over the years, 23,500 Family Welfare Assistants were recruited.

Family Welfare Assistants play a very important role: they are the first contact person for maternal and child health and family planning services in the community. They complement the facility-based services provided by skilled human resources through their outreach services

and they link their services with the static service for referral of clients as and when required. In addition, they conduct advocacy programmes and are part of a network comprising local government representatives, local elites, non-governmental organizations (NGOs) and other government agencies. This network creates broader social support for the Family Planning Programme.

Description of the Practice

The Family Welfare Assistants are female grass-roots-level fieldworkers of the Directorate General of Family Planning. Their immediate supervisors are the Family Planning Inspectors. Initially, one Family Welfare Assistant was recruited for one ward of the Union *parishad*.[1] In 1990, each ward was divided into two or more units and one Family Welfare Assistant was given the responsibility of one unit comprising 500 to 600 eligible couples. Nowadays, the number of eligible couples has increased to 900 to 1,200 couples per unit. Family Welfare Assistants are locally appointed and operate from their own houses.

It is important to mention that women's mobility, that is, women's ability to leave their homes and to visit health facilities, was restricted in the 1970s. Doorstep family planning services for rural women were introduced in an effort to ensure universal coverage of services upon considering the restricted mobility of village women (Rob, Talukder and Ghafur, 2006). Moreover, because Bangladesh is a moderately conservative Muslim country where women feel more comfortable receiving family planning services from women service providers, the Government adopted the policy of employing only women to work as Family Welfare Assistants.

The Family Welfare Assistants providing door-to-door services to village women are paid by the Government exchequer (financial department). Their salaries are included in the revenue budget. Initially, they were recruited under the development budget but were absorbed into the regular payroll once the importance of their services was realized.

Features of the Domiciliary Approach

The domiciliary approach has the following characteristics:

- **confidentiality.** Bangladesh is a country where contraception issues need to be dealt with confidentially. Women in particular do not like to talk with others about the need for and use of contraceptives. For this reason, confidentiality is a top-priority issue in delivery of family

[1] A *parishad* is the lowest local-government administrative unit, comprising around 30,000 to 35,000 people. One Union *parishad* was then divided into three wards. Later it was divided into nine wards.

planning services;

- **generation of demand.** Given that the total fertility rate was high at the time when domiciliary services were introduced and the contraceptive prevalence rate was very low (7.7 per cent), creating demand for contraceptives was another major function of domiciliary services;
- **interpersonal communication.** A country such as Bangladesh with poor economic conditions, a low literacy rate, a high level of gender disparity and low accessibility to the information network requires interpersonal communication for the discussion of family planning. The development of good interpersonal relationships with the clients is the key strategy for domiciliary services. It is also essential for disseminating information, providing counselling and increasing the demand for family planning services;
- **upholding the cultural and social values.** In the rural areas, social taboos and reservations about women's mobility, family planning and reproductive health issues were prevalent. To address this issue, the Family Planning Programme has been designed in such a way that it will not create any conflict with the existing social norms and values of the country;
- **special care for the marginalized people.** A high level of poverty exists in Bangladesh, with almost half of the people living below the poverty line. Poverty is a barrier that hinders the access to services. The domiciliary service-delivery system has broken this barrier as it has been specially designed to reach the poor and the marginalized people;
- **female-focused service.** Both the health and the economic status of women are low in Bangladesh. One of the primary focuses of domiciliary services has been to improve women's reproductive health status through contraception and counselling;
- **informed choice.** One of the basic features of this service-delivery model is to disseminate information regarding different contraceptive methods to help the clients to choose the option best suited for her, taking into account the age of the woman, the number of children that she has and her reproductive health condition; and
- **client screening.** Since all contraceptive methods are not suitable for all clients, screening is needed to identify the most appropriate contraceptive method for an individual client. The primary screening for contraception is done by Family Welfare Assistants.

Recruitment and Training of Family Welfare Assistants

Recruitment

The Family Welfare Assistants had to meet the following requirements:

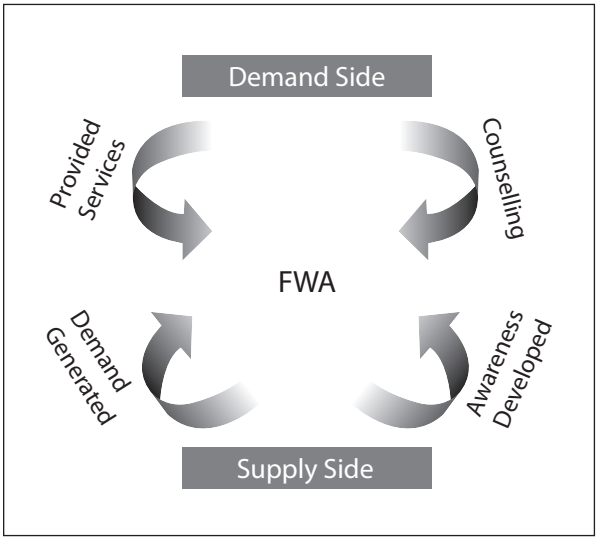
- **be female.** The primary objective of domiciliary service delivery is to reach the poor, vulnerable women of rural Bangladesh, where gender inequality exists at all levels. Women are the target beneficiaries, and to reach them, women service providers have been assigned to provide domiciliary services;
- **reside in the same locality.** Maternal and child health and family planning service providers were recruited from the same locality (unit). Being part of and responsible to the community ensures Family Welfare Assistant accessibility to the households as well as the trust of the people;
- **at a minimum, be a high school graduate.** Women with the minimum of a high school certificate were recruited for this special type of service; and
- **cover a specified number of eligible couples.** Initially, each Family Welfare Assistant had to provide services to 500 to 600 couples in her working area.

Training

Two months of basic training were provided to the newly appointed Family Welfare Assistants. The training covered family planning, maternal health, child health, primary health care, limited curative care, nutrition, gender issues, sexually transmitted diseases and communication skills (especially one-to-one and one-to-many). New topics such as reproductive health and HIV/AIDS were added at a later stage to the foundation training.

Maternal mortality in particular is a sensitive indicator of inequity. It reflects the status of women and their access to health-care services that respond to their needs. High maternal mortality in Bangladesh is due to the alarmingly low use of professional maternity care. The percentage of deliveries attended by medically trained persons is very low (18 per cent). For this reason, the Government has undertaken an initiative to provide midwifery training to the Family Welfare Assistants so that they can give assistance at home births. Some of the Family Welfare Assistants received six-month, competency-based, skilled-birth-attendant training. Family Welfare Assistants trained in midwifery are now conducting safe deliveries at home, on average performing three deliveries per month. They also provide antenatal care and postnatal care services and are trained in administering misoprostol and oxytocin.

Figure 1 | Demand and supply model of domiciliary services.



Objectives of the Domiciliary Services

The main objectives of the domiciliary services are to:

- provide reproductive health and family planning services as per clients' needs;
- increase the number of contraceptive acceptors;
- reduce the total fertility rate;
- increase the demand for long-acting and permanent methods of contraception;
- improve women's health status;
- ensure safe motherhood;
- improve the nutritional status of the community; and
- improve children's health status.

Job Responsibilities of Family Welfare Assistants

A clearly defined job description was initially formulated for the Family Welfare Assistants: they were to provide family planning services at the household level, the main aim being the regulation of population growth. Later on, some adjustments were made to the original job description to widen the scope of family planning services.

The Family Welfare Assistant is the principal fieldworker of the Maternal and Child Health and Family Planning Programme. During home visits, Family Welfare Assistants regularly collect information on eligible couples, acceptors of contraceptive methods, pregnant women, and birth and death statistics. They also provide services to young children, assist in child vaccination and provide adolescent health-care services. They register all these data in the Family Welfare Assistant register. For each month, the Family Welfare Assistants make a work plan, which must be approved by the immediate supervisor, namely, the Family Planning Inspector. After approval, Family Welfare Assistants, through door-to-door visits, distribute temporary methods of contraception and give advice on safe motherhood, nutrition and other related topics. At the end of the month, they submit a performance report to their

supervisors. The responsibilities of the Family Welfare Assistants are described below.

Planning and Organizing

In the Maternal and Child Health and Family Planning Programme, Family Welfare Assistants must participate in the target-setting process and prepare a work plan for achieving the set target. They attend monthly and fortnightly meetings, organize satellite clinics, refer clients and assist Family Welfare Visitors in providing services to the pregnant mothers.

Responsibilities Regarding Service Delivery

Family Planning

Through information, education and motivation activities, Family Welfare Assistants create demand among eligible clients for accepting contraception. They do this through home visitations. Family Welfare Assistants play a vital role in many aspects of reproductive health such as the screening of new acceptors, the distribution of oral pills and condoms to the clients, and the referral of clients for sterilization, intrauterine devices (IUDs), Norplants, injections and menstrual regulation. They also follow up with clients and provide injectables from the second dose. To provide need-based services, Family Welfare Assistants design their work plan according to client segmentation.

Satellite Clinics

Another important task of Family Welfare Assistants is to help in selecting sites for satellite clinics. It is important to mention here that satellite clinics are located in the outreach area within the working unit of the Family Welfare Assistant, at a considerable distance from the static service centres (Union Health and Family Welfare Centre). Satellite clinics are usually set up in suitable houses in the community. A Family Welfare Visitor from the nearby static service centre goes to a satellite clinic to provide services such as family planning, antenatal care, postnatal care and immunization. Family Welfare Assistants inform the communities about the locations, dates and times of the satellite clinics. They motivate the mothers to attend health sessions, tell the Family Welfare Visitor to visit complicated cases at home, and provide health education at satellite clinics.

Pregnancy and Childbirth

Pregnancy and childbirth constitute another important area where Family Welfare Assistants play an active role. Family Welfare Assistants maintain a current list of pregnant mothers in the area and submit an updated list to the Family Welfare Visitor each month. They give mothers and family members basic information on safe delivery, exclusive breast feeding, safe water and sanitation, nutrition and immunization. They also identify high-risk pregnancies and refer them to satellite clinics or the health and family welfare centres at the union level. In addition, they refer complicated cases to the Medical Officer (Maternal and Child Health and Family Planning) at the Upazila Health Complex and normal pregnancies to Family Welfare Visitors,

community-based skilled birth attendants and trained traditional birth attendants for safe delivery. Family Welfare Assistants also provide postnatal care to the mother and to the newborn. Community-based skilled birth attendants (midwifery-trained Family Welfare Assistants) perform deliveries and provide postnatal care and essential newborn care.

Immunization

Family Welfare Assistants participate actively in the national immunization programme. They educate mothers and women of childbearing age about the importance of immunization for themselves and for their children, inform the community about the time and place of the sessions of the expanded programme of immunization, immunize the children in the outreach centres of the expanded programme of immunization, and follow up on and motivate the drop-outs to achieve full immunization. Each Family Welfare Assistant prepares a list of the children living in her working area.

Nutrition

Family Welfare Assistants also put a great deal of effort into improving the nutritional status of malnourished women and children. They provide information and education on health and convey nutrition messages to mothers by using flash cards or through practical demonstrations. They distribute vitamin A capsules to children 12 to 59 months old twice a year and to post-partum mothers within 42 days of delivery. They also provide counselling on the early initiation (within one hour of birth) of breastfeeding and exclusive breastfeeding for six months.

Monitoring and Supervision

To ensure effective service delivery, a systematic, goal-oriented monitoring and supervision mechanism is ensured from the national to the grass-roots level. At

Figure 2 | A Family Welfare Assistant gives advice on the use of contraceptives.

Figure 3 | A Family Welfare Assistant and a Family Planning Inspector attending a courtyard meeting.

the bottom level, Family Welfare Assistants provide performance reports to their supervisors, which are then compiled by the supervisor and sent to the next-higher authority. Finally, the reports are analysed at the Directorate level and feedback is given to the lower level. To ensure smooth operational activities, the Directorate General of Family Planning has an administrative setup from the national to the ward level. Various categories of technical and non-technical personnel with a standardized skill mix work in the service centres as well as in the administrative offices. The Director General along with the directors supervises and monitors the activities.

Implementation

Overview

After adopting the domiciliary service policy, the Government started to recruit and train Family Welfare Assistants nationwide. A Family Welfare Assistant register was developed to record family planning and demographic events of every household. This is a comprehensive register in which all demographic information on eligible couples and their children is recorded.

The couple register is updated once a year. After completion of the registration, Family Welfare Assistants prepare their "advance tour programme". Once their advance tour programme is approved by their immediate supervisor (the Family Planning Inspector), they start visiting the households. To cover all the couples within a two-month round, they visit 15 to 20 couples each day. Family Welfare Assistants always carry temporary methods of contraception (oral pill and condom) for distribution among eligible couples along with the register and flip charts. Besides home visits, they also organize courtyard meetings with the clients, non-users, adolescents and pregnant women where they discuss issues such as contraception, safe motherhood and immunization and motivate the clients to receive the related services.

Partnerships

The programme is being implemented by the Government and the NGOs.

Government Initiatives

The public sector provides contraceptives to half of all the users, particularly in the rural areas. Government fieldworkers are the most important source of contraceptives for the rural population, supplying one in five users (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International, 2009). Government supplies contraceptives through multiple channels. One fifth of the total contraceptive supply is distributed through doorstep services. The remaining 30 per cent is distributed in hospitals (3.8 per cent), Upazila Health Complexes (9.1 per cent), Mother and Child Welfare Centres (2.2 per cent), Health and Family Welfare Centres (9.1 per cent), satellite clinics (5.2 per cent) and community clinics (0.2 per cent). It is important to note that the urban population

does not fall under the direct purview of the Government Family Planning Programme. In urban areas, family planning services are provided by fixed service centres, mostly by NGOs with the local government authority coordinating the programme.

Non-governmental Initiatives

NGOs also provide reproductive health and family planning services along with the Government programme. There are 160 NGOs currently working in Bangladesh that provide maternal and child health and family planning services, primarily in disadvantaged urban areas and in selected rural areas. NGO clinics provide a full range of family planning services along with maternal and reproductive health services and a functional referral system. In general, an NGO network has three levels of service delivery: a comprehensive reproductive health-care centre, a static clinic and a satellite clinic. The most important facility in the NGO health network is the comprehensive reproductive health-care centre, which serves as a referral centre for the static and satellite clinics. With the support of the referral centre, family planning, pregnancy care and immunization have been brought to the community through satellite clinics. Doorstep services are also in place to publicize available services as well as to provide necessary information (Talukder, Rob and Rahman, 2009).

NGOs provide services to 5.2 per cent of all the contraceptive users in Bangladesh (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International Inc., 2009). Some of the NGOs provide services through a depot-holder approach. The depot holders are women from the community who keep a stock of commodities (contraceptive pills, condoms, oral rehydration saline, etc.) at home to distribute to women and children in time of need. They also promote good health practices and refer clients to nearby clinics. NGO fieldworkers coordinate their activities with Family Welfare Assistants.

Social Marketing Programme

The Social Marketing Programme was started in 1974 through an agreement between Population Services International and the Population Control Department of Bangladesh. The country has an active contraceptive Social Marketing Programme that distributes pills, condoms, injectables and oral rehydration solution through a network of retail outlets (pharmacies, small shops). Forty-five per cent of pill acceptors use social marketing brands compared with 52 per cent who use the Government-supplied brand, "Shukhi". The Social Marketing Company sells a wide variety of pills with a nominal margin while the Government distributes only a single brand free of charge. Condom brands sold by the Social Marketing Company have a high market share: almost three in five condom users buy Social Marketing Company brands. This marketing system supplements the Family Welfare Assistant network.

Challenges

A few challenges remain that must be addressed appropriately to achieve maximum results, including the following:

- **timely recruitment and training.** The recruitment procedure in the Government sector is sometimes time-consuming in Bangladesh. In the near future, the country will have to face the challenge of mobilizing new human resources since a large number of government fieldworkers in the family planning sector will be retiring soon (Rob and Talukder, 2008). There is apprehension that a shortage of well-trained, skilled and competent service providers and fieldworkers at the local level will slow down the performance of the Family Planning Programme across the country (ibid.);
- **reducing the unmet need for contraception.** Overall, 17 per cent of the currently married women in Bangladesh have an unmet need for family planning services.[2] Unmet needs increased from 11 per cent in 2004 to 17 per cent in 2007. The apparent increase in unmet needs reflects problems in the supply of family planning services and/or an increase in the demand for family planning (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International Inc., 2009). Reducing the unmet need for contraception requires the particular attention of the fieldworker. To respond to these unmet needs, Family Welfare Assistants must update their registers to identify the clients who are not using any contraceptives and they need to ensure an uninterrupted supply of contraceptives; and
- **an uninterrupted supply of contraceptives.** Family Welfare Assistants distribute short-acting contraceptives (pills, condoms and injectables) to the clients. However, when they do not have enough supplies, they hesitate to perform their regular home visits. This has resulted in a reduction in the frequency of visits.

In addition, the following challenges should be considered:

- Initially, each Family Welfare Assistant was in charge of 500 to 600 couples. She could easily make her round and was able to visit each and every couple within the two-month schedule. Nowadays, however, the number of couples to visit has almost doubled for each Family Welfare Assistant. Consequently, it is difficult for them to ensure home visits to all the couples in due time. Moreover, the overall workload of the Family Welfare Assistants has increased significantly;

[2] Fecund women who are currently married and who say either that they do not want any more children or that they want to wait two or more years before having another child but are not using any contraception are considered to have an unmet need for family planning.

- Another important issue is the absence of scope for carrier development. After a certain period (15-20 years) of working in the same position, Family Welfare Assistants become reluctant to do their job. Their work is demanding and tiring. House-to-house visits are made on foot. Commitment gradually declines and this is reflected in the reduced number of visits by Family Welfare Assistants and in the services offered by them.

Results and Achievements

Direct Impact

From 1976 to 1997, the Government of Bangladesh recruited and trained married women to provide family planning counselling and services to couples in rural households. At the peak of the programme, a total of 23,500 Family Welfare Assistants worked throughout the country. By the early 1990s, doorstep service delivery had helped to increase family planning awareness as well as the rate of method uptake and continuity of method use among rural couples (Koenig, Hossain and Whittaker, 1989).

Home visitation by Family Welfare Assistants affected women's fertility behaviour since it increased their awareness of family planning and maternal and child health services. The more visits the women received from Family Welfare Assistants, the more likely they were to experience an increase in status (Phillips and Hossain, 2003). However, the gender benefits came from the programme's impact on fertility regulation rather than directly from the social interaction occurring during home visits. Family Welfare Assistants indirectly enhanced the status of women by fostering reproductive health autonomy. Nevertheless, domiciliary service delivery had a direct influence on the following areas:

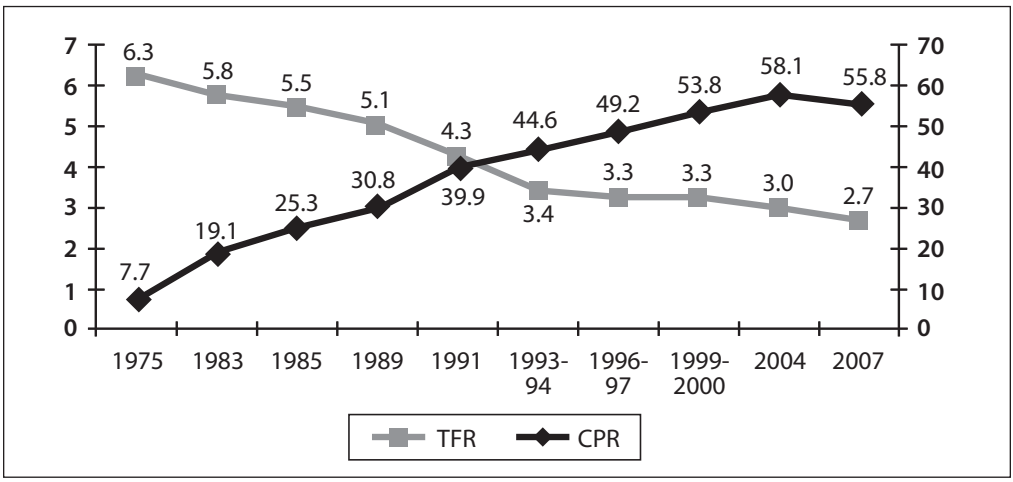
- **reducing social barriers.** Reproductive health and family planning services had been suffering from a social taboo in Bangladesh, where people hesitated to talk about the issues. By providing domiciliary services, an existing social barrier was broken. Women in particular were encouraged to receive family planning and maternal and child health services, which made them socially empowered. The Government accepted the help of local elites and opinion leaders from different levels to motivate women to work in the family planning sector;
- **increasing the contraceptive prevalence rate.** Domiciliary services had a strong influence on increasing the use of contraceptives. Various studies reported that the use of contraception was greatly influenced by the fieldworkers' visits. For example, studies showed that clients who had more than one contact with a worker were more knowledgeable and used family planning methods more often (Huq and Al-Sabir, 1992). The same study indicated

that clients who had not received information on family planning from fieldworkers preferred having male children and large families. Moreover, it was found that the frequency of home visits also reduced religious contentions regarding family planning. The domiciliary services enabled the system to achieve the objectives of the programme successfully and effectively. Evidence suggests that the introduction of domiciliary services into the Family Planning Programme sharply increased its performance. The contraceptive prevalence rate increased from 7.5 per cent in 1975 to 56 per cent in 2007. The Bangladesh Family Planning Programme earned a worldwide reputation and much of the credit should go to the pro-poor service-delivery system in rural areas (Rob, Talukder and Ghafur, 2006);

- **reducing the total fertility rate.** With the increase in the contraceptive prevalence rate, the total fertility rate came down substantially, from 6.3 births per woman in 1975 to 2.7 in 2007 (see graph). Findings suggest that contraception is the most important proximate determinant, contributing to more than 50 per cent of the total fertility reduction (Islam, Chakraborty and Rob, 2004);

- **reducing the maternal mortality ratio.** Family planning is the pillar of safe motherhood. The Family Planning Programme adopted the maternal and child health-based approach in 1976, and since then, maternal and child health-based family planning has been the key feature of the Family Planning Programme (Mabud and Akhter, 2000). Maternal and child health-based family planning services

Trends in the total fertility rate (TFR) and the contraceptive prevalence rate (CPR), 1975-2007.



were extended to the community level and large numbers of female fieldworkers (Family Welfare Assistants) were deployed to provide maternal and child health and family planning services at the doorstep level. Domiciliary services have encouraged pregnant women to visit the static centres for antenatal check-ups. As a result, the rate of antenatal visits has increased over the years, reaching 52 per cent in 2007. The increase in the contraceptive prevalence rate, number of antenatal check-ups, safe deliveries and postnatal check-ups has contributed to the recent decline in the maternal mortality rate;

- **increasing the knowledge of contraception.** It has been observed that counselling and advisory services by the Family Welfare Assistants helped to increase couples' knowledge of contraception. Awareness of contraceptive methods is now high; roughly nine out of ten women know what pills, condoms, injectables and female sterilization are (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International Inc., 2009). Findings from a study suggest that this knowledge was acquired primarily from family planning fieldworkers (39 per cent) but also from the mass media (26 per cent) and from neighbours (23 per cent) (Huq and Al-Sabir, 1992); and
- **reducing dropout rates.** Retaining users of temporary methods is another important aspect of the family planning service. Domiciliary services have proved to be an effective approach in this context. Routine visits by the fieldworkers help clients to obtain contraceptive methods and resupplies in due time, especially in remote areas where there is no alternative source of contraceptives. Moreover, in case of problems linked to the use of contraceptives, timely and effective help can be provided to the clients.

Indirect Impact

A qualitative study concluded that doorstep delivery of services enhanced women's status (Simmons et al., 1988). For example, Family Welfare Assistants themselves benefited directly from receiving cash wages and indirectly from gaining mobility, prestige and authority from their work. In turn, the large-scale deployment of female family planning workers changed people's perceptions of women's roles: every hamlet in Bangladesh had a Family Welfare Assistant acting as a household visitor, adviser and confidante, clearly showing that women were employable, mobile, socially gregarious and autonomous, without depending on male partners or the extended family. Young female clients were particularly influenced by interactions with Family Welfare Assistants. The programme was thus characterized as having a "beyond-supply" social effect. In

addition, by helping clients to achieve control over their fertility and therefore their lives (Huq and Murdock, 1997), doorstep delivery produced benefits extending beyond those arising only from the receipt of family planning services. The work of the Family Welfare Assistants initiated a wider social impact: it has impacted women's empowerment and gender equity and has brought about greater social change.

Assessment and Evaluation

The Bangladesh Family Planning Programme is a success story and a model programme for many countries. Its success is due to a large extent to the deployment of a large contingent of government and NGO fieldworkers who made door-to-door visits to promote family planning and who distributed contraceptives. These visits along with mass media campaigns resulted in a remarkable increase in the contraceptive prevalence rate within a very short time span. Studies have shown that frequent home visits to all eligible couples, irrespective of their current status, are associated with higher family planning performance (Phillips et al., 1989).

A study has shown that the success of the Family Planning Programme is due to the contributions made by Programme interventions over the last two decades and more particularly in the mid-1970s, when the first Five Year Plan of the Government of Bangladesh on health and family planning was launched (Ali et al., 1994).

The development of interpersonal contacts through home visits has proved to be undoubtedly effective. The key players in this process of building interpersonal contacts were the large number of full-time female fieldworkers recruited and deployed within the locality of their permanent residence.

Almost 83 per cent of rural eligible couples using family planning methods received contraceptives from Family Welfare Assistants. A continuous supply of contraceptives prevents unwanted pregnancies and ensures safe motherhood. By improving the health status of the mother, child mortality and morbidity have been reduced to a large extent.

The source of contraceptives is an important issue of the Family Planning Programme, which has a direct linkage with the domiciliary services. In Bangladesh, both the public and private sectors are important sources of modern contraceptive methods (50 per cent and 44 per cent, respectively) (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International Inc., 2009). The table shows that with the introduction of domiciliary services, the total fertility rate declined dramatically from 6.3 births per woman in 1975 to 4.3 in 1991. After that date, the rate remained stagnant for more than a decade (1993-2004). This was the time when domiciliary services were withdrawn. When the domiciliary service

Total fertility rate, contraceptive prevalence rate, unmet need for family planning, prevalence of domiciliary services, dropout rate in contraceptive practice, and percentage of contraceptive supplies provided by the fieldworkers, 1975-2007.

Data Source	Total Fertility Rate (Births per Woman)	Contraceptive Prevalence Rate (%)	Unmet Need (%)	Domiciliary Visit (%)	Dropout Rate in Contraceptive Practice (%)	Percentage of Contraceptives Provided by Fieldworkers
BFS 1975	6.3	7.7				
CPS 1983	-	19.1				
CPS 1985	-	25.3				
BFS 1989	4.9	31.4		41.0		
CPS 1991	4.3	39.9		36.0		
BDHS 1993-1994	3.4	44.6	19	38.0	47.8	41.8
BDHS 1996-1997	3.3	49.2	16	35.0	46.9	39.0
BDHS 1999-2000	3.3	53.8	15	21.0	48.6	27.9
BDHS 2004	3.0	58.1	11	18.0	49.4	23.0
BDHS 2007	2.7	55.8	17	15.7	57.0	20.0

BDHS = Bangladesh Demographic and Health Survey; BFS = Bangladesh Fertility Survey; CPS = Contraceptive Prevalence Survey.

system was reintroduced in 2003, however, the total fertility rate started to decline again, as evidenced in 2004.

Contraceptive discontinuation, another source of concern for the Family Planning Programme, has a negative correlation with domiciliary visits: the decreasing number of home visitations caused the dropout rate to increase (see table). However, in reading the table, a question arises: why, despite the decrease in home visits over the years, is the contraceptive prevalence rate increasing and the corresponding total fertility rate decreasing? As explained earlier, Family Welfare Assistants not only provide family planning services but they also strive to generate demand for family planning services from the health facilities among the people. This is why, although the number of domiciliary visits gradually declined from 1989 to 2007, the impact of demand generation in the early years facilitated the increase in the contraceptive prevalence rate and fostered the corresponding decrease in the total fertility rate in the following years.

The political standpoint on how to deliver family planning services in the communities is changing over time and new approaches are being examined. Domiciliary services, although very

effective and needed at a time when communication networks and media coverage were not good, may be replaced by other types of services.

In the absence of domiciliary services, people can receive contraceptives from other sources such as pharmacies, shops and fixed service-delivery points. The problem is that in most cases, the husbands are the ones buying the contraceptives for their wives; thus women no longer have access to key aspects of maternal and child health and family planning services: contraceptive counselling and follow-up services.

During the implementation of the first sector-wide programme (the Health and Population Sector Programme 1998-2003), domiciliary services were withdrawn, and for that reason, the percentage of home visitations dropped to the minimum (see table). It was reported that rural people wanted to receive family planning services through home visitations. The Government started to provide domiciliary services again with the second sector-wide programme (the Health, Nutrition and Population Sector Programme 2003-2011).

Lessons Learned

- The introduction of domiciliary services was a milestone for maternal and child health and family planning services in Bangladesh, which contributed to the success of reproductive and family planning services.
- Women are especially efficient in providing family planning and reproductive health services at the doorstep.
- Domiciliary services contribute to the improvement of women's status and their empowerment at the grass-roots level.
- Initially, the domestic financial involvement was high but international agencies such as the United Nations Population Fund, the Canadian International Development Agency, the Norwegian Agency for Development Cooperation, the Overseas Development Administration (now DFID) (United Kingdom) and the Swedish International Development Cooperation Agency came forward and offered financial assistance. The initial financial burden was thus reduced.
- No major change has taken place in the domiciliary delivery pattern until now except for some changes in the job description of the Family Welfare Assistant, which now includes more areas of service delivery. The increasing literacy rate, women's empowerment, the existing micro credit system, a different lifestyle and the development of mass media have brought about significant changes in the way of life. However, there is still a strong demand for more trained and capable Family Welfare Assistants to respond to the needs of a growing population, especially of the huge number of newly-wed couples.

- The reproductive behaviours of the people changed over the years thanks to the motivation and counselling activities of Family Welfare Assistants.
- Couples trust Family Welfare Assistants. Not only do they trust them with regard to family planning and reproductive and child health issues but also with respect to other family-related matters such as children's education and the receipt of micro credit from NGOs.

It is therefore possible to say that domiciliary service delivery is suitable for replication in similar settings in other countries.

Potential for Replication Elsewhere

Domiciliary services have been established and recognized as an effective service-delivery model, especially for rural communities. This model is suitable mostly in low socio-economic settings where the demand for priority services has not yet been created. During the last three decades, this service-delivery pattern has changed the overall demographic profile of Bangladesh.

Domiciliary services are suitable in the following situations:

- Domiciliary services can be a good option for providing specific priority services in settings with low economic resources, a poor level of education and low accessibility to service facilities.
- In situations where particular services are needed urgently, domiciliary services can be introduced to achieve immediate results.
- This service-delivery model is also suitable when the geographic locations are dispersed over a large area and are hard to reach.
- In case of natural disasters, when all communication channels collapse, doorstep service delivery is a window through which primary health care, reproductive health, family planning and other emergency services can be provided.

This service-delivery pattern is not needed in areas where economic development has taken place and demand for maternal and child health and family planning services has already been created. This kind of service delivery can also be conducted on a voluntary basis, keeping a close watch on the achievements because professionalism is a must for achieving any desired goal.

Overview of the Evolution of Domiciliary Services

Domiciliary services have gone through various stages, as has the Bangladesh Family Planning Programme. The Government policy guidelines contributed a great deal to these changes. Initially, when domiciliary services were introduced, the primary goals were

twofold: generation of demand through counselling and distribution of contraceptives. With the introduction of domiciliary services into the Family Planning Programme, Bangladesh achieved immediate results: an increase in the contraceptive prevalence rate from 7.7 per cent in 1975 to 18.6 per cent in 1980 and a decrease in the corresponding population growth rate from 3.0 to 2.32 per cent. Currently, the contraceptive prevalence rate is 56 per cent and the growth rate is 1.39 per cent. In time, new activities (e.g., safe motherhood, immunization, adolescent health and early childhood development) were introduced into the national Family Planning Programme and Family Welfare Assistants are now providing all these services through the domiciliary model.

The following is a chronology of the significant events in the evolution of the domiciliary services:

- 1976: full time fieldworkers providing domiciliary services were deployed;
- 1980: registers of Family Welfare Assistants were introduced at the unit level to record family planning and demographic events of households. In the same year, special training institutes

Experiences of a Family Welfare Assistant

Ms. Alima Begum became a Family Welfare Assistant in 1980 at the age of 28. Her working area was 1/ka unit of the Toakul union of the Gowainghat Upazila in Sylhet District, which is the remotest part of Bangladesh and one of the lowest-performing areas in the context of reproductive health and family planning activities. During the 1980s, poor infrastructure, coupled with religious barriers, made the family planning activities difficult to conduct.

When Ms. Begum started her journey as a Family Welfare Assistant, local people initially did not welcome her as a service provider. On the contrary, they pressured members of her family to make her resign from her job. Putting those adversities aside, Ms. Begum continued her work. When she joined the domiciliary services, the population of her working area totalled 3,445, among whom were 685 eligible couples. Out of the total number of eligible couples, only 15 were using family planning methods. Ms. Begum used to leave home in the morning and walk far to reach the clients' houses. In the beginning, people did not listen to her advice but she did not give up and continued with her mission: she incited people to use contraceptive methods and to keep the size of their family small.

After six years of relentless effort and hard work, she was able to increase the number of contraceptive acceptors to 101 out of 715 eligible couples. All the people in her working area used to call her by her nick name,"Maya apa". Maya was the brand name of the oral contraceptive pill supplied by the Family Planning Department. After serving 30 years with the Government, she retired in 2010. At the time of her retirement, she left 1,054 eligible couples in her unit; 631 of them were contraceptive users with a corresponding contraceptive acceptance rate of 59.43 per cent.

(the National Institute of Population Research and Training and the Regional Training Centre) were established;

- 1990: a broad-based, multisectoral approach was initiated to mobilize the community and engage civil society;
- 1998: domiciliary services were withdrawn;
- 2003: domiciliary services were reintroduced.

Acknowledgements

This case study was prepared to highlight domiciliary services as a best practice approach in the context of providing family planning and reproductive health services in Bangladesh. While writing this paper, I was greatly supported by Mr. Md. Mahbubul Alam, Family Planning Officer, and Dr. Bishnupada Dhar, Programme Manager, Maternal and Child Health Unit, Directorate General of Family Planning, among other experienced officials. Without their contribution and suggestions, this case study would not have become a reality. Before submitting this paper to Partners in Population and Development for external evaluation, it was submitted to internal evaluators. Mr. Peter Kim Streatfield, Head, Population Programme, and Head, Health and Demographic Surveillance Unit, Public Health Sciences Division, International Centre for Diarrhoeal Disease Research, Bangladesh, and Mr. Ubaidur Rob, Country Chief, Population Council, Bangladesh, made valuable contributions to this paper as internal evaluators. I also would like to express my gratitude to the external evaluators for their outstanding contributions, which helped me to refine this study and prepare this write-up.

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2 China

Focusing on Quality of Care in the Family Planning Programme

Prof. Zhenming Xie

Summary

Since the 1990s, many national population and family planning programmes have been under re-examination and reorientation in light of the Programme of Action adopted at the International Conference on Population and Development in 1994. This is the case in China.

The present case study documents an experiment initiated by the State Family Planning Commission – now the National Population and Family Planning Commission – in 1995 to introduce the quality-of-care approach into China's family planning programme in a few counties and districts. The introduction of this approach, which focuses on the standardized services and the client's choices, was to serve as a means of reorienting the programme away from its previous demographically driven track as well as scaling it up nationwide thereafter.

Following the official call of the State Family Planning Commission to reorient the family planning programme in both its guiding ideology and implementation approaches, the experiment was intended to demonstrate, through the pilot projects, how the programme could be reoriented and what a client-centred and quality-focused programme might look like in the context of China. With the field evidence, the experiment also sought to convince the people in charge of the programme at all levels that the full-fledged promotion of the reorientation of the programme nationwide would be feasible.

Summary (continued)

To achieve sound implementation of the quality-of-care experiment, the latter was carried out in various settings but based on three major objectives: changing to a client-centred ideology, upgrading services through overall retraining, and improving the facilities to achieve the best care that could be provided. The strategy used in implementing the experiment consisted of four mutually supportive components: phase in before phasing out, pilot before scaling up, be flexible and encourage diversity, and learn via experience.

The experience of the pilot project has provided firm evidence that with an approach oriented towards quality of care, not only is the programme able to provide better services to the clients and to protect the clients' health and rights but the approach is also able to lead to a more effective programme and even better demographic outcomes.

The quality-of-care approach was later adopted in several major international endeavours such as the United Nations Population Fund (UNFPA) Reproductive Health and Family Planning Project and the Japanese Organization for International Cooperation in Family Planning Integrated Project. It also was scaled up under the name of the "Quality-of-Care Advanced Unit" nationwide campaign.

While the State Family Planning Commission experiment was initiated with virtually no external assistance, the need to subject the experiment to international exposure as well as to request support from international collaboration was well acknowledged.

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Background

The quality-of-care approach, well known as quality of care in family planning, focuses on the standardized services and the client's choices. It was initiated in small areas and expanded to the whole country as the means of reorienting the family planning programme in China.

The emergence of the pilot experiment in improving quality of care was by no means an isolated event; rather, it resulted from the interplay of a number of factors emerging in the early 1990s within and outside of China.

The nationwide family planning programme was initiated in the early 1970s when the population of the country was

growing more than 2 per cent per annum and the fertility level was around six children per couple. The next two decades witnessed a drop in the population growth rate to less than 1 per cent. Thus China can no longer be regarded as a country with "rapid growth" of its population. In addition, the fertility level has been below the replacement rate since the early 1990s; thus the country can no longer be regarded as having a "high-fertility" population. By the end of the twentieth century, China's population dynamics had experienced a historic transformation.

Meanwhile, the "reform and opening era" initiated from the late 1970s triggered China's booming economy and social transformation towards a modern society. As the result of the market-driven economy, people tended to be more attuned to quality-of-life issues, including personal reproductive health care and reproductive rights as well as gender equality. The family planning programme faced an entirely new generation, which had grown up with the exposure to enormous amounts of information and an ever-changing life reality. Internationally, the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 exposed China to a whole set of new concepts such as "informed choice", "reproductive rights and health", "women's empowerment" and "gender perspective".

All these necessitated the reform of the family planning programme according to the changing situation. Therefore, the State Family Planning Commission issued an official call in 1995 for the "two reorientations", with the intention of initiating the programme reform all over the country. As the first step in the reorientation, several counties and one district were selected in the mid-1990s for an experimental project to explore the programme, changing the focus from demographic targets to quality of care.

State Family Planning Commission Goal in the Reorientation

At the beginning of the period of the Ninth Five-Year Plan (1996-2000) in late 1995, the State Family Planning Commission issued an official call for reorientation of the family planning programme from an emphasis on demographic targets towards client-centred approaches and from a narrow focus on contraceptive prevalence towards relevant integration, with reproductive health and women's empowerment objectives. In early 1998, it reiterated and elaborated its goal in reorienting the programme, specifying that with the successful demonstration of the innovative experiment in a number of pilot counties and districts by the year 2000, the client-centred and quality-focused approach to family planning would be gradually expanded throughout the country and the nationwide reorientation of the programme should be realized by the year 2010.

Objectives of the Experiment

While the State Family Planning Commission had explicitly called for the reorientation of the family planning pro-

gramme, the overall objective of the experiment was to demonstrate, through the pilot projects, how the programme could be reoriented and what a client-centred and quality-focused programme might look like in the context of China. The experiment also sought to convince the people in charge of the programme at all levels throughout the country of the feasibility of the reorientation process as integral preparation for the full-fledged promotion of the reorientation of the programme after 2000. The specific objectives of the experiment crystallized over the course of the experiment and are threefold: changing the ideology, upgrading management and services, and improving facilities and institutional support.

Changing the Ideology

China's programme had been on a demographically driven track for so long that many of the programme managers and service providers had become used to it and found it very difficult to conceptualize, implement or manage the programme in an alternative manner. Some worried that negative demographic consequences would result from a less stringent approach to the programme or that the experiment would meet resistance from the local managers and service providers because it would imply a greater workload and responsibility. Others also worried that they would receive very little appreciation from the clients, who might not be aware of and might even be skeptical about the need for reproductive health care. Therefore, changing the ideology to accept a client-centred approach was the priority goal of the experiment.

Upgrading Management and Services

While the demographically driven approach was in place, the quality of services and the care of clients tended to lose priority in the programme. After the experiment unfolded, many managers and service providers found that they did not have the capacity to provide services according to the goals of the experiment. For example, while the providers were trained to do insertions and removals of intrauterine devices (IUDs), they had not been trained in the advantages and disadvantages of the various IUDs nor were they knowledgeable about the potential side effects of a given IUD. The providers lacked awareness of and skills in pre-operation counselling and post-operation follow-up services and had no professional training in interpersonal communication. Therefore, the Quality-of-Care Pilot Project considered the upgrading of management and services as the main content of the experiment.

Improving Facilities and Institutional Support

When the quality of services rather than demographic targets is stressed, the working conditions of the programme with regard to infrastructure and facilities, resource allocation, contraceptive supply and staff recruitment must be reshaped. Greater priority should be given to the observance of aseptic conditions in the clinics and to service-procedure protocols, with more space allocated

for examination and counselling and more attention paid to the privacy and confidentiality of the client. Many of the local service clinics in the pilot areas had been expanded or renovated, and the equipment necessary for quality of care and reproductive health care had been purchased and installed. With the support of the local government, additional resources had been allocated and more qualified and capable staff were recruited throughout the experiment. Thus, improving facilities and institutional support were necessary as the safeguards for a successful experiment.

Strategies

To ensure a sound and healthy programme transition in sensitive circumstances, an innovative strategy had to be developed in the experiment among the pilot counties and districts. The strategy had four mutually supportive components:

- "**Phase in, phase out**". To ensure a smooth transition, the pilot projects adopted a strategy called "phase in, phase out". This means that throughout the experiment, the priority was to introduce the new and innovative approaches into the programme first and then make them workable within the local programme and acceptable to the local people, including the clients, providers, managers and local leaders. This process takes time. Every effort was made to avoid overzealous attempts to abandon the existing approach and systems prematurely. When the new approach became well established in the programmes and was recognized and welcomed by the local people, then it was time to phase out the old approach;
- "**Pilot first, expand later**". Introducing a quality-of-care approach in the context of China was an experiment without precedent. To proceed with the experiment in a step-by-step manner, a few pilot areas were first carefully selected as the quality-of-care pioneers or models. The intention was to initiate the experiment in smaller areas with relatively favourable socio-economic conditions and sound performance in their family planning programmes to ensure that the pilot would succeed more easily. With the successful demonstration of the experiment, the approach was introduced to larger areas, following the successful models. The goal of scaling up the strategy had been kept in mind from the very beginning of the project;
- "**Be flexible and encourage diversity**". The experiment in each pilot area was initiated with what was locally deemed acceptable and doable. Though the State Family Planning Commission set the overall goals for the experiment as stated above, from the very beginning of the experiment, no fixed timetable or specific procedures were dictated from the top. The entire experiment emphasized great respect for local initiatives and encouraged a great deal of

diversity. The experiment among the pilots started with a variety of innovative efforts, such as the adoption of informed choice of contraceptives and development of new information, education and communication materials. Other innovations included the issuance of the newly designed *Reproductive Health Care Handbook*, restructuring of service clinics by placing the contraceptive display desk in the front of the clinic, invention of contraceptive display packages, creation of "quiet-talk" rooms for private counselling and installation of a 24-hour hotline telephone service. All of these local efforts were acknowledged and encouraged so long as they contributed towards a client-centred, quality-focused approach to their family planning programmes;

- "**Learn via experience**". Throughout the course of the experiment and even now, understanding of the concepts of "quality of care", "programme reorientation" and even "informed choice" have varied considerably among the leaders, managers and providers involved. Rather than debating and attempting to clarify the concepts once and for all, the experiment followed the principle of "practice first", i.e., letting people learn and begin to understand the concepts of "quality of care" and "reproductive health and rights" not only from books or lectures but also through their own experiences. The experiment suggests that for the local programme managers and service providers, rather than attempting to understand the concepts theoretically, it is most useful to conceive the concepts in concrete terms.

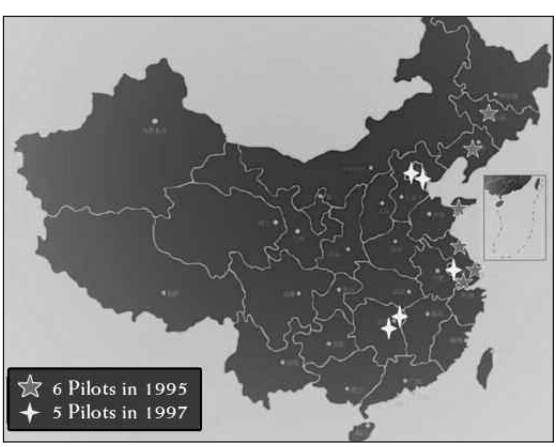
Implementation of the Pilot Project

During the period of initiating and implementing the Quality-of-Care Pilot Project (from 1995 to 1999), a number of activities were carried out. These are described in the following sections.

Pilot Selection

The main mechanism adopted by the State Family Planning Commission to develop and establish the quality-of-care models was the selection of a few counties and districts as pilots for quality of care. At the beginning of 1995, the Commission selected five rural counties

Figure 1 | Quality-of-care pilots, 1995 and 1997.



and one urban district as the first pilots for the experiment (fig. 1). In 1997, five more pilots were added.

Leadership Development

In early 1995, the State Family Planning Commission set up the leadership group of the Quality-of-Care Pilot Project at the national level with a vice minister of the Commission as the head and all Directors General from departments of the Commission as the members. The operational office of the Quality-of-Care Pilot Project, under the Planning and Statistics Department of the State Family Planning Commission, was in charge of planning, monitoring and evaluating at the national level. It was facilitated by the adviser group and the resource team from some international or domestic universities or research institutions. The State Family Planning Commission required that, under its leadership, all pilot counties and districts set up their own leadership groups, issue their own official documents and work plans, and conduct initiation activities, such as social mobilization and advocacy.

Partnership Development

International organizations and funding agencies as well as international and national expertise became involved in the Quality-of-Care Pilot Project with financial and technical support, especially in training, supervision, monitoring and assessment. These included the Population Council, the International Council on Management of Population Programmes (ICOMP) and the University of Michigan. More than 20 scholars or experts from universities or institutes in China were involved in the Quality-of-Care Pilot Project from the beginning. Some of them were assigned as members of the advisory group; others participated as resource persons.

Capacity-building

To implement the Pilot Project, several activities for capacity-building were conducted as follows, with facilitation from some international agencies and domestic institutions:

- Training-of-trainers (TOT) training workshops were organized by international and domestic experts to train national and provincial managers and service providers. Cascade training sessions were conducted in each pilot county and district.
- Family-planning service stations at the county and township levels were rebuilt or improved in most pilot counties and districts, following the client-centred approach, to make them a "user's home".
- Several study tours and training activities for directors of pilots were also organized by the Quality-of-Care Pilot Project Operational Office in Thailand in October 1996 and in the United States in July 1999.
- Training of high-level officials was undertaken in the United States for Directors General in the State Family Planning Commission and provincial family planning commissions (1998-2002), organized by the State Family Planning

Commission in cooperation with the Public Media Center in the United States.

Supportive Communications

With respect to supportive communications, several activities were well organized as follows:

- several seminars and symposiums in pilot areas, such as an international seminar on the evaluation of the Quality-of-Care Pilot Project held in Yandu County in May 1997 and an international symposium on the quality-of-care approach in Beijing in November 1999;
- a dialogue between China and India on population and family planning in April 1998;
- exchange activities among pilot-project counties and districts, organized by the Quality-of-Care Operational Office of the State Family Planning Commission for exchanging experiences; some models selected from pilot areas to be visited and followed; and
- sharing of experiences of several international cooperation projects in China following the quality-of-care approach since 1998; the experiences from the international cooperation projects also enriched the contents of quality-of-care approaches in China.

During the experimental period (1995-1999), many formal or informal supervisory and monitoring visits were made by international and domestic experts, the Quality-of-Care Operational Office, the State Family Planning Commission officials and international agencies, such as the Beijing offices of UNFPA and the Ford Foundation.

Results and Achievements of the Pilot Project

After three years, a follow-up survey and an assessment of the pilots were conducted. Significant changes resulting from an effort to achieve the two reorientations were observed at all pilot sites from different perspectives. For example, positive feedback from local people showed that the clients welcomed the Quality-of-Care Pilot Project, as did the service providers and managers working at the grass-roots level. The long-term impact of the quality-of-care initiatives could also be observed from national surveys years later.

Achievements

The changes in the contraceptive method mix were the result of the promotion of informed choice. Meanwhile, more information on family planning and reproductive health was provided to people, with the information and education approaches improved. In addition, the clients received more high-quality clinic services, counselling and follow-up services, with services upgraded and facilities improved. Finally, changes in administra-

tive and management practices had been brought about as well.

Informed Choice and Changes in the Contraceptive Method Mix

Informed choice is the key component for client-centred service. For many years, IUDs had been highly recommended by providers of family planning services for spacing, and sterilization for limiting the number of children born. After the introduction of informed choice, more clients received counselling before choosing the contraceptive method, more diverse contraceptive methods were made available, and more clients took the decision by themselves.

The percentage of survey respondents who reported that the current contraceptive used was required or recommended by family planning workers rather than chosen by clients on their own dropped from 38.7 per cent before the quality-of-care experiment to 17.8 per cent after quality-of-care implementation. More female users consulted with service providers or had discussions with their husbands before they chose a method to use. Furthermore, women's knowledge about the contraception that they used was greatly improved, such as the type of IUD, its function and its possible side effects.

In addition, the contraception method mix changed to a more diversified pattern, dominated not merely by the IUD and sterilization, implying a more individualized selection of methods. For example, in Deqing, one of the pilot counties, the contraception method mix of 14,339 couples with informed choice was as follows: IUD, 44.8 per cent; sterilization, 12.2 per cent; condom, 31.2 per cent; hormonal methods, 10.5 per cent; and others, 1.3 per cent.

Improved Information and Education Approaches

A large amount of funding and human capital was input on information, education and communication approaches. Major changes were made to readjust the focus of the content of information and education in line with the needs of local people and to change the forms of information and education.

The family planning workers used to distribute family planning regulations and information, education and communication materials in general to families. The materials were not taken seriously by local people since they were often not easy to read and were not of interest to the people. After the quality-of-care experiment, more specific information, education and communication materials were developed with pictures and words to correspond to different needs of people at different life stages, such as contraceptive informed choice, premarital education, breast feeding, infant nursing and prevention of reproductive tract infections. The knowledge was also spread via mass media, such as broadcasting, television and wall newspaper. Nong'an County, for example, developed a portable information, education and communication package with contraceptive samples and a user's handbook for

family planning workers to communicate with clients face to face (fig. 2).

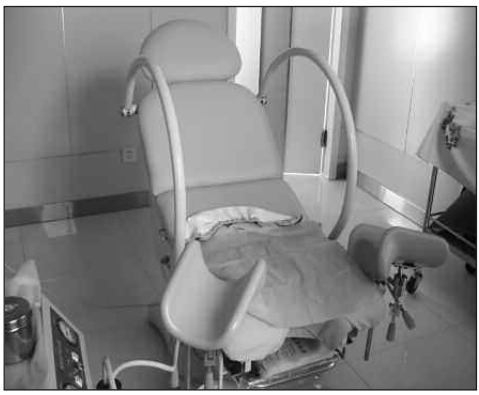
Figure 2 | Home visit by family planning workers with a portable information, education and communication package in Nong'an County.

Improved Quality of Services, Especially Counselling and Follow-up Services

With the reconstruction or renovation of service sites in counties, townships and villages of the pilots (fig. 3), a client-friendly environment was created, including some educational materials and a video display in the waiting room and a touch-screen information counselling system in the reception area.

With the standardization of the informed-choice procedures, the quality of services was emphasized, especially counselling and follow-up services (see table for more details), which had not received adequate attention in the past. There were more varieties of different contraceptive methods available with improved validity, which gave people more choices for either spacing or limitation.

Figure 3 | Equipped operation room in a township family-planning service station in Yandu County.



Extended Scope of Service in Reproductive Health Care

With the promotion of the quality-of-care experiment, the service provided at pilot sites greatly expanded to include a wide range of family planning services and related reproductive health care, such as diagnosis and treatment of reproductive tract infections. Many of the pilots launched the life-cycle service in reproductive health care for people in different age and sex groups, for instance sex education and contraception for adolescents and health care for women in menopause. The check-up for and treatment and prevention of gynecological diseases were considered as important components of the "universal access to primary reproductive health care" campaign at each pilot site. The 1998 follow-up survey found that about 90 per cent of women had a gynecological check-up, a much higher proportion than the national average (about 61-65 per cent).

Counselling and follow-up services received before and after 1995, as reported by women at pilot sites.

Service Provided before or after the Operation	Family Planning Operation	Service Received (%)	
		before 1995	after 1995
Introducing advantages and disadvantages of contraceptives	Female sterilization	61.1	93.7
	IUD insertion	66.6	89.9
Explaining the procedure of the family planning operation	Female sterilization	50.5	81.0
	IUD insertion	56.9	85.2
	Abortion	50.5	70.5
Introducing possible risks and their treatments	Female sterilization	79.8	93.7
	IUD insertion	81.0	94.9
	Abortion	67.9	86.0
Making a follow-up appointment	Female sterilization	65.0	77.8
	IUD insertion	71.2	91.8
	Abortion	50.5	79.8

Source: Zhang, Gu and Xie (eds.), 1999.

Changed Administrative and Management Practices

The reorientation of the way of thinking was considered as the key point in each pilot site, meetings, training workshops and various discussions at different levels. After years of efforts, the ideology changed and it brought changes in administrative and management practices, such as the changing of "Birth Certificate" to "Reproductive Health Service Record Handbook" (this change was followed nationwide later), which recorded the date and type of contraceptive use and shift, pregnancy, maternal check-up and child-birth as well as other service records.

A computerized information system was set up at all the pilot sites to keep a record of information about child-bearing and contraceptive use, which serves as information for both management (for regular statistics) and service provision (as a source of service need and follow-up visits).

All pilot sites explored the possibility of new ways of evaluating, such as a change or modification of evaluation indicators and a change in methods of evaluation, especially adding information on client satisfaction to the evaluation content. Although the period of the pilot experiment was not long enough to test the new indicators or to complete a list of recommended evaluation indicators, the practice created a foundation for evaluation reform of the system in the near future.

MAIN OUTCOMES OR DIRECT IMPACT OBSERVED

The outcomes of the quality-of-care project were analysed from the perspective of the clients and the service system. Some are direct and immediate outcomes while others have long-term impact.

From the Clients' Perspective

The feedback from local people about the Pilot Project was very positive and supportive. People enjoyed the improved services, especially with much more interpersonal communication while the services were being provided. More people felt respected and cared for in the new approach. The providers listened to the clients and tried to provide better and suitable contraceptives as well as to meet the reproductive health needs of the clients. The managers were concerned about the reaction of the people in terms of quality of care and their satisfaction with the services. All these actions sent clear messages to clients that they were no longer patients to be watched but rather that they, as masters of family planning, were respected and cared for.

Counselling, informed choice, knowledge-focused information, education and communication, and follow-up visits, all of these measures adopted in the experiment made clients, particularly women, more knowledgeable about contraceptive use. In return for this, women as beneficiaries of the project more actively participated in informed choice. Thus fewer unnecessary contraceptive failures and fewer abortions were the direct results of increasing the user's responsibilities in family planning. According to annual statistics in a pilot county, the cases of unintended pregnancy in the first nine months of 1998 represented a 57 per cent reduction from the same period in 1995.

Impact on the Service System

The service facilities and personnel involved in service provision were greatly improved to meet the requirements of the quality-of-care approach in the pilots. There were prominent changes in the age structure and service knowledge of the local service providers. The technical capacities of the technical personnel in service stations were strengthened through enhanced training and recruiting. For example, during the three years of the Pilot Project, the number of professional technicians increased from 7 to 12 in the service stations at the county level in Deqing County while Yandu County recruited 60 university or polytechnic school graduates into the family planning service team. Intensive on-the-job training was carried out to emphasize standardized service procedures, to learn new technology, to improve technical skills and to improve skills in interpersonal communication.

All pilot sites input/allocated resources to improve the service environment at the county, township and village levels to ensure that each service station had standardized service rooms for different functions. Strict regulations and standards were developed and implemented for all types of technical services, especially emphasizing counselling during the

whole process of any family planning operation and follow-up visits (as shown in the table).

Assessment and Evaluation of the Pilots

Through carefully designed impact assessments with mixed research methodologies, it was determined that changes at the pilot sites were significant, and the experiments were successful regarding the goal of achieving the two reorientations in different aspects (management and decision-making) and the principle of "quality of care". The assessment team suggested that the pilot experiences were expandable and sustainable.

Methodology

Immediately after the Quality-of-Care Pilot Project was initiated in six pilot counties and districts in 1995, a baseline survey of knowledge, attitudes and practices was conducted regarding the six pilots to interview the sampled clients, programme managers and service providers. The main purpose of the baseline survey was to assess the needs of local people. The survey was also designed to provide a base to measure the effectiveness of the Quality-of-Care Pilot Project. Three years later, follow-up surveys and the rapid assessment survey were designed and carried out.

The follow-up surveys in the six pilot areas in mid-1998 employed two kinds of questionnaires: one for clients and the other for services providers and managers. Valuable quantitative data were collected for comparative analysis with the baseline survey of 1995.

The rapid assessments in the six pilot areas were conducted in October-November of 1998 by an interdisciplinary team consisting of Chinese and international specialists in sociology, management, demography, women's studies, public health, etc. The methodologies adopted in the field included focus-group discussion, in-depth interviews with clients, home visits and other qualitative methods. The qualitative data and information were also collected for in-depth analyses as a complement to the quantitative data obtained from follow-up surveys. A general report and six subreports (one for each pilot county and district) were drafted and published by the Quality-of-Care Operational Office in 1999 (Zhang, Gu and Xie (eds.), 1999).

Major Findings and Impact

The follow-up survey and the rapid assessment in 1998 indicated that most clients were satisfied with the family planning performance: 85.8 per cent of respondents overall in the follow-up survey in 1998 expressed their satisfaction with family planning although with a wide variation among the pilots, ranging from 75.6 per cent to 95.6 per cent. Furthermore, 76.9 per cent of respondents in the survey indicated that they always or often participated in family planning activities in their community.

Local people mentioned some indirect impacts of the Pilot Project, and some of the impacts were not expected at the initial stage. These indirect impacts would have a long-term influence on the family planning programme both locally and nationally.

Improved Awareness of Reproductive Rights and Benefits

The key message delivered by the quality-of-care approach and emphasized by the Pilot Project initiatives was to respect people's reproductive rights. For example, the new information, education and communication approaches focused not only on the knowledge of reproductive health care but also on the reproductive rights and benefits. Both programme managers and clients clearly understood that the family planning had to be carried out in a lawful manner, and people had the right to enjoy the benefits defined by the Government. In some of the pilot counties and districts, a system was set up whereby the client would be compensated if the programme failed to provide the service promised or in a timely manner.

Female clients felt that their reproductive rights were more respected after the introduction of informed choice. A comparison of the findings from the follow-up survey in 1998 with the knowledge, attitudes and practices baseline survey in 1995 showed that the number of women who reported that a contraceptive method used was suggested by family planning workers or others fell significantly. Nearly 50 per cent of female respondents in 1998 reported that either they or their husbands made the decision on the choice of the method of contraception. This practice of free choice would affect more people in the longer term. The 2006 National Population and Family Planning Survey found out that among 24,176 female respondents using contraceptive methods, 76 per cent reported that the decision was made by themselves or by the couple, and the percentage was even higher among women ages 20 to 29 (83 per cent).

Improved Relationship between Clients and Service Providers

Service providers also felt the effect of the change on their work, which became easier even though their workload increased owing to more pre- and post-operation services, and door-to-door visits. They felt very good that their services had met the clients' needs, and some of their clients became their friends. In the family-planning service stations, more efforts were made to improve the relationship with clients, such as putting more colourful and decorated signs and greetings in the stations, setting up more private counselling rooms, using polite and soft words, and providing patient explanations for a trusting relationship between the service providers and the clients. The de-hospitalized and client-friendly appearance and atmosphere attracted more clients to the service stations. In villages or communities, family planning workers or doctors became the most welcomed persons for counselling on

health issues, daily life and even home businesses.

A county doctor said that in the past when she had visited villages, people had kept a distance from her (because her job was mainly to delivery contraception). After the services had expanded to include gynecological check-ups and counselling, local people were looking forward to her visit and were anxious to know her schedule for the village because she provided more services that local people needed. Some women called her affectionately "elder sister" or "aunt" instead of "doctor". The improvement in the relationship encouraged service providers and family planning workers to build a more trusting relationship between service providers and clients and to make great efforts to operate the programme more efficiently.

Improved Image of the Family Planning Programme

The quality-of-care experiment in the long run changed the image of the family planning programme from an approach driven purely by demographic targets to a more comprehensive and human-centred one. Under the target-driven approach, the programme was seen as a tool to achieve the targets or a demographic outcome rather than the goal of caring for people. The experiment reoriented the focus of the programme to people's well-being and reproductive health care, thus greatly improving the image of the programme among the clients in particular and in society in general.

Stable Low Fertility Rate

After the new approach was introduced, couples' needs for family planning and reproductive health were better met, and therefore there were fewer unintended pregnancies. The low fertility rate became even more stabilized in all the pilot counties at a level much lower than the replacement level (total fertility rate = 2.1). Statistics showed that the crude birth rates before (1994) and after (1997) the quality-of-care approach in each county and district were stable at a low level. The fact that there was stable low fertility in the regions eased the concern about the negative impact of quality-of-care approaches and provided supporting evidence for the scaling up of the project later.

Experiences and Lessons Learned from Pilots

The successful experiment of the quality-of-care project not only sets the model for programme reform but also provides the experiences and lessons for anyone who is interested in the model.

Government Commitment to Quality-of-care Approaches

In China, the government commitment at four levels – State, province, prefecture and county – is the key to the success of the quality-of-care pilots.

The State Family Planning Commission has been in charge of the population and family planning programme at the national level, initiatives of the Quality-of-Care Pilot Project, and the promotion of scaling up nationwide. Its roles were to:

- develop national project strategies and implementation and scaling-up plans;
- create a supportive policy environment for quality-of-care innovation; and
- mobilize the financial and technical resources from international and domestic agencies.

The host provinces and prefectures of the pilot sites involved in the whole process of the Quality-of-Care Pilot Project played the role of linkage and bridge between the State Family Planning Commission and pilot counties and districts. The county/district is the basic administrative unit of social structure in China. Governments and family planning commissions at the county/district level made their own choice and decision to participate in this Pilot Project. They were encouraged to mobilize local resources to implement the innovation.

Framework of the Quality-of-care Working Mechanism

The three systems – the decision-maker/leadership system, the service system and the management system – backed up the client-centred interactions of the quality-of-care approaches and comprised the framework of the quality-of-care working mechanism.

The theoretical framework of the quality-of-care working mechanism includes four groups of people involved in the quality-of-care project: leaders/decision makers, service providers, managers and clients. There is a logical connection among these four groups. The main activity of the leaders/decision makers is to focus on the inputs, which guarantees the regular running of the service system and the management system. The main activity of service providers and managers is to focus on implementing quality of care. The aim is to have clients participating in the family planning/reproductive health activities to maintain the clients' own rights and their level of reproductive health. The relationships among these four groups of people are presented in figure 4.

The three elements in the framework of the quality-of-care approach – target people (clients), service system and management system – have an interactive relationship to carry out client-centred interactions. From the experiences of the pilots, none of the three elements can be absent. With the upgrading of the service system, clients receive higher-quality family planning and reproductive health services. With the reform of the management system, which was to remove the quota of sterilization for service providers' evaluation, clients were free to choose the methods that they preferred. The participation of target people/clients is the dynamic for changing or reforming the

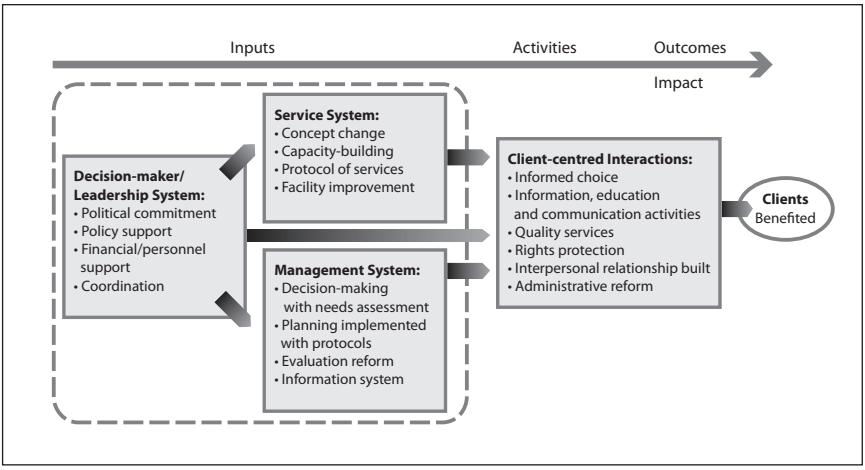


Figure 4 | Working mechanism of the quality-of-care approach in China.

service system and the management system based on the needs of people.

External Support for Pilots

The success of quality-of-care approaches in pilot counties did not rely on a large amount of external financial input. Although the socio-economic development of China in the last decade made it possible to have financial resources in place, pilot counties were told from the very beginning that they would not receive any external financial support either from the central government or international donors. They had to mobilize local resources to implement the changes and could not count on any external financial assistance. This was considered essential in order to ensure sustainability because quality of care was to become a regular programme orientation, which was intended to become institutionalized within local resource constraints. It proved to be strategic and ensured the subsequent project expansion to Western China where the socio-economic situation was underdeveloped. However, to keep innovation moving in the correct direction, technical support such as training workshops and domestic and international visits were important. They were supported by the central government and external donors.

Replicability and Scalability

With the successful demonstration of pilots in smaller areas, the State Family Planning Commission immediately proposed a scaling-up strategy to push the quality-of-care approach forward to the whole country.

Prerequisites for Replication

Before the experiences of the Quality-of-Care Pilot Project are replicated by

potential users, some elements of the scaling-up procedure, such as the innovations, the environment and the resource team, should be in place.

Acceptable Innovations

The experiences of the quality-of-care pilots have been systematically summarized and well documented as innovations, including the national guidebook, a series of publications on the pilot experiences, and an advocacy package containing the main aspects of the quality-of-care approach. Some training curriculums and teaching materials have also been developed. These documents, some with English translations, are available and can easily be adapted by different user organizations.

The innovations of the quality-of-care project are also in line with the "CORRECT" attributes that enhance the potential for scaling up as proposed by the World Health Organization (WHO) and ExpandNet (Simmons, Fajans and Ghiron (eds.), 2007):

- **C**redible in that the innovations are based on sound evidence and/or advocated by respected persons or institutions;
- **O**bservable to ensure that potential users can see the results in practice;
- **R**elevant for addressing persistent or sharply felt problems;
- **R**elative advantage over existing practices so that potential users are convinced that the costs of implementation are counteracted by the benefits;
- **E**asy to install and understand rather than complex and complicated;
- **C**ompatible with the potential users' established values, norms and facilities; fit well into the practices of the national programme; and
- **T**estable without committing the potential user to complete adoption when results have not yet been seen.

Favourable Environment

In China, governments at all levels involve the population and the family planning programme in the national or local socio-economic development plan. This means that the main leaders of government must take responsibility for dealing with population and family planning issues. Since 2000, several national laws and regulations have been issued. For example, the Law on Population and Family Planning and the Regulation on Family Planning Technical Service and Management issued in 2001 emphasize the client's rights such as contraceptive informed choice and quality of service. In 2002, the National Population and Family Planning Commission proposed quality-of-care approaches as the innovations of population and family planning reformation and required the governments at all levels to adopt the quality-of-care approaches. Then several official documents and policies were issued for scaling up, which created a favourable policy

environment for expanding quality-of-care innovations to the whole country.

Support of a Resource Team

The Quality-of-Care Pilot Project had a resource team that included both international and domestic experts with different academic backgrounds and practical experience in the field of family planning and reproductive health. The resource team was involved in the process of project design, supervision, monitoring and evaluation. Having a good relationship with national and local government officials, it facilitated the pilots and the scaling-up process with high-level advocacy and supervision. The names and designations of the experts can be found in the "Contacts" section of this case study.

Replication and Scaling Up

The process of replicating the quality-of-care experiences in other areas in China could be divided into two periods: spontaneous duplication (1998-2000), and scaling up vertically and horizontally (2000-2010).

In the first period, with the positive results from the quality-of-care pilots found in the follow-up evaluation and assessment, some provincial family planning commissions were encouraged to follow State Family Planning Commission pilots and to implement their own experiments. Meanwhile, some international cooperation projects, such as the UNFPA Reproductive Health and Family Planning Project and the Japanese Organization for International Cooperation in Family Planning Integrated Project, decided to replicate the innovations of the quality-of-care pilots. With the experiences of quality-of-care pilots spontaneously duplicated, the number of counties and districts adopting quality-of-care approaches in China increased to 200 in 1998, 300 in 1999 and more than 800 by 2000.

In the second period, the State Family Planning Commission officially announced the expansion of the innovation of the quality-of-care pilots to the whole country. In order to spread the quality-of-care approach as well as to scale it up systematically, it adopted a top-down strategy and model demonstration to initiate a national campaign on the Quality-of-Care Advanced Unit in 2002 (the name has the same meaning as Quality-of-Care Pioneer or Model given to quality-of-care pilot counties/districts selected in the mid-1990s). The State Family Planning Commission set the unified criteria and indicators for the Quality-of-Care Advanced Unit and requested provincial family planning commissions to select the provincial models first and recommend them to the national Commission. Since 2003, the National Population and Family Planning Commission (formerly the State Family Planning Commission, which was renamed in 2003) has organized several evaluation teams each year, comprising experts and officials, to evaluate the candidates for national Quality-of-Care Advanced Unit proposed by provincial commissions. Up to 2009, about 2,021 counties and districts had been evaluated and awarded recognition as the national (918) or provincial (1,103) Quality-of-Care Advanced Units, accounting for 70

per cent of the counties and districts in China. This campaign will not end until the quality-of-care innovations have spread to the entire country.

Experiences and Lessons Learned from Scaling Up

The experiences and lessons learned from scaling up could be adapted and applied by other regions or countries, especially those still not achieving a great deal in the area of family planning and reproductive health care. Several issues that arose from the scaling-up process are listed below for further discussion:

- **Advantage vs. disadvantage of a top-down strategy**
  The national campaign of the Quality-of-Care Advanced Unit was initiated by the National Population and Family Planning Commission with a top-down strategy. Being awarded the designation of national Quality-of-Care Advanced Unit means a great honour for county leaders and their superiors and some local officials will spare no effort to win such an honour. However, the disadvantage of this top-down strategy is that it might excessively push local governments at provincial, prefecture and county levels to chase the award instead of following the innovation.
- **Centralization vs. decentralization**
  In a country with a vast territory such as China, the role of local governments such as those at the provincial level must be brought into full play in scaling up. The National Population and Family Planning Commission requested provincial family planning commissions to select the provincial models first and recommend them to the national Commission. With decentralization in China, the local governments have more power to take decisions based on their socio-economic affairs including population and family planning. Therefore, some provinces overstated their privileges and refused to follow the national standard for recommending advanced units, which may produce an adverse effect on scaling up.
- **Unified standard vs. flexible adaptation**
  To control the quality of the scaling up, a unified evaluation module with 33 indicators and a methodology was developed by the National Population and Family Planning Commission and followed by all provinces. With rapid changes in the socio-economic situation in recent years, the concepts and content of quality-of-care approaches have been extended and improved. For example, integrating gender perspectives and considering ageing issues, family planning and reproductive health services should be provided not only to women of reproductive age but also to the family members including the husband, the elderly and youths as well as to migrants. Quality of

care is an open-ended approach. The standard of quality of care must be modified according to social changes. Meanwhile, owing to the regional differences, adaptation to the standards of quality of care should always be encouraged.

- **Ownership vs. sharing of resources**
  The National Population and Family Planning Commission had initiated and has the ownership of the quality-of-care project. This does not mean that the project is an isolated, static project. In the past few decades, China conducted some international cooperation projects and many domestic projects. Although these projects had their own executive agencies, the Commission adopted the integration approach and established a coordination mechanism for sharing resources and experiences with one another.

Future Plan

Challenges

Although the overall goal of reorientation of the family planning programme has been realized in most regions in China, the scaling up of the quality-of-care approaches is still ongoing.

- Currently, about 30 per cent of counties in China have yet to reach the standards of quality of care. Most of these counties are located in the western regions with poor economic conditions. Considering that people in poor regions are in urgent need of better-quality family planning and reproductive health services, more supportive policies and inputs need to be put forward by governments at all levels.
- Some counties have been evaluated and named as a "Quality-of-Care Advanced Unit", but with the changing situation, there is in fact a gap between their work and the quality-of-care approaches. This is shown in two areas: lack of capacity to meet the increasing needs of clients, and lack of gender sensitivity and inadequate male participation.

Policy Objectives

The State Council of China has emphasized family planning as a programme for the people's well-being. It was pointed out in the 2010 Report on the Work of the Government that China *"will do a good job in population and family planning work. We will continue to maintain a low birthrate. We will provide good family planning services for the floating population. We will provide regular gynecological examinations and subsidize hospital childbirths for rural women. We will strengthen intervention in birth defects; carry out a pilot program of free pre-pregnancy checkups; and provide quality health services for infants, pre-school children, and prenatal and nursing women… We will intensify strategic research on coping with an aging population and move more quickly to create a sound system of old-age services so that people can live a happy life in their old age."*

The National Population and Family Planning Commission has realized that further promotion of the quality-of-care approaches should be integrated with comprehensive reform of the family planning programme, socio-economic development, the anti-poverty strategy and the Millennium Development Goals (MDGs).

Action Plan

In 2009, the National Population and Family Planning Commission announced that the "Quality-of-Care Advanced Unit" national campaign would be "upgraded and sped up". It requested that the public service and management in family planning and reproductive health be equalized in urban and in rural China and that the quality-of-care standards should reach everywhere in the country. A nationwide public service system, which meets the needs of family planning and reproductive health, should be established by 2015.

Specific goals of the action plan include:

- further strengthening the construction of a quality service system, strengthening professional development, improving the competencies and capability of technical services, and providing family-based family planning and reproductive health services;
- promoting the healthy-baby project, fully carrying out first-level intervention in birth defects, and developing the pilot project for free pre-pregnancy health check-ups;
- establishing the whole-population information system and increasing accessibility of clients to quality service with information technology; and
- speeding up the reform of the Target Responsibility Management System in the family planning programme in China, establishing an assessment and evaluation system for population and family planning in the new era, and promoting the "Quality-of-Care Advanced Unit" national campaign.

The overall goal of promoting the quality-of-care approaches consists of family planning programme reform, pays greater attention to people's needs and requirements, respects their rights to access necessary information and high-quality services, and helps people to enjoy happier and more decent lives.

Acknowledgements

I would like to thank the countless people, agencies and institutions both in China and in other countries that have been heavily involved in the implementation and have contributed tremendously to the success of the experiment over the last 15 years.

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3 Ghana

Training in Incorporating Population Factors into Development Planning

Dr. Yaw Nsiah-Peprah

Summary

Since 1990, the Government of Ghana has put in place several mechanisms to reduce poverty and improve the standard of living of Ghanaians. These include the New Local Government System on Decentralization consolidated by the Local Government Act (Act 462) of 1993, the National Development Planning Commission Act (Act 479) of 1994 and the National Planning Systems Act (Act 480) of 1994. The goal of this legislation was to promote local development and encourage grass-roots participation in development.

In 1996, when the National Development Planning Commission introduced the preparation of district development plans as part of the decentralization process, the aim was to promote a comprehensive and responsive approach to solving the problem of poverty by allowing District Assemblies to prepare their own plans to meet the needs and aspirations of their people. By 2000, it was clear that most of the district development plans prepared had not been implemented. This failure was held to be due to the theoretical nature of the plans, which did not reflect what departments could implement and what central government, the private sector and non-governmental organizations (NGOs) were able and prepared to fund. This lack of linkage between the plans and the ability to carry them out was related to the limited capacities of District Assemblies, which are responsible at the grass-roots level for designing comprehensive plans aimed at poverty reduction. Thus in the preparation of the Ghana Poverty Reduction Strategy 1 and 2 policy documents, human resource development and good governance were seen as key to poverty reduction.

Summary (continued)

Based on the objectives of the decentralization system in Ghana, the Government and the United Nations Population Fund (UNFPA) developed a fourth Country Programme under which UNFPA assisted the Government in implementing its population programme. The population programme identified the interrelationship between population, sustained economic growth and sustainable development as a critical issue that required urgent attention. Thus the National Population Council took steps to build the capacity of District Assembly staff in the area of integrating population variables into the preparation of district development plans to tackle the problem of poverty. The Department of Planning of Kwame Nkrumah University of Science and Technology was contracted to design and implement population training modules to build the capacities of District Planning Officers and District Budget Officers who were mandated to prepare district development plans for their districts. Fifteen modules were developed and were used to train these Officers of District Assemblies all over the country. The modules have been used to train over 250 Officers to integrate population variables into the preparation of district development plans so that the plans meet the needs and aspirations of people and communities, helping to reduce poverty and improving their living conditions.

Since 1999, poverty in Ghana has dropped from 39.5 per cent to about 28 per cent, using the international poverty line of US$1.25 a day (Government of Ghana, National Development Planning Commission, 2009). This success has been attributed partly to the improved capacities of District Planning Officers and District Budget Officers as a result of their training in development plans. The simple nature and comprehensiveness of the training programmes that link population variables to poverty reduction mean that the programmes can be replicated in the whole of Africa and beyond. Most importantly, the training programmes have been reviewed by beneficiaries and stakeholders, who have identified them as relevant for preparing district development plans with the aim of reducing poverty in Ghana.

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Introduction

For countries such as Ghana that practise decentralization and thus depend on local governments for their development, well-trained local government officials are critical to any efforts aimed at decentralization. Decentralization involves highly charged, political decisions about new roles and responsibilities, the way in which organizational structures and terms and conditions of service are revised, and how staff are allocated between the central and peripheral levels. Developing staff capacity to meet these challenges is of paramount importance.

Good development planning must also be responsive to the needs and aspiration of citizens, use resources efficiently and promote the sustainable development of communities. Based on the needs and capacities of the local population, development planners can identify the potential, scale, location, speed and patterns of development. These population factors serve as indicators to measure welfare improvement; by identifying changes in these population variables, the success or failure of a development intervention can be assessed. It is crucial that development planners understand population factors and integrate these population variables when producing effective and sustainable development plans.

Figure 1 shows the relationships between population factors and develop-

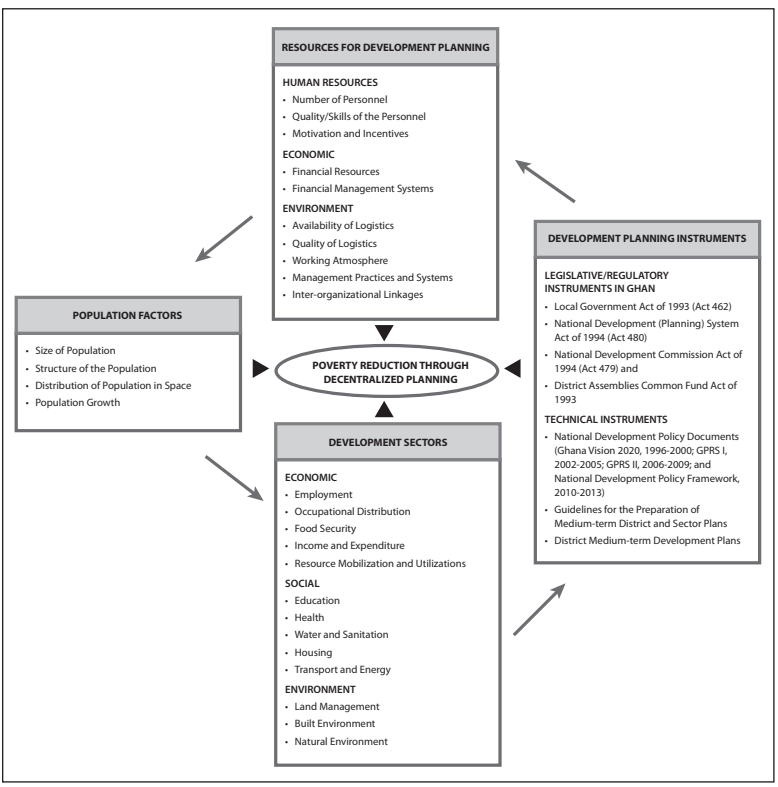


Figure 1 | A schematic presentation of population factors for poverty reduction through decentralized planning.

Note: GPRS = Ghana Pverty Reduction Strategy

Source: Author's construct, October 2010.

ment sectors. It underscores the rationale for the development of the integration of population factors into the Ghanaian model. It illustrates that effective decentralized development planning to support poverty reduction can happen if the planning is supported by instruments that provide a legal basis for planning functions and by well-trained people and if there is enough money to support the planning process.

The ability of a country to reduce poverty is dependent on four major variables: population factors, the development sector, development planning instruments and resources. Population factors include the size of the population, its structure, its distribution and its growth. Development planning instruments, including national development policy documents and regional and district development plans as well as the legislative instruments that establish the institutions, their roles and their functions, are highly critical. Finally, in order for the institutions to perform their roles effectively, efficiently and sustainably, resources and facilitating factors are needed. These include personnel training, adequate financial resources and a reliable working environment including management systems as well as an effective administration system.

The Innovative Development Planning Practice

Background

Integrating population variables into development planning requires a comprehensive and integrative approach to development planning at the local level.

The National Population Council identified the issue of integrating population issues into development planning as a key objective in the implementation of its population programme.

In its revised National Population Policy (1994), the Government identified the interrelationship between population, sustained economic growth and sustainable development as an important issue requiring urgent attention. This was in line with the tenets and objectives of the Programme of Action adopted at the International Conference on Population and Development held in Cairo (Egypt) in September 1994. This Conference sought to encourage Governments to fully integrate population concerns into the formulation, implementation, monitoring and evaluation of policies and programmes relating to the cultural, economic and social development of their countries.

Based on this objective and the implementation of the National Population Policy (Revised Edition, 1994), the National Population Council took steps to build the capacity of District Assembly staff in the area of integrating population issues into development planning. By this means, it was hoped that District Assembly plans would be more comprehensive and responsive and would drive poverty-reduction interventions at the local level.

The Government of Ghana and the

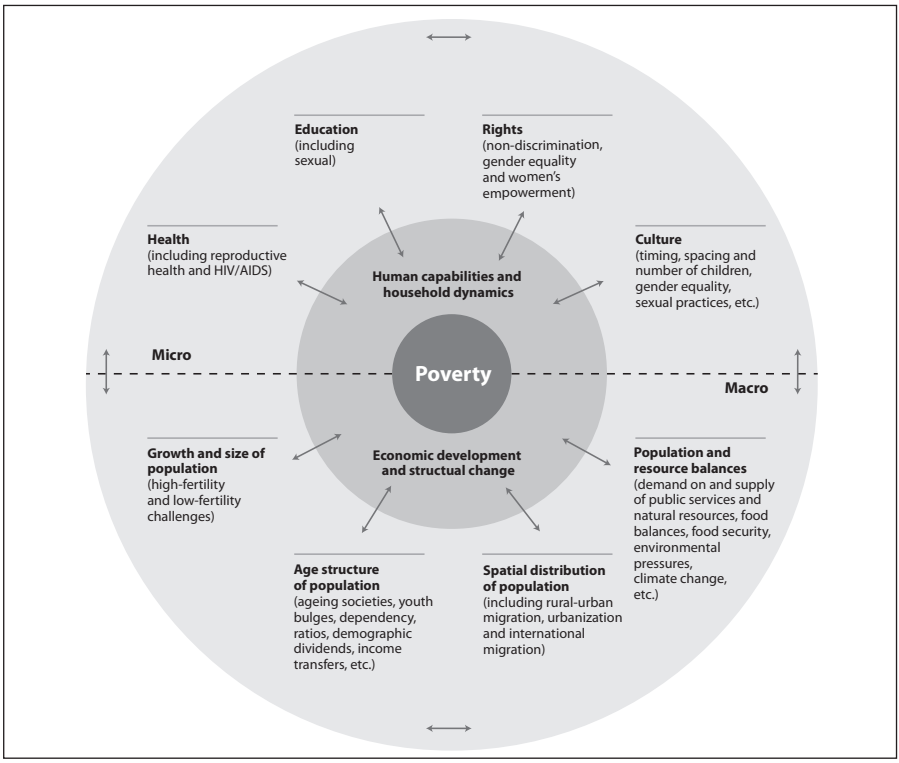
United Nations Population Fund (UNFPA) developed the Fourth Country Programme (2001-2005), which had two components: population and development, and reproductive health. Under this Programme, UNFPA would assist the Government in implementing its population programme.

The integration of population variables into development planning has also been a key objective of the International Commission on Population and Development and the Revised National Population Policy of 1994. To achieve this objective, the National Population Council, in collaboration with the Department of Planning of Kwame Nkrumah University of Science and Technology, produced a training manual titled "Integrating Population Variables into Development Planning" in 2002. The manual, a compilation of the lecture notes prepared by the facilitators for the Integrated Training Programme that began in 2002, consists of 15 training modules covering population and development, health needs, education needs assessment, water and sanitation, housing needs, land, food security, employment, rural transportation, man-made environment, natural environment, energy needs, and fiscal resource mobilization and management. These modules are seen as critical areas that must be considered to reduce poverty at the local level. A computer-based template for the Integrated Training Programme was also produced.

The modules were influenced by the multi-dimensional nature of poverty where emphasis on the causal factors of poverty includes not only economic indicators but also social, environmental, cultural and institutional factors. Although UNFPA (2010) identifies poverty as a complex and multifaceted phenomenon that can only be approximated, not adequately captured, by the level of household income or consumption, the agency further asserts that poverty can be understood either as the lack of economic opportunities, associated with economic underdevelopment (at the macro level), or the lack of human capital, which is closely associated with health and education (at the micro level). This highlights the many interdependencies between these two spheres since human capabilities are determined not only by internal factors (health and education) but also by external factors (political environment, infrastructure, human rights), as illustrated in figure 2. This brings to the fore the need for a comprehensive approach to building the capacity of human resources to effectively integrate all the causal factors into development planning and interventions.

The manual was used to train District Planning Officers and District Budget Officers in Ghana to build their capacities to efficiently prepare development plans that integrate population variables into the district planning process, thereby addressing poverty while also driving sustainable national and local socio-economic development.

Figure 2 | Population-poverty linkages.



Source: The chart is a stylized representation of population and poverty linkages. It is reproduced here from UNFPA (2010). *Impacts of Population Dynamics, Reproductive Health and Gender on Poverty*, a UNFPA Concept Paper prepared for the United Nations Summit on the Millennium Development Goals, New York, September 2010, p. 8, unpublished.

Problems Addressed by This Practice

The incidence of poverty in Ghana was 50 per cent in 1990, decreasing to 39.5 per cent in 1998-1999 (*World Development Indicators* 2006). Notwithstanding this achievement, the incidence was still high. Five out of ten regions had more than 40 per cent of their population living in poverty in 1999. The worst-affected area comprised the three northern savannah regions (the Upper East, Upper West and Northern regions). Ninety per cent of people in the Upper East, 80 per cent in the Upper West and 70 per cent in the Northern region lived in poverty. This contrasted with the Central and Eastern regions, where 50 per cent of the population was classified as poor in 1999 (Government of Ghana, National Development Planning Commission, 2003).

In 1996, the National Development Planning Commission introduced the preparation of district medium-term development plans by District Assemblies and included specific objectives. One critical objective was for development planning at the district and local levels to be responsive to the needs

and aspirations of the people. The development planning process was to be participatory and comprehensive to help to improve the standard of living of all Ghanaians and achieve the Government goal of Ghana's becoming a middle-income country (US$1,000 per capita) by 2015.

The National Development Planning Commission designed guidelines to aid in the preparation of district medium-term development plans for 1996-2000. After this period, certain challenges were identified through the process of development planning at the district level. One critical issue was the low level of understanding of development issues by the District Planning Officers who are responsible for preparing development plans. For instance, between 1996 and 2000, most of the prepared district plans were not implemented. This failure was said to be due to the theoretical nature of the plans, which did not reflect what departments could implement or what central governments, the private sector and NGOs were able and prepared to fund. Laryea-Adjei (2000) found that, generally, the guidelines emphasized comprehensive planning at the expense of strategic planning. The district plans that were prepared were not responsive to the needs of the people. This was believed to be because those who prepared the plans did not understand the importance of population variables, which are critical in the development planning process.

Although local governments made efforts to reduce the poverty rate, which fell from around 40 per cent in 2001 to 28.5 per cent in 2008 (an indication of improved development planning practices in the country), they had limited capacity to design responsive and comprehensive interventions to completely mitigate this phenomenon. Thus in the preparation of the Ghana Poverty Reduction Strategy 1 and 2 policy documents, human resource development and good governance were seen as priority areas for poverty reduction. The rationale was that technical staff at the district level who could implement interventions that responded to the needs and aspiration of people at the grass-roots level were fundamental for poverty reduction. Consequently, training modules were designed to build the capacity of these district technical staff. The goal was to provide them with training so that, by integrating population variables into their development planning process, they could prepare development plans that would help to reduce poverty and promote human welfare in their districts.

Description of the Integration Training Programme for Innovative Development Planning

Overall Objective

It is said that effective decentralization is achieved only when development planning at the local level is responsive to the

needs of the people and ensures effective use of resources. This was the fundamental goal of the Training Programme.

In terms of the objective, the Training Programme was developed mainly to achieve the revised National Population Policy objective of integrating population variables into development planning. The intent was to equip participants with the necessary capacity and skills to be able to carry out this integration, focusing on the preparation of district development plans so as to help to reduce the poverty of the people in the districts and improve their living standards.

Organizing the Development of the Training Programme

The achievement of the objective of the Training Programme depended on the local technical staff who were the planning and budget officers at the district level; they needed to have the requisite knowledge and skills to carry out the integration of the population variables into their district development plans. The Metropolitan, Municipal and District Assemblies constitute the highest political, legislative and executive body at the local level, charged with the responsibility for planning for the development of the districts. Consequently, the National Population Council took steps to build the capacity of the local technical staff through training to enable them to be able to integrate population variables into development planning.

The National Population Council contracted the Department of Planning of Kwame Nkrumah University of Science and Technology to design and implement a training programme for District Planning Officers and District Budget Officers who were mandated to prepare development plans for the districts. The facilitators were mainly from academia, the Department of Planning of the University, and technical staff from the National Population Council. There was also an information technology specialist attached to the Training Programme. These facilitators were people with diverse professional backgrounds in health, education, housing, demography, statistics, environment, finance, development planning, transport and infrastructure, energy, and water and sanitation among others. They had in-depth knowledge of how the local government worked as a result of the consultancy work and training programmes that they had undertaken for development partners for the District Assemblies.

Components

Fifteen modules were designed for the Training Programme. With the exception of the first two – "Decentralized Planning as a System" and "Population and Development" – which are considered to contain basic information, the remaining 13 modules have practical application using field data to demonstrate the integration of population variables into development planning through the use of a simple Excel computer programme.

Objectives of the Individual Modules

The Training Programme, as indicated earlier, seeks to build the capacity of the district technical staff who are mandated to prepare district development plans so that they are equipped with the necessary skills to enable them to integrate population variables into the preparation of these plans. The plans will in turn be used to help to provide the local people with the necessary basic infrastructure including housing, potable water, health facilities and educational facilities in order to further improve their living conditions. The objectives of the 15 modules are described below:

1. "Decentralized Planning as a System":
   To introduce participants to the concept of a system; the understanding of development as a system is discussed under this particular module. Also provides an overview of the relationships among development and the systems inherent in it as well as the basis for the integration of population variables into development planning. This module was designed for the course;
2. "Population and Development"
   To equip participants with the requisite techniques of finding, analysing and organizing population data to ascertain district development needs. Comprises two parts: population and development planning issues, and issues to be considered in development planning;
3. "Health Needs Assessment"
   To provide a comprehensive understanding of planning for health. More specifically, the module aims to enable participants to appreciate the importance of health needs in development planning and to understand the concept of "health" in the context of planning and development;
4. "Education Needs Assessment"
   To develop participants' awareness that a population's educational needs vary according to its culture and level of development, for instance, the educational needs of a predominantly young and growing population in developing countries compared with those of an ageing population, and capacity to respond to this fact. Since there are scarce resources in most developing countries, planning must provide a sound basis for meeting the educational needs of the people. Based on this idea, trainers using this module worked with participants to use population data to assess educational needs, identify the type(s) of educational needs to be assessed and help participants to select the most appropriate means of determining educational needs.
5. "Water and Sanitation"
   To build the capacity of participants to understand the Ghanaian water supply systems and ways to plan for the management and sustainability of these systems.

Emphasizes water supply systems in the country, major demand determinants of water consumption, methods of forecasting demand for water, and the main methods of demand projection available to planners.

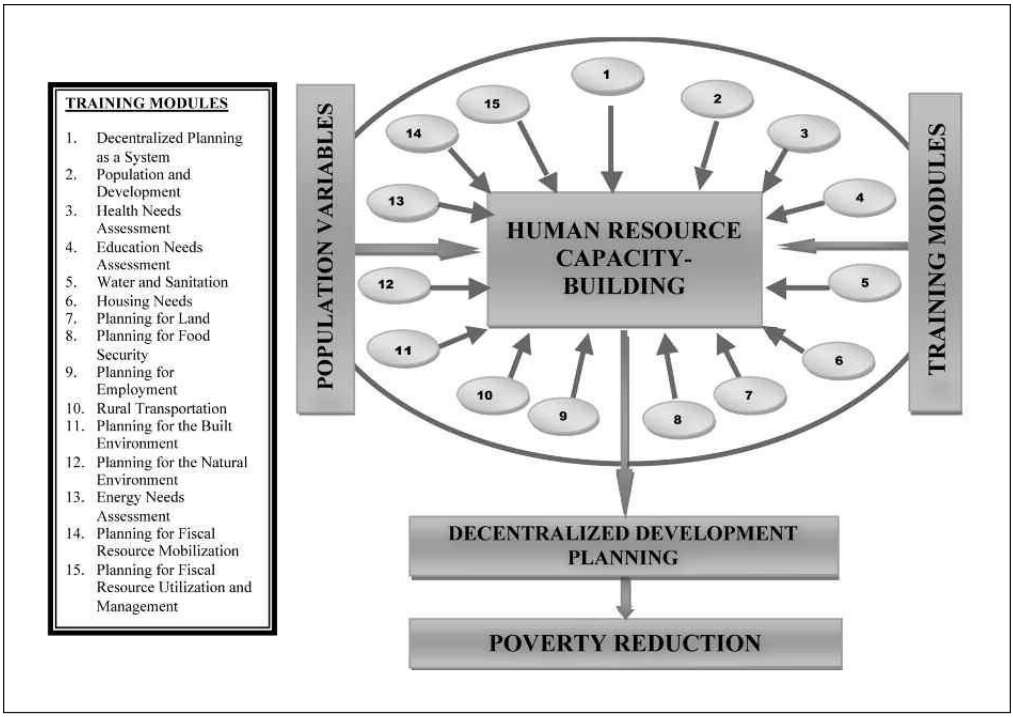
6. "Housing Needs"
   To raise participants' awareness of the importance of housing (economic and social), the concept of housing need (existing and future), housing demand and supply (factors affecting the demand for and the supply of housing), methods of assessing housing need, housing demand analysis (assessment of current housing need and projection of housing need and household income), estimation of housing needs (determination of different packages, assessment of affordable level and identification of target group(s) for housing programmes), estimation of housing investment, and analysis of delivery systems.
7. "Planning for Land"
   To guide participants to relate population growth and the distribution of land resources, including use and conservation, since land is a fundamental resource for human survival and is even more crucial in a country where the majority of the people are farmers. Specifically, the objectives are to: assess the land carrying capacity of any given population size; identify and analyse the land-use capability of any given space and the implication for population distribution; and assess land suitability for the required resource needs of a given population.
8. "Planning for Food Security"
   To increase participants' awareness of sustainable development and resource management and to build their capacity to assess the sustainability of resources and the mechanisms for integrating the outcomes of the assessments into development planning in the context of the focus on food security. Land capability analysis, analysis of land carrying capacity and analysis of land suitability were the critical concepts discussed under this module.
9. "Planning for Employment"
   To focus on three main topics for discussion: the elements of employment, data needs for employment projections, and meeting the employment demand. This module is underpinned by the understanding that employment is the means to survival. In addition, discussions about the unemployment and underemployment that have bedeviled developing countries since their independence and the failure of development interventions to address these problems were used by trainers to build participants' capacity to handle employment problems in their districts.
10. "Rural Transportation"
    To increase participants' understanding of the link between development and transportation together with the issue of the country's

transportation problems and the various options that existed to tackle them. More specifically, the objective of this particular module was to increase participants' knowledge of the challenges of rural transportation and how to effectively plan to increase accessibility.

11. "Planning for the Built Environment"
    To look at the natural environment that provides a livelihood for all people, especially for rural dwellers, focusing on implications of use, abuse or misuse of resources for the environment.
12. "Planning for the Natural Environment"
    To introduce participants to the issues of sustainable development and environmental management through training in four main areas: (a) the principles of ecosystem functions and their implications for humans; (b) principles of ecosystem sustainability and implications for a human population; (c) ecosystem balance and the implications for the human population; and (d) estimation of the impact of population growth on the natural environment.
13. "Energy Needs Assessment"
    To provide training regarding the uses of energy, including sources of energy, and energy needs assessment tools and techniques since satisfying energy needs is an important component of any development strategy. Energy is vital for industrial and agricultural production and for transport; thus energy availability is an essential determinant of economic development.
14. "Planning for Fiscal Resource Mobilization"
    To enable participants to analyse the relationships between revenue mobilization and population and to develop the capacity to deal with the challenges that characterize revenue mobilization: fiscal policy formulation, revenue collection, monitoring of operations and performance assessment. The objectives were achieved by increasing awareness and understanding of the following: local revenue instruments, revenues and revenue mobilization including critical issues, analysis of revenue performance, and methods for improving local revenue mobilization.
15. "Planning for Fiscal Resource Utilization and Management"
    To build the capacity of participants to plan how to manage their budgets by teaching them the skills and giving them knowledge regarding the expenditure estimation outline, how to use the existing expenditure base, increases in expenditure and expenditure measures.

A schematic presentation of the training modules for human resource capacity-building is shown in figure 3. It should be noted that all these modules mutually interact in that they all aim at building the capacity of District Planning Officers and District Budget Officers to integrate population variables into development plan-

Figure 3 | A schematic presentation of the training modules for human resource capacity-building.



Source: Author's construct, October 2010.

ning, with the aim of reducing poverty and improving the welfare of the local people.

Implementation of the IntegrationTraining Programme

The Integration Training Programme was a National Population Council activity under the third Government of Ghana/UNFPA Country Programme. The structures for the management of the Country Programme as well as existing structures and systems at the National Population Council, the Metropolitan/ Municipal Assemblies and District Assemblies were used in the implementation of the Training Programme. The Department of Planning of the Kwame Nkrumah University of Science and Technology (KNUST) was contracted by the National Population Council with support from UNFPA to develop the modules. However the actual development of the modules involved the National Population Council; the KNUST Department of Planning, Centre for Land Studies and Centre for Settlement Studies; and the Centre for Scientific and Industrial Research. In all, 25 experts contributed to the design of the modules.

The Training Unit of the Programmes, Research and Training Division of the National Population Council Secretariat

was responsible for the coordination of the Integration Training Programme. The Council used its regional officers to contact the district officers including the District Chief Executives and Regional and District Coordinating Directors to release and sponsor their District Planning Officers and District Budget Officers, who are mandated by Local Government Act 462 of 1993 to prepare, implement and monitor district development plans. The Council also arranged the venues and other logistics in the regions.

The Government/UNFPA Programme also had structures for managing the Country Programme that were also used to manage the Integration Training Programme. The quarterly programme review meetings of implementing partners also provided an opportunity for the partners to report on their activities, share ideas, clarify issues and identify areas of collaboration among partners. The main collaborating agencies, however, were the National Population Council, Kwame Nkrumah University of Science and Technology, District Assemblies and UNFPA.

The entire Training Programme was held in 10 working days through lectures, seminars, discussions, exercises and computer applications. It was divided into two main components of five days each.

In the first week, participants were taken through lectures, group discussions, participant-led seminars and practical exercises. Fifteen modules were taught during this week, during which the Integration Training Programme concentrated on principles underpinning the training modules. They were divided into two phases: an introductory phase and a main phase. The introductory phase took the participants through the systems view of development (modules 1 and 2) while the main phase focused on the remaining 13 modules.

The second week was devoted to practical training of the participants in the use of computer-based packages for the 13 modules. This section was handled by a computer facilitator and the resource persons who delivered the lectures in the first week. A number of cross-cutting issues were identified, such as the relationship between housing, environment and health and how these affect the welfare of people and thus reduce their poverty.

In addition to the training given to the District Planning Officers and District Budget Officers, the Ministry of Local Government and Rural Development and the National Population Council, in collaboration with the Department of Planning, also organized one-day orientation and training workshops for District Chief Executives and District Coordinating Directors since, as the two critical members of District Assemblies, they play a crucial role in drawing up and indeed in implementing district development plans. The objective of these orientation workshops was to help the District Chief Executives and the District Coordinating Directors appreciate the importance of

these training programmes in the development planning process.

Experiences and Issues Arising Out of the Implementation

Before the training programmes, District Chief Executives and District Coordinating Directors were not enthusiastic about financing and encouraging District Planning Officers and District Budget Officers in the preparation of district development plans since they did not find the Officers to be competent enough. As a result, they employed consultants in the preparation of their district development plans.

The District Planning Officers and the District Budget Officers also were not confident and lacked the necessary skills for the preparation of their district development plans. As a result, the plans that they prepared were not responsive to the needs and aspirations of the people in their districts. Therefore, the people did not give their necessary support to the implementation of the plans.

After the orientation given to the District Chief Executives and District Coordinating Directors, however, they were motivated to provide the necessary support to their District Planning Officers and District Budget Officers for the preparation of their district development plans. In addition, as a result of the training given to these Officers, the District Chief Executives and the District Coordinating Directors found the Officers to be competent in the preparation of their plans. They therefore allocated financial resources through investing in computers, printers and other necessary equipment to support these Officers in preparing their development plans rather than giving the assignments to consultants.

Similarly, the training of District Planning Officers and District Budget Officers provided them with the necessary skills and confidence to prepare district development plans that met the needs and aspirations of the people in their districts in terms of reducing their poverty and promoting sustainable development in their respective districts.

Results and Achievements

The modules have been used to train the core staff of District Assemblies since 2002. Most importantly, the conception, preparation and publication of the modules constitute a great achievement. These modules were realized after many consultations between the National Population Council and key partner agencies. To date, around 15 training programmes have been conducted and over 250 staff have been trained using these modules. From a review undertaken by the National Population Council and its stakeholders, it was observed that as a result of the training programmes, the performance of participants in the preparation of their district development plans

has improved greatly according to their District Chief Executives and District Coordinating Directors. These Officers are now capable of preparing their plans instead of the District Assemblies engaging the services of private consultants to perform these tasks for them at a very high financial cost.

Prioritizing training for about 40 District Planning Officers and District Budget Officers in all the districts of the three northern regions (Upper East, Upper West and Northern) was also an achievement. As noted earlier, these regions are among the poorest in the country. It was thus appropriate that the human resource capacity-building programme started from there. Subsequently, around 210 Officers from the other districts in the country have also been trained. This has helped to build the human resource capacity of these core Officers in the preparation of their plans.

The training has also contributed to reducing poverty levels in Ghana by building the capacity of District Planning Officers and District Budget Officers in preparing and implementing programmes and projects that respond to the needs and aspirations of the local people. Since 1999, poverty in Ghana has dropped from 39.5 per cent to about 28 per cent of the population using the international poverty line of US$1.25 a day (Government of Ghana, National Development Planning Commission, 2009).

Assessment and Evaluation of the Content, Impact and Sustainability of the Training Programme

Assessment by Participants

One important aspect of the Integration Training Programme is an assessment of its relevance. This is done by the implementers of the Programme, who ask participants to complete structured questionnaires with questions relating to:

- achievement of Programme objectives;
- training methods;
- level of instruction and relevance of Programme content to participants' work;
- computer application and relevance;
- length of the Programme; and
- overall evaluation.

The overall evaluation of the Integration Training Programme by participants showed that 82.3 per cent graded the Programme as "excellent", 11.8 per cent rated it as "very good" and 5.9 per cent of the participants deemed it to be "good". None of the participants graded the course as "fair" or "poor".

The evaluation has served as a basis for planning subsequent courses. Generally, when asked, about 69 per cent of the participants observed that the course objectives had been completely met, 23 per

cent asserted that the course objectives had almost been met and only 8 per cent judged that the participants' objectives had been met fairly well.

The method of delivery of the Integration Training Programme was identified as being easy to understand, participatory and flexible. It encouraged team-building and individual dynamism, critical attributes that development planners at the local level must possess. In terms of the length of the Programme, the majority (52.9 per cent) of the participants responded that their preferred length of time for the Programme was three weeks, 23.5 per cent mentioned four weeks and 11.8 per cent indicated six weeks. After the evaluation, it was decided that the duration of the course should be increased to three weeks, with the first two weeks devoted to lectures and the third week devoted to computer application.

Module 12, which looked at the natural environment, was deemed to be difficult by participants. This can be attributed to the fact that it involves a great deal of complex mathematical calculation. Most importantly, participants observed that Module 14, "Planning for Fiscal Resource Mobilization", and Module 15, "Planning for Fiscal Resource Utilization and Management", were very important and that the issues covered by those modules were extremely relevant. The reason for this assessment is that the capacity of District Assemblies to promote development is constrained by inadequate financial resources. It has therefore been recommended that District Assemblies be properly resourced by the Government by increasing the District Assembly Common Fund from 5 per cent to 7 per cent of gross domestic product. District Assemblies are being requested to increase the capacity of their resource mobilzation staff to collect the internally generated funds efficiently. As far as utilization is concerned, it is recommended that the capacity of budget officers in the district, i.e., the District Coordinating Directors and the District Chief Executives, should be improved through rigorous training.

Participants who attended the Integration Training Programme found it to be very useful. The response to the training was very positive and participants returned to their districts with copies of both the modules and templates on a CD-ROM. As far as the participants and authors are concerned, the modules simplified the planning process and made it easy for its users to undertake needs assessment and planning in order to identify the specific needs of the people and plan to address them.

Assessment by Institutions and Individuals

The National Population Council organized a review of the training programmes to assess whether or not they truly increased the capacity of the participants who attended the training. At this review meeting, 44 individuals from 18 institutions participated. Participants were very happy about the way in which the modules were being integrated into development planning. Officers who participated

in the training programmes were said to be very skillful in the preparation of their district development plans. They recommended that the course be extended by one week so that participants would be well schooled in the theoretical aspects of the modules. They also corroborated the observation that Module 12 ("Planning for the Natural Environment") was difficult because it was very mathematical.

Participants also indicated that the training seemed to be working. They cited the example of trained District Planning Officers who were using the modules to effectively plan and mobilize resources in their districts. They also stated that supervisors (the District Chief Executives and District Coordinating Directors) of these District Planning Officers also were satisfied with the outputs of the Officers.

Participants further stated that the knowledge acquired by the Officers in the Integration Training Programme was translated into the preparation by these Officers of better district development plans, which were very responsive to the needs of their people. They acknowledged that more than 70 per cent of the well-prepared district development plans came from districts where personnel had been trained. They therefore recommended that this Programme be continued to increase the effectiveness of decentralized development planning in Ghana and help to reduce further the poverty of the people.

Overall, the institutions and individuals that helped to evaluate the Integration Training Programme were satisfied with the general conduct of the Programme and the output of Officers who had been trained. Many districts with trained officials have stopped employing consultants in the preparation of district development plans since their own officials can prepare them effectively.

Lessons Learned in Terms of Positive and Negative Impact

Between 1996 and 2000, when the first medium-term development plans of District Assemblies were prepared and implemented, the plans were found to be rigid and non-responsive to the needs of the people. Thus there was a need to intervene to make development plans more effective. The Integration Training Programme subsequently provided the technical staff who prepared these plans with the necessary skills to assess the needs of their various communities in terms of housing, health, education, water and sanitation, economic development, transportation and the environment to make development planning more responsive to their needs. The technical staff also learned how to mobilize fiscal resources and how to advise on the use of such resources in their districts, with the aim of reducing poverty among their people. From 2002 when the Ghana Poverty Reduction Strategy 1 was being implemented, components of the training modules were integrated into the guidelines prepared by the National

Development Planning Commission for Districts Assemblies in the preparation of their medium-term development plans.

Another major positive impact is that district political heads (District Chief Executives and District Coordinating Directors) have supported the implementation of the training programmes by encouraging their staff and providing them with financial support to attend the training. This was made possible by sensitizing the District Chief Executives and District Coordinating Directors about the benefits of the Integration Training Programme and its relevance for development. Again, the involvement of major stakeholders, including ministries and agencies, and the National Development Planning Commission at the national level has made the inclusion of these modules in national policy programmes possible.

Even though around 250 District Planning Officers and District Budget Officers have been trained in the use of the modules to integrate population variables into development planning, certain challenges have been identified. These include the fact that, in 2005, when the National Population Council assessed the effectiveness of the training programmes, it found that some of the trained Officers had either been transferred from their districts or had resigned and had taken jobs with NGOs because of their improved capacity. It was therefore necessary to train more Officers to be able to replace those who left. It should be noted that even though these Officers left the districts, they carried with them the knowledge gained and are therefore still very useful to the country.

Replicability of the Integration Training Programme

Since the first implementation of the Integration Training Programme in 2002, which targeted only the three regions in the north of Ghana (Upper East, Upper West and Northern), the modules have been used to train staff of District Assemblies across the country. This was informed by the understanding of the Government that to promote effective development and poverty reduction at the local level, population factors had to be integrated into the formulation, implementation, monitoring and evaluation of policies and programmes relating to cultural, economic and social development including resource allocation at all levels in the country.

The modules have been used to train staff of District Assemblies to appreciate the critical issues that determine the needs and aspirations of people and communities. Although the training was started in districts in the three northern and poorest regions, extending the training to cover other districts did not pose any challenge. Participants understood the relevance and appreciated the need to have their development plans reflect the needs and aspirations of the people for whom they plan.

It is the authors' view that the Integration Training Programme can be replicated in the whole of Africa and beyond. In terms of substance, the Programme has been designed to look at all the components and various factors captured in the modules that affect the lives of the people by examining the detailed relationship between these factors and the lives of the people.

Political backing, which is quite strong for the Programme in Ghana, is needed to ensure the success of the Integration Training Programme in other African countries. There is also a need for an umbrella coordination institution like the National Population Council in Ghana to liaise between the national and subnational levels (e.g., District Assemblies). This facilitates easy interaction between the two parties and ensures the provision of necessary resources by the national leadership to the district leaders.

The national and the local government must work together to provide resources for the Integration Training Programme. Resources such as computers, printers and photocopiers as well as funds for data collection are prerequisites for the adoption of these modules in the preparation of district development plans.

If all these conditions are met, then the Integration Training Programme can be replicated in other countries in Africa and elsewhere to help to reduce poverty and improve the living conditions of the people of these countries.

Impact

Following the introduction of the Integration Training Programme, all activities at the local level have revolved around the issues and approaches recommended by the training. This has encouraged the Government to fully integrate population concerns into the formulation, implementation, monitoring and evaluation of policies and programmes relating to cultural, economic and social development including resource allocation in all the regions of the country. This assertion is based on the fact that everyday activities of all human beings, communities and countries are influenced by population change, the use of natural resources, the state of the environment, and the pace and quality of social and economic development.

The innovative practice was integrated into the Growth and Poverty Reduction Strategy (GPRS II) (2006-2009) and has also been incorporated into the current Medium-term National Development Policy Framework (2010-2013). Guidelines prepared by the National Development Planning Commission for the preparation of sector and district development plans identified population as a cross-cutting issue based on the knowledge gained from the practice. The National Population Council, which facilitated the practice, succeeded in the inclusion of the population variables in the two above-mentioned documents. The preparation of these two national policy documents was facilitated

by the National Development Planning Commission, which established cross-sectoral planning groups on various themes.

Under GPRS II (2006-2009), there were three major themes: priorities for private-sector competitiveness, human resource development, and good governance and civic responsibility. The Medium-term National Development Policy Framework (2010-2013), on the other hand, has five themes: Ghana's competitiveness in industry and service, accelerated agricultural modernization, expanded development of production infrastructure, human resources for national development, and transparent and accountable governance. The cross-sectoral planning groups discussed the various key issues that the participating ministries and agencies wanted to be included in the national documents. The National Population Council served on all the cross-sectoral groups; however, it focused on the human development group. Apart from the cross-sectoral groups, the National Development Planning Commission also established a core team that drafted the documents. The National Population Council participated intensively in the activities of the core team and noted that serious consideration needed to be given to population variables in the national policy programmes.

Conclusion

Justification of the Integration Training Programme as a Best Practice

When promoting effective decentralization, there is a need for effective planning, implementation, budgeting and monitoring at the local level. In Ghana, the decentralization process is relatively young and the effective functioning of the system requires that officials respond to the objectives of this decentralization process, which are poverty reduction and improved living conditions. Several studies have illustrated the need to build capacity at the local level, especially when it comes to human resources. The reasoning behind this is that if District Assemblies drive development at the local level, then it is critical that the conditions necessary to promote the effective, efficient and sustainable use of resources that responds to the needs of Ghanaians (i.e., reducing poverty) be enhanced. After the implementation of the first phase of Ghana Vision 2020 and the introduction of the medium-term development plans approach to development planning, it became obvious that attention must be paid to the needs of people at the local level. The only way to train the necessary personnel to be able to facilitate this was to provide them with the skills needed to be able to integrate population variables into the development planning process.

The training modules have facilitated the easy integration of population variables into development planning. The Integration Training Programme is a best practice in the sense that it provides an innovative basis for more holistic and effective planning for the future. The modules are also user-friendly, and dis-

trict development plans have been reviewed and made more focused using them.

The continued training of district officers by the National Population Council and the Department of Planning of Kwame Nkrumah University of Science and Technology in the use of the modules in the preparation of development plans continues to show the importance of this approach to the development planning process in Ghana.

Future Plans

It is envisaged that new modules will be added to the existing ones. These could include topics such as "youth in development", "women in development" and "risk and vulnerability".

The Integration Training Programme modules have been in use for some time and the National Population Council and the Department of Planning in collaboration with UNFPA are in the process of reviewing them to rectify gaps and to update them to include new and emerging issues. The Council also plans to advocate that they be incorporated into the curricula of some training institutions in Ghana to enable many more district personnel to be equipped with the skills to use them.

Acknowledgements

Many institutions and individuals have contributed in one way or the other to the preparation of the Training Manual, the use of the Manual for the training programme, the review of the Manual and the financing of the entire exercise. I would like to express my sincere appreciation to all of them since without them, this case study could not have been written and the training programme could not have been held.

First, I am very grateful to the National Population Council for initiating the idea of preparing the modules and the training programmes to integrate population variables into development planning. I also wish to thank the Department of Planning of Kwame Nkrumah University of Science and Technology, which put these ideas into practice, and especially the lecturers in the Department who prepared the modules and were the facilitators for the training programmes. My thanks also go to Dr. Seth Ohemeng Dapaah, a statistician and a computer expert from the Centre for Scientific and Industrial Research (CSIR) Kumasi, who helped to develop a template on computer-aided techniques in support of all of the 13 main modules to help the trainees to update the data on their districts for the preparation of their district development plans, and to Mr. I. K. Kitrisku, who edited the training manual before its publication.

I am grateful to the many government ministries, departments and agencies that participated in the review of the modules and the programmes that were organized using the modules. My very special thanks go to the United Nations

Population Fund for the provision of financial resources for the exercise.

I would also like to express my gratitude to the individuals who contributed at the review meeting on the modules, especially Mrs. Ester Apewokin, Former Executive Director, National Population Council; Mr. Steve Gray, Deputy Director, National Population Council; Ms. Marian Kpakpah, Director, Technical Services, National Population Council; Nana Prof. J. S. Nabila, President, National House of Chiefs; and many other top officials too numerous to mention individually here.

I also wish to express my sincere appreciation to Partners in Population and Development for selecting the manual on "Integration of Population Variables into Development Planning" as a best practice and inviting me to its two technical meetings in 2010 in Dhaka and Bangkok as well as to all the authors/experts who attended both technical meetings for their constructive comments that have helped in many ways to shape this case study into its present form.

Finally, I wish to thank Mr. Stephen Kofi Diko, my teaching and research assistant, for his immense contribution in the data collection and for typing this whole case study.

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4

India

Addressing Reproductive and Sexual Health Issues of Adolescents

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Summary

Investment in adolescent reproductive and sexual health yields dividends in many important ways. The Ministry of Health and Family Welfare, under the Reproductive and Child Health-II project, has included the adolescent reproductive and sexual health strategy to take care of the emerging needs and demands of adolescents. The present case study highlights the successful interventions carried out by the Society for Women and Children's Health, a national NGO, in partnership with the State government in Yamuna Nagar District of Haryana, India.

Prominent deficiencies existed such as a lack of provisions for privacy and confidentiality in the health centres and hospitals, no special clinic or fixed hours for adolescents, and inadequate information about the adolescents in the available records. The modules developed by the Government of India were used for the training of staff, and the health personnel in the district were trained through three-to-five-day training courses. Peer-group educators were selected according to the criteria developed and were trained in how to address queries by using the "'frequently-asked-questions" approach.

Youth *melas* (youth fairs/festivals) were organized during a period of one year and were attended by adolescents and youths as well as some elders and opinion makers. The youth

Summary (continued)

festivals offered an opportunity to specifically address sexual and reproductive health needs. The organization of these festivals was part of the implementation strategy to help to create awareness of adolescents' issues.

It was observed that over a period of nine months, a total of 2,851 adolescents (927 males and 1,924 females) visited the general outpatient departments and 283 cases were recorded as referral cases.

Evaluation consisted of household surveys and quality assessments of health facilities based on standards set by the Government. A household coverage survey on 1,200 adolescents in 60 village clusters (30 control and 30 intervention clusters) was carried out, which demonstrated impressive improvements in the intervention villages. Remarkable improvements were demonstrated in the knowledge and use of adolescent-friendly health services and the utilization of public health services and better coverage in the iron deficiency anaemia prevention package, the purchase of sanitary napkins for menstrual hygiene, better access to contraception, knowledge of sexually transmitted infections (STIs) and the use of condoms.

Quality assessment was carried out in 12 health facilities (10 sub-centres and 2 primary health centres) each in the control villages and intervention villages where the adolescent-friendly health centres were established. The scores for different standards varied between 44 and 94 per cent in adolescent-friendly health and counselling service facilities in comparison to 1 to 59 per cent in the control facilities.

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Background

Target Population

Haryana is one of the wealthiest States of North India. According to the 1991 Census of India, three quarters of Haryana live in rural areas. Thirty-seven per cent of the population is below 15 years of age (according to the 2005-06 National Family Health Survey). Eighty-nine per cent of children ages 6 to 14 attend school. The disparity in school attendance by sex grows with increasing age. For example, between 6 and 10 years of age, 93 per cent of boys attend school compared with 90 per cent of girls, and between 15 and 17 years of age, 68 per cent of boys attend school compared with 50 per cent of the girls. Forty-seven per cent of females have some degree of anaemia, 31 per cent are mildly anaemic and 15 per cent are moderately anaemic, the prevalence being higher for rural women. A considerable proportion of females in Haryana still marry before reaching the legal minimum age of 18 years. Twenty-three per cent of women 15 to 19 years old are already married and the proportion for married females is higher in rural areas. More than two out of five women in Haryana did not receive an antenatal check-up for births in the three years preceding the 2005-06 National Family Health Survey. Sixty-three per cent of women from rural areas are aware of all modern methods of family planning (contraception, birth control and spacing) compared to 79 per cent of their urban counterparts.

Origin of the Project

The adolescent reproductive and sexual health strategy was implemented as per the National Policy Guidelines by the Government of India in the nine selected districts in Haryana, including Yamuna Nagar.

Problems Identified Relating to Adolescent Reproductive and Sexual Health

Findings of a Mapping Exercise

A mapping exercise to assess the services provided for adolescents revealed that more than 90 per cent of all the health facilities were far below the standards as recommended in the Implementation Guide of the Government. Some of the prominent deficiencies noted in the provision of adolescent-friendly health services were as follows:

- the providers were not trained in the adolescent-friendly health services package;
- supplies such as iron and folic acid tablets and contraceptives were available (although supplies were erratic) but were not provided to adolescents;
- there were no provisions to maintain privacy or confidentiality in the health centres and hospitals;
- no special clinic or fixed hours for adolescents were observed;
- the available records contained inadequate information on adolescents (the records only identified disease symptoms) and this information was neither analysed nor

reported. Sometimes even the age of the adolescents was not recorded;

- there was very low use by the adolescents of public health services relating to reproductive and sexual health issues;
- the girls who were not going to school demonstrated a high prevalence of anaemia and low coverage of tetanus toxoid; and
- there was a lack of knowledge among service providers of the key issues relating to physical, psycho-social, and reproductive and sexual health.

Findings of Formative Research

Formative research revealed the following:

- the attendance rate of adolescents in government health facilities was only 5 to 10 per cent;
- when sick, 64 per cent of girls and 52 per cent of boys reported to village doctors (mostly unqualified) for treatment;
- about 70 per cent of the boys and 45 per cent of the girls were not aware of the physical changes in their body;
- the main sources of information about sexual health were media (television) and friends;
- the main stressors for adolescents were financial problems, fights among parents, tension about studies and relationships;
- prominent health concerns included pain during menstruation (girls), pimples (boys and girls) and physical illnesses;
- 88 per cent of adolescent girls were using home-made pads during menstruation;
- information on sexual activity, especially premarital sex, was difficult to obtain but those who stated that they had had sexual activity did not adopt safe sexual practices;
- a survey of adolescents who were and who were not attending school showed a very high prevalence rate of anaemia; and
- the coverage with tetanus toxoid was 96 per cent in girls attending school and only 44 per cent in girls not attending school.

The mapping exercise and the findings of formative research provided the benchmark information on the gaps and helped to identify specific areas needing intervention and improvement. In order to address these deficiencies, the decision was taken to adopt a multi-pronged strategy in line with the guidelines of the adolescent reproductive and sexual health strategy by the Government of India, as outlined below.

A State Programme Implementation Programme (PIP)[1] was prepared that included the important components relating to planning the adolescent and sexual reproductive health strategy for the State of Haryana. The case study presented was implemented in the selected community health centres/primary health centres/sub-centres in Yamuna Nagar

[1] PIP is the standard title used by the States for developing future implementation programmes relating to health.

District in Haryana in 2008-2009. The operational area was selected in consultation with the Chief Medical Officer and District Nodal Officer, Haryana.

Intervention Area

District: Yamuna Nagar

Population: 100,000 (estimated)

Villages: 88

Primary health centres: Kot, Kharwan, Kalanaur and Burhia

Community health centres: Khizrabad and Naharpur

Sub-centres: 17

Objectives of the Intervention

The objectives of the intervention were to:

- improve the reproductive health and well-being of youths and adolescents in the selected districts through a multisectoral and integrated approach;
- strengthen the ability of youths and adolescents to delay marriage and make informed decisions about reproductive health matters, especially among girls; and
- increase the access of married and unmarried adolescents to modern family-planning and reproductive-health information and services.

Strategy Formulation

A comprehensive package (box 1) of adolescent-friendly reproductive and sexual

Box 1 | The innovative adolescent reproductive and sexual health strategy at a glance.

Organizing effective services	Service providers in place; Available supply of equipment and basic amenities; Notice board outside the centre in prominent position; Display of services offered.
Conducive environment	Designated staff available; Registration of adolescents; Privacy and confidentiality; Special clinic day/time, as decided by community.
Service delivery package	Promotive – focused care during the antenatal period, counselling and provision for emergency contraceptive pills; Preventive – services for tetanus immunization, prophylaxis against nutritional anaemia and nutrition counselling; Curative – treatment for common reproductive-tract infections/sexually transmitted infections, counselling for menstrual disorders and sexual concerns of male and female adolescents; Referral – Voluntary Counselling and Testing Centre, any other issue; Outreach – periodic health check-ups, community camps and health education activities.

Box 1 | The innovative adolescent reproductive and sexual health strategy at a glance (continued).

Capacity-building	Health-care providers.
Communication with adolescents through convergence	Peer-group educators; Addressing adolescents attending and not attending school; Letter-box approach; Frequently-asked-questions (FAQs) approach.
Environment-building	Establishing adolescent action groups; Community involvement; Youth festival/cultural show/competitions/debates on key issues.
Monitoring and evaluation	Household Survey; Quality assessment of adolescent-friendly health services as per the seven standards recommended by the Government of India.

health services was planned as per the recommendations by the Ministry of Health and Family Welfare.

Partnership with Non-governmental Organizations

The implementation of the strategy was undertaken by adopting the partnership approach in which six mother non-governmental organizations (NGOs) were selected to work with the Government. The role of the NGOs was primarily community mobilization and training of health providers and other stakeholders including the peer-group educators in the districts selected. The Society for Women and Children's Health implemented the innovative adolescent reproductive and sexual health strategy in Yamuna Nagar, Haryana.

Innovations: Description of Activities

Adolescent-friendly health clinics were selected and established at the sub-centre/primary health centre/community health centre level and at the district level based on the criteria contained in the standards recommended by the Government. The innovative strategy consisted of the following activities carried out simultaneously.

Organizing Effective Services

The following were ensured:

- adequate service providers in place;
- a Notice Board outside the centre in a prominent position;
- posters displaying the services offered and visible to the clients;

- adequate waiting space and reasonable cleanliness;
- availability of the specified supplies, equipment and basic amenities such as clean water and a clean toilet facility; and
- reasonable privacy and confidentiality.

Conducive Environment

A conducive environment was created through the following:

- designated staff were present, and punctuality and regularity were ensured;
- registration was required for all adolescents;
- privacy and confidentiality were ensured;
- a special clinic day and time were established as decided by the community; and
- reading material was displayed on relevant issues.

Service Delivery Package

As part of promotive care, focused antenatal care was provided to all adolescent pregnant mothers. Counselling information, advice on and the supply of contraceptives, sexual and reproductive health issues and the common concerns of the adolescents (both boys and girls) were addressed. Service for toxoid, iron and folic acid tablets and counselling for nutritional anaemia were provided. Wherever required, the adolescents were referred to a primary health centre/community health centre for treatment of common reproductive-tract infections/sexually transmitted infections and for voluntary counselling and testing for HIV/AIDS.

Two types of outreach services were added: periodic health check-ups under the school health programme and community camps, and information about the health services provided by the peer educators.

During the period under review, 13 such clinics were established at various levels. The peer-group educators and health workers at the village level ensured that the demand for health services by the adolescents was created. Clients availing themselves of services were also contacted to assess their satisfaction level. Over a period of 10 months (June 2008-March 2009), a total of 1,676 cases attended the adolescent-friendly health and counselling services (544 male and 1,132 female) and 1,175 cases (383 male and 792 female) in the General Outpatient Department (total number of cases = 2,851). During this period, 283 referred cases were addressed. The attendance of females outnumbered that of males more than twofold. One major reason for this was the reluctance of the male adolescents to be seen by a female provider. Another reason for the higher number of consultations by females related to menstrual problems. The types of problems addressed are summarized in table 1.

Table 1 | Types of problems addressed in health facilities (General Outpatient Department and Adolescent-friendly Health and Counselling Services).

Serial No.	Problem	Male No. (%)	Female No. (%)
1.	Menstrual problem	-	404 (21.0)
2.	White discharge	8 (0.9)	173 (9.0)
3.	Itching in and around genital area	66 (7.1)	76 (3.9)
4.	Lower abdominal pain	15 (1.6)	138 (7.2)
5.	Facial blemishes	85 (9.2)	174 (9.0)
6.	Burning micturition	71 (7.7)	100 (5.2)
7.	Weakness	133 (14.3)	185 (9.6)
8.	Diarrhoea	51 (5.5)	66 (3.4)
9.	Boils on the skin	68 (7.3)	104 (5.4)
10.	Acute respiratory illness (ARI)	110 (11.9)	136 (7.1)
11.	Fever	149 (16.1)	163 (8.5)
12.	Abdominal pain	80 (8.6)	103 (5.3)
13.	Mouth ulcer	91 (9.8)	102 (5.3)
	Total	**927**	**1,924**

Capacity-building of the Adolescent-friendly Health-care Providers

Health-care providers form the backbone of the health system and many of them could be tapped and designated to become providers of adolescent-friendly health services in the community. They include the doctors, auxiliary nurse midwives, *anganwadi* workers, peer-group educators and teachers. Capacity-building of these health-care providers was undertaken by providing training. The purpose of the training was to orient the health-care providers with respect to the adolescent-friendly health and counselling services so that they would become a pull factor in attracting the adolescents and encourage them to avail themselves of the health-care services. The training also focused on how to improve the quality of services rendered.

The following criteria were set for the selection of adolescent health-care providers:

- has been trained in adolescent-friendly health services (has participated in the full training package);

- keeps and uses the training material given to him/her;
- is functional in sharing information, maintains records and provides data;
- participates in meetings and provides feedback;
- promotes adolescent-friendly health services; refers adolescents to adolescent-friendly health service facilities regularly and follows them up; and
- participates in promotional activities for adolescents, i.e., anaemia prevention and control, tetanus prevention, menstrual hygiene, family planning and prevention of sexually transmitted infections and HIV/AIDS.

The training was carried out using the training package developed by the Ministry of Health and Family Welfare. A five-day State-level training programme on adolescent reproductive and sexual health was undertaken by the Society for Women and Children's Health in collaboration with the State government. This was followed by training of trainers comprising medical officers/dental surgeons/counsellors in collaboration with the district trainers for a period of three days in 2008. These trainers in turn trained the lady health visitors/auxiliary nurse midwives/*anganwadi* workers in the district through five days of training. The details of the training sessions organized in Yamuna Nagar are given in table 2.

Table 2 | Capacity development in adolescent reproductive and sexual health (total number of training courses: 3).

Serial No.	Category of Trainer	No. of Trainees	Days
1.	Medical Officer	1	5
2.	School Medical Officer/Medical Officer	6	3
3.	Dental Surgeon	6	3
4.	Counsellor	2	3
5.	Lady Health Visitor/ Auxiliary Nurse Midwife	40	5
6.	*Anganwadi* Worker	20	5
	Total	**75**	

Communication with the Adolescents: Peer-group Educators

Adolescents/young people prefer to discuss sensitive issues with their peers. Keeping this in mind, the peer-group educators were selected to serve the school children/out-of-school adolescents in the community to deal with issues of a sensitive nature, to participate in selected

public health efforts (distribution of iron and folic acid tablets, tetanus toxoid, contraceptives, clean pads) and to increase use of adolescent-friendly health service centres. The criteria used for the selection of peer-group educators were as follows: is a good communicator, is acceptable to adolescents, is interested in work, is able to understand the problems of adolescents, has a good personality, and is confident and ready to work on a voluntary basis.

A total of 200 peer-group educators (100 males and 100 females) were selected from 88 villages and training was provided once a month by the Society for Women and Children's Health. Details of topics covered in the various rounds/phases of training and participants are summarized in table 3.

Table 3 | Topics covered and participants in the training of peer-group educators.

Rounds/Phases	Topic Covered	Number of Participants					
		PGE (M)	PGE (F)	Total PGEs	ASHA	AWW	ANM
1.	Selection Round	100	100	200	-	-	-
2.	Body Image	88	92	180	-	-	-
3.	Nutrition and Anaemia	86	86	172	41	-	-
4.	Health Problems	90	97	187	39	-	2
5.	Menstrual Problem	88	95	183	50	4	3
6.	Friendship, Love and Marriage	87	88	175	54	20	1
7.	Psychological Issues	92	86	178	53	10	3
8.	RTI, STI and HIV/AIDS	83	90	173	47	23	-
9.	STI, Sexual Health, HIV/AIDS	69	74	143	48	16	2
10.	Accidents	54	65	119	32	7	1
11.	Adolescent Pregnancy and Abortion	53	59	112	36	9	2
12.	RTI/STI/ Safe Sex	40	64	104	26	11	3
13.	Education, Employment and Work Plan	21	22	43	13	06	2

Note: PGE = peer group educator; ASHA = accredited social health activist; AWW = *anganwadi* worker; ANM = auxiliary nurse midwife; RTI = reproductive tract infection; STI = sexually transmitted infection.

Addressing the Adolescents Attending and Not Attending School

A sizeable proportion of adolescent girls and boys (about 35 per cent) were not attending school; therefore, school-based interventions were not expected to cover them. Keeping this in mind, peer-group educators were trained to raise awareness of the youths and peers to enhance the demand for services for the out-of-school adolescents.

Letter-box Approach

To encourage conversation on the issues and concerns of the adolescents and

maintain confidentiality, letter boxes were set up in selected schools and in selected villages. The adolescents were briefed that they could put the question, issue or any problem relating to health in the box without identifying themselves but that they should mention the class. A similar strategy was used for out-of-school adolescents by the peer-group educators. The letter boxes were opened once in a week and the answers were provided by project staff and subsequently by teachers and thereafter by the peer-group educators. It was observed that initially the questions asked were not related to reproductive or sexual health concerns but as a result of friendly discussion with the peer-group educators, more questions and concerns relating to sexual and reproductive health were gradually expressed to the project staff.

Frequently-asked-questions Approach

More than 10,000 questions were received. Based on these, a total of 105 most-frequently-asked questions and their responses were consolidated in the form of a simple book in English and in Hindi as a resource and material for training of selected peer-group educators. The training was participatory and the focus was on hands-on practice and on improving communication and counselling skills. It focused mainly on being able to provide accurate and adequate knowledge to the adolescents. It was stressed that wherever it was felt that the knowledge provided was inadequate or the adolescent did not appear convinced and/or there was a need for medical intervention, the peer-group educators should immediately refer such adolescents to the Medical Officer or the auxiliary nurse midwife.

During the monthly interactions, the peer-group educators were trained in how to fill out the Record Form. The follow-up of their work was done by reviewing the Record Form filled out by the peer-group educators and their ability to solve the adolescents' problems. An assessment of the work done was undertaken regularly by a community coordinator/counsellor in collaboration with health workers.

The peer-group educators were not remunerated for their work although they received 100 rupees as motivation to attend meetings and to cover the expenses that they incurred on travel to the place of training as well as expenses. All the key health-care providers and peer-group educators were given an identity card that helped the adolescents to identify them as adolescent-friendly health-care providers.

In the beginning, most adolescents approached the peer-group educators for their general health problems. These were addressed by referral and by taking the ill adolescents to local village doctors or auxiliary nurse midwives. After about six months, the trend had changed and the concerns reported were more psychosocial or reproductive and sexual in nature. This showed that the peer-group educators were able to increase the awareness of and demand for services. Besides the provision of accurate information, the

increase in demand for services was also attributable to the following: availability of trained and motivated providers who were adolescent-friendly; provision of services and supplies to adolescents; and the organization of a dedicated clinic on a fixed day and time of the week. The increased referral of about 271 adolescents by providers, volunteers and peer-group educators was an impressive contribution towards creating a demand in a population for availing the health facilities for reproductive and sexual health issues. It is important to emphasize here that the adolescents were reluctant to use these services before the intervention.

ENVIRONMENT-BUILDING THROUGH COMMUNITY INVOLVEMENT OF ADOLESCENT ACTION GROUPS

Involvement of community is essential to the sustainability of any intervention. The decision was taken to identify interested persons from the community (villages) and obtain their agreement to become adolescent-friendly providers. Therefore, community-based voluntary groups were established in 12 villages. They were called "adolescent action groups". The adolescent action group was formed as a voluntary group of 9 to 13 members comprising care providers and care recipients in the villages. The care providers included the auxiliary nurse midwives, *anganwadi* workers, accredited social health activists and school teachers. The care recipients included Mahila Panch (women's group), peer-group educators (male and female) and teachers. The idea was to bring convergence to the health and development of adolescents. An agreement was made to meet once in a month on a voluntary basis and participate in the activities that improve adolescent health and development.

Planning

A handout written in simple Hindi relating to the above-mentioned subjects was distributed. The plan identified a SMART objective to be achieved and included details of what, why, by whom, when and where. A detailed plan for implementation during the next one month was chalked out, which listed the roles and responsibilities of each member. A copy of the written plan was left with the peer-group educator or a member chosen by the group members for ease of reference and follow-up meetings. The programme of meetings also included the agenda to review the previous month, with identification of achievements and gaps.

From the beginning of the project, eight meetings were held for each action group and were attended by more than 77 per cent of the group members. In order to provide recognition to the action groups, efforts were made to take up the adolescent sexual and reproductive health issues with the village health and sanitation committee. The experience showed that these health and sanitation committees had not been constituted or were not functional. Therefore, the adolescent action group served as the starting point for the functioning of such a committee.

The subjects covered in the meetings of adolescent action groups included: prevention and control of anaemia; menstrual problems and menstrual hygiene; adolescent pregnancy and unsafe abortion; and prevention of reproductive tract infections, sexually transmitted infections and HIV/AIDS among the adolescents and young people.

The adolescent action group succeeded in bringing about convergence in the services, an improved understanding among the providers of services and a supportive community attitude towards the goals and objectives of the adolescent health and development programme. It helped to remove any doubts and misgivings concerning the sensitive nature of the issues to be addressed in the community and it was enthusiastic in providing cooperation in supporting different aspects of the implementation of various adolescent reproductive and sexual health activities in the village. The adolescent action group took the initiative to establish intersectoral convergence wherever it did not exist and strengthen existing linkages wherever they were already in place.

Organization of Youth *Melas* (Youth Fairs/Festivals)

Youth *melas* (youth fairs/festivals) were organized as per the State programme Implementation Plan as a partnership between district health authorities and the Society for Women and Children's Health. During the one-year implementation period, six such fairs were organized, with the objective of mobilizing the adolescents and youths in the community. The intent was to increase the awareness of and enhance the demand for services. The attendance at the youth festivals was as follows: 550 persons at Kot, 573 at Kharwan, 601 at Khizrabad, 327 at Primary Health Centre Bhurian, 356 at Naharpur and 486 at Kalanaur.

The activities were comprised of debate competitions, poster competitions and slogan competitions on topics relating to adolescent and other issues of concern such as: the right age for marriage, sexually transmitted infections, HIV/AIDS, substance abuse, alcohol and tobacco addiction, female foeticide and education of the girl child, short height, the dowry, climate change and nutrition. Cultural shows were also organized during the youth festivals that dealt with prominent issues relating to adolescent health by organizing role plays, street plays and folk dances.

Important Outcomes of Peer-group Educators

During the monthly interactions with peer-group educators and other village-based health workers, the adolescents seen in Yamuna Nagar District were reviewed by the staff of the Society for Women and Children's Health. Male peer-group educators reported having addressed 13,193 problems and concerns of the male adolescents. The female peer-group educators reported having addressed 20,653 problems and concerns of female adolescents. Accredited social health activists reported having handled 3,317 concerns, i.e., 9.8 per cent of the

total cases. The types and numbers of problems and concerns addressed by peer-group educators and health workers are summarized in table 4.

Table 4 | Types and numbers of problems and concerns addressed by peer-group educators.

Serial No.	Type	Male No.	(%)	Female No.	(%)
1.	Body image	6,308	(47.8)	9,535	(46.2)
2.	Food and eating habits	249	(1.9)	333	(1.6)
3.	Health-related concern	4,645	(35.2)	6,002	(29.1)
4.	Substance abuse and its consequences	157	(1.2)	26	(0.1)
5.	Problem relating to menstruation	-	-	2,915	(14.1)
6.	Sexually transmitted infection, HIV/ AIDS and sexual health	604	(4.6)	492	(2.4)
7.	Friendship, love and marriage	56	(0.4)	67	(0.3)
8.	Psychological and emotional problems	973	(7.4)	1,148	(5.6)
9.	Economic problem	201	(1.5)	135	(0.6)
	Total	**13,193**	**(100.0)**	**20,653**	**(100.0)**

government on a regular basis. Each volunteer, worker and doctor was contacted at least once a month. This provided an opportunity to review the progress of the work, identify problems and decide about the possible solutions.

Evaluation Mechanisms

Two types of evaluation were conducted to identify the impact of the interventions: the household survey and the quality assessment of the adolescent-friendly health services.

Assessment and Evaluation

Monitoring Mechanism

Monitoring was undertaken by using the reporting formats provided by the State

Evaluative Results of the Household Survey

The evaluation of the impact of adolescent reproductive and sexual health innovations was undertaken with the help of a household survey conducted in Yamuna Nagar 10 months after the implementation of the project. The tool for this survey included a questionnaire, which was developed by the Society for Women and Children's Health, with technical and financial support from the World

Health Organization Headquarters. The household survey was carried out in two areas of the Yamuna Nagar District, Haryana. One area represented the implementation site of the adolescent reproductive and sexual health interventions and the other a control area where the interventions had not been implemented. In both areas, 30 village clusters each with a total of 600 adolescents were covered. After thorough training of the surveyors, the survey was carried out in November 2008 in a two-week period during which 1,193 adolescents were interviewed.

The findings of the household survey on various indicators are as follows:

Coverage of adolescent-friendly health services

- The awareness of adolescent-friendly health services in the intervention area (68 per cent) was more than eight times that in the control area (8 per cent).
- The use of government health facilities was 55 per cent in the intervention area compared to 36 per cent in the control villages. Among the government health facilities visited, the sub-centre topped the list, followed by the community health centre and the district hospital.
- The supply of contraceptive services to unmarried adolescents was denied to a majority both in the control as well as in the intervention area.
- A higher proportion of adolescents in the intervention area (83 per cent) understood the explanations about the health problems compared to 42 per cent in the control area.
- Only 39 per cent of adolescents in the control area reported the availability of medicines while this figure was 80 per cent in the intervention area. Furthermore, a large proportion of adolescents visited private providers (qualified and unqualified) in the control area.

Coverage for the prevention and control of anaemia

- Awareness of anaemia and understanding about it were substantially higher (82.6 per cent) in the intervention area than in the control area (49.4 per cent). In the intervention area, almost all the adolescents were aware of the role of iron and folic acid tablets and a good diet in the prevention and control of anaemia.

  According to adolescents, the availability of iron and folic acid tablets is greater in the intervention area (94 per cent) than in the control area (73 per cent). About 89 per cent of the adolescents received the deworming tablet free of cost in the intervention area while only 52 per cent received the same in the control area.

Coverage in the use of sanitary pads

- Sanitary pads were used by 56.3 per cent in the intervention group in comparison to only 29.6 per

cent in the control villages. Local peer-group educators and volunteers were popular providers in the intervention villages.

- In both areas, the reasons for not using the sanitary napkins were:
  - too embarrassed to obtain the pads;
  - lack of knowledge about their availability;
  - too expensive; and
  - did not perceive any problems with current practice of using home-made pads.

Coverage of sexually transmitted infections, HIV/AIDS and contraceptives

- Although more than 85 per cent of adolescents in both areas were aware of HIV/AIDS, the knowledge of sexually transmitted infections was substantially higher in the intervention villages (73 per cent) compared to the control villages (27 per cent). The main source of information was the peer-group educator in the intervention area. The knowledge of the role of the condom in preventing HIV/AIDS was 20 percentage points higher in the intervention area compared to the control area. The knowledge about contraceptive availability was higher in the intervention villages (90 per cent) compared to the control villages (64 per cent).

The findings of the household survey showed the positive effect of the implementation of the adolescent-friendly health services strategy in the District. It also provided a benchmark for the control area. The survey showed a very low proportion of married adolescents and an extremely low proportion of pregnant adolescents. The fact that awareness of adolescent-friendly health services was high in the intervention area was attributed mainly to the influence of peer groups and locally available health services from health-care providers.

Evaluative Results from Quality Assessment

Quality assessment was done based on the seven standards of adolescent-friendly health services set out in the Adolescent Reproductive and Sexual Health Implementation Guide of the Ministry of Health and Family Welfare about 15 months after establishing adolescent-friendly health services. These are summarized below. A comprehensive tool was developed for assessment of the standards of adolescent-friendly health services covering all seven standards recommended in the Implementation Guide by the Government of India. The tool provided information on the general performance of the provision of health services at the sub-centre and primary health-centre levels as well as information on the quality of adolescent-friendly health services.

The objectives of the quality assessment of adolescent-friendly health services were to:

- assess the current status of the quality of care delivered under

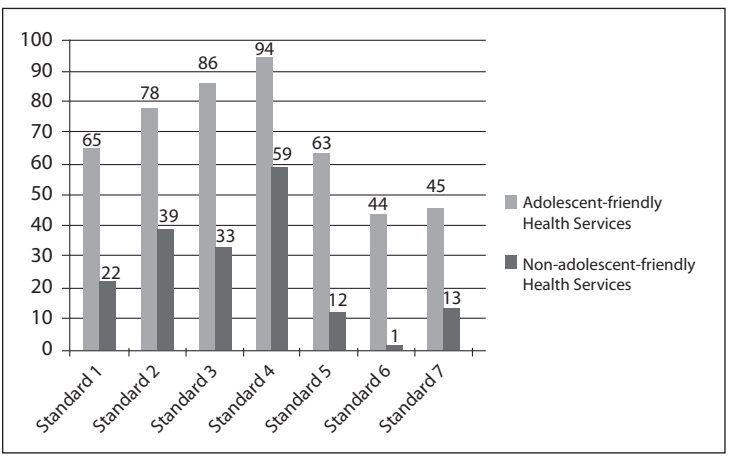
adolescent-friendly health services at selected health facilities in Haryana;

- determine the availability of key types of health system support required for implementation of the adolescent-friendly health services;
- identify the principal barriers to effective implementation of adolescent-friendly health services; and
- compare the quality of health-care services provided to adolescents in the identified adolescent-friendly health service facilities and non-adolescent-friendly health service facilities.

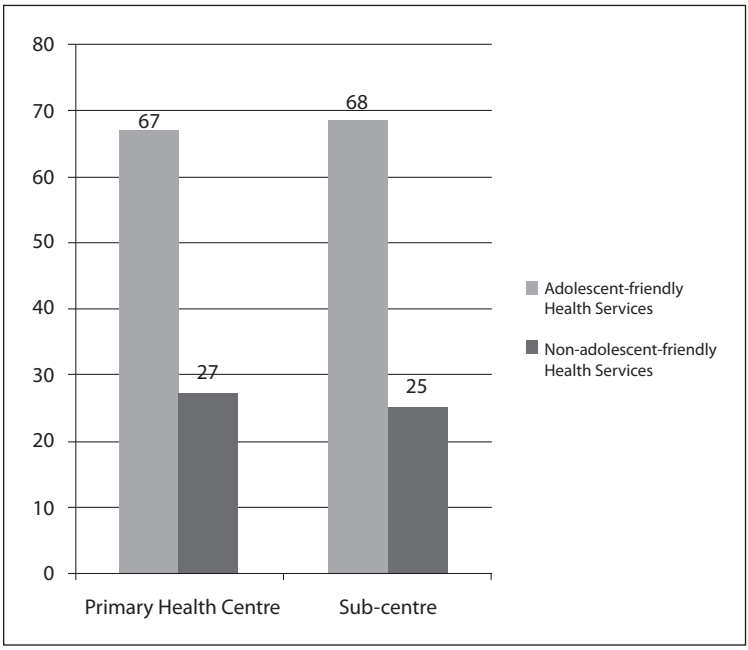
Seven standards set by the Government of India were used for the quality assessment of adolescent-friendly health services:

1. Health facilities provide the specific package of health services that adolescents need.
2. Health facilities deliver effective services to adolescents.
3. Adolescents find the environment at health facilities conducive to seeking treatment.
4. Service providers are sensitive to adolescent needs and are motivated to work with them.
5. An enabling environment for adolescents to seek services exists in the community.
6. Adolescents are well informed about the health services.
7. Management systems are in place to improve/sustain the quality of health services.

The key findings of the quality assessment of the performance of facilities where adolescent reproductive and sexual health services were implemented for about one year showed substantial achievement in all the standards set for the quality of care of services for adolescents as compared to facilities where the programme had not been introduced. Noticeable differences were observed in the implementation of all seven standards (graph 1). The majority of the adolescent-



Graph 1 | Implementation of standards in adolescent-friendly and non-adolescent-friendly health service facilities.



Graph 2 | Performance of health facilities designated as adolescent-friendly and non-adolescent-friendly.

friendly health service facilities scored above 50 per cent and as high as 94 per cent, whereas all non-adolescent-friendly health service facilities scored below the average and as low as 1 per cent.

As stated earlier, the success of the adolescent reproductive and sexual health strategy in the District of Haryana has been attributed to implementation of all seven standards set for the quality of care of services for the adolescents. The differences in the attainment of standards by adolescent-friendly and non-adolescent-friendly health services are summarized in box 2.

Box 2 | Differences in the attainment of standards by adolescent-friendly and non-adolescent-friendly health facilities.

Key Indicator	Survey Result
Standard 1: Health facilities provide the specific package of health services that adolescents need.	
Dedicated adolescent-friendly health service clinics	Nine out of ten centres were organizing adolescent-friendly health services for a period of at least 2 hours per week.
Referral services	Referral services and procedures were in place in 60% of the health facilities in the intervention area and were found to be functional.

Box 2 | Differences in the attainment of standards by adolescent-friendly and non-adolescent-friendly health facilities (continued).

Key Indicator	Survey Result
Outreach services	Health services and health-education activities were being organized as outreach services in 69% of the intervention-area facilities while some health-related activities were reported in 27% of the control-area facilities.
Equitable services	Services to the adolescents were reported to be equitable (i.e., they were provided irrespective of age, sex or social status) in 77% of the health facilities in the intervention areas as compared to 44% in the control areas.
Standard 2: Health facilities deliver effective services to adolescents.	
Staff adequacy and training relating to adolescent-friendly health services	More than 60% of the staff in the intervention villages considered themselves competent and skilled to manage the problems of adolescents while this proportion was only 25% in the control villages. The reason for this lower percentage is that only some of the staff members in the control villages had received some training that related to adolescent health.
Drugs and supplies	Drugs and supplies were available to the adolescents in a higher proportion (81%) in the intervention areas compared to only 54% in the facilities where the programme was not implemented. Some staff members in the intervention areas agreed to give iron and folic acid tablets to adolescents and condoms by making condoms accessible without embarrassing the staff or the adolescents.
Waiting time and medical consultation	According to the perception of the 120 adolescents interviewed, the waiting time and the time spent during consultation were satisfactory and acceptable to more than 90% in both the control and intervention groups.
Standard 3: Adolescents find the environment at health facilities conducive to seeking treatment.	
Basic amenities and conveniences of adolescent clients	Basic amenities as assessed by the adolescents were considered satisfactory by 85% of the adolescents interviewed in the intervention area while the comparable proportion was 32% in the control area.

Box 2 | Differences in the attainment of standards by adolescent-friendly and non-adolescent-friendly health facilities (continued).

Key Indicator	Survey Result
Provision of privacy and confidentiality	Adolescents were satisfied about the privacy and confidentiality during consultation with health-care providers (8 to 9 out of 10 adolescents) in the intervention area as compared to three out of 10 in the control area.
Standard 4: Service providers are sensitive to adolescent needs and are motivated to work with them.	
Provision of supportive and non-judgmental care for adolescent clients	The interpersonal skills of providers were used to demonstrate supportive and non-judgmental care in 88% of the instances in the intervention area compared to only 38% in the control area.
Standard 5: An enabling environment exists in the community for adolescents to seek services.	
Information, education and communication materials and information dissemination	Communication materials relating to adolescent reproductive and sexual health were available and distributed to 80% of stakeholders in the intervention villages and none in the control areas. Linkages with 70% of stakeholders in the community were established in the intervention villages and with only 40% in the control villages. Mass media and folk media were playing a minimal role in the control as well as the intervention villages.
Standard 6: Adolescents are well informed about the health services.	
Awareness and communication activities in communities on adolescent reproductive and sexual health/adolescent-friendly health services	There was no evidence of awareness-generating activities in the control area. In the intervention area, awareness was being created through *anganwadi* workers, accredited social health activists, peer-group educators and other outreach mechanisms.
Standard 7: Management systems are in place to improve/sustain the quality of health services.	
System of reporting and monitoring adolescent-friendly health services information	Records for adolescents were maintained in all facilities but were not kept confidential. Efforts were made to keep separate records in 40% of the facilities. Even though the data were collected, they became a part of information only in 30% of the facilities in the intervention villages. Supportive supervision was claimed to have been undertaken by 40% of the managers in the intervention area and only 10% in the control area.

Recommendations by the project implementing authority regarding quality assessment, were as follows:

- The tool for quality assessment needed to be reviewed and revised (a) for quality assessment for planning adolescent health services at the State/national level, and (b) because a greatly simplified version was required for quality assessment and quality improvement at the local level. If possible, the simplified tool should be integrated with the Reproductive and Child Health-II project. In addition, the tool needed to be translated into local languages.
- The quality assessment tool should add on an observation element and focused group discussion to improve it further.
- Additional tools for assessment of clinical skills needed to be developed.

Successes and Lessons Learned

Successes

The success of the interventions is attributable to the adoption of a three-fold strategy:

- addressing the intended beneficiaries of the adolescent-friendly reproductive and sexual health services (target group);
- addressing the health problems/issues that need to be addressed (service package); and
- involvement of the service providers of the health facilities.

Pull-and-push Approach

The Intervention adopted a dual strategy of "pull and push". The "pull" strategy attracted the adolescents to avail themselves of the health services, which were made more adolescent-friendly. The "push" strategy focused on enhancing the service delivery package and organizing the effective services by the Government of India.

Quality Services

The intervention focused on improving the quality of services rendered. Success was demonstrated by the implementation of the seven standards set forth in the Implementation Guide mentioned earlier.

Assuring Accessibility

The case study clearly demonstrated that assuring access to the adolescent-friendly health clinics on the dedicated days resulted in an increase of a substantial number of cases seen and referrals made to the primary health centres.

Adolescent-friendly Health Services

Another reason for the success of the intervention was the adoption of the adolescent-friendly approach and the attitude of the health workers in the general Outpatient Departments. The health personnel addressed the issues with appropriate counselling and maintained confidentiality and privacy.

Providing Information about the Health Services to Adolescents

Youth festivals provide an opportunity for adolescents and young people to advocate for adolescent health and address social issues such as early marriage, sex selection, dowry, household violence and the dangers of HIV/AIDS. Advocacy measures used during the programme such as the logo, the setting up of notice boards to identify adolescent-friendly health clinics, the display of posters that articulate the services available for the adolescents, and the provision of identity cards to adolescent-friendly providers were found to be extremely useful.

Delivering Effective Services to Adolescents

Capacity-building of the health personnel is an important aspect of delivering effective services. A systematic approach to building the capacity of all health personnel and peer-group educators was adopted by conducting training. The training sessions were assessed for quality, which was rated as high.

Regular Supply of Essential Items

The timely supply of items such as condoms is an important measure of the quality of services. If the supplies meant for adolescents are not provided regularly in the health facility, this dampens the enthusiasm of newly inducted peer-group educators.

Intersectoral Convergence

Forming "adolescent action groups" and engaging them for voluntary work for a period of about one year demonstrated that the caregivers (auxiliary nurse midwives, accredited social health activists, *anganwadi* workers, teachers, etc.) and the community (peer-group educators, Mahila Panch (women's group), other activists in the village) can bring about a convergence in the services for adolescents.

Monitoring and Evaluation

The monitoring of adolescent reproductive and sexual health services focused on problem identification, solving problems through appropriate activities, and tracking the progress made on the take off and use of adolescent reproductive and sexual health services. For this purpose, the monthly adolescent reproductive and sexual health-service register was created, which reflected the progress in training and communication activities.

Health Management Information System

In the Indian context, although the information about the adolescents is recorded in the registers and the information on adolescents visiting the public health facilities is available, the information is incomplete and never analysed. It is not included in the reporting format of the Reproductive and Child Health project. There is a need to insist that the health-care providers collect data accurately and incorporate them into the information system. This should become a part of the monthly reporting format.

This case study provides an example of policy planning and adopting and implementing an adolescent-friendly

approach in line with the National Rural Health Mission and the Reproductive and Child Health-II project. It demonstrates that this is only the first step and that the application of the best practice through continuous innovation is necessary for the success of the programme.

Lessons Learned

The following lessons can be drawn from the implementation of the innovative practice described in this case study:

- Training of all levels of health-care providers is essential to make the health service adolescent-friendly. However, one-time training is not sufficient. Regular, follow-up, interactive training and supportive supervision are equally necessary to sustain it.
- Age- and sex-disaggregated data, particularly on adolescents, are still not maintained. The existing health information management system has not yet internalized the data.
- The peer-group-educator model works well in addressing adolescents' concerns provided that the educators receive quality training followed by regular contact and support to keep their motivation level high.
- The performance of school-going peer-group educators shows a decline during examination days.
- The adolescent action group can be a good advocacy mechanism at the grass-roots level to improve adolescent health.
- Awareness and advocacy can bring behavioural change among adolescents provided that there is a regular supply of essential commodities, e.g., iron and folic acid tablets, sanitary napkins and condoms.
- With respect to addressing the concerns of male peer-group educators, one of the lessons learned is that, although the services to the adolescents have been provided equitably, the adolescent males were at a disadvantage since all the service providers were females below the primary health-centre level. Male adolescents were reluctant to consult the female health-care providers, especially when the reason for the visit related to sexual or reproductive health concerns as well as psycho-social problems. Even though male peer-group educators assisted in addressing the problems of male adolescents, there was still a big difference in the number of adolescents who contacted them in comparison to females. This concern needs to be addressed by the programme since male involvement is crucial to the success of the reproductive and sexual health of male adolescents.

Future Plans: Extensions

Strengthening the Clinical Skills

In addition to the adoption of an adoles-

cent-friendly health services approach, it would be necessary to strengthen the clinical skills of the providers trained in adolescent-friendly health services. The credibility of health-care providers would increase only when they were able to effectively and convincingly treat and counsel the adolescents in addition to using an adolescent-friendly approach.

Adding Climate Change to the Training Curriculum

Climate change and its adverse impact on health constitute a problem that concerns all adolescents. The youths and adolescents can play a meaningful and decisive role in addressing this problem.

Efforts to Improve the Nutritional Status of Adolescents

Efforts to improve the nutritional status of adolescents and tackle the widespread problem of anaemia can contribute to nation-building in addition to addressing the health and reproductive problems of adolescents and youths. A supportive and specific policy in the form of once-a-week iron and folic acid supplementation as a package for anaemia control and mid-day meal programmes as an entry point for achieving optimum potential for physical growth should contribute to the scaling up of the programme to include a large number of beneficiaries. This would contribute significantly to higher educational attainments and productivity in employment.

Use of Sanitary Pads and Napkins

Even though efforts have been initiated to promote and popularize the use of clean pads during menstruation, these need to be scaled up and sustained. The main challenge to be addressed is not so much demand creation or unaffordable cost; rather, it is related to lack of access.

Replicability

Prerequisites for Replication

- **Supportive policy.** A support policy to ensure supplies to adolescents that relate to basic rights of all adolescents irrespective of age, sex, caste or creed is the basis for improving the quality of services rendered to adolescents.
- **Strategic information.** Strategic information would be required for replicability in order to quantify the felt needs based on age and disaggregated by sex. Further, the assessment of coverage and assessment for quality improvement based on the seven standards articulated in the Implementation Guide would have to be set forth based on felt needs and baseline data.
- **Resources.** Additional resources would be required to add value to the existing sexual and reproductive health services within the framework of the National Rural Health Mission. It would be crucial to recognize the vast unmet

needs of adolescents. In this context, resource commitment is to be considered as a critical investment.

- **Capacity development of male health-care providers.** Limited provisions for the male adolescents to be able to obtain guidance and treatment for their personal, sexual and reproductive problems and concerns from males have been one of the major weaknesses. There are no male health workers or volunteers below the level of primary health centres. Therefore, in the majority of the cases, the closest accessible place for the males is a public health centre. This situation deprives the male adolescents of access to information and services close to the place of their residence. Without male involvement, the success of the adolescent reproductive and sexual health programme cannot be achieved to its fullest. Capacity development with a focus on community-based providers to meet the enormous needs of this large population by training more male peer-group educators would ensure increased success of the programmes.
- **Sustainable partnerships and partnership with a mentoring agency.** Partnership with key sectors such as education and the media and entities such as village health and sanitation committees, the Department of Women and Child Development, the Department of Youth and Sports, and Panchayati Raj institutions would have to be created and sustained. The NGOs could take a forward-looking role in mentoring, initiating and sustaining intersectoral linkages.
- **Role of NGOs.** This case study highlights the value addition from the partner NGO with substantial and sustained efforts along with the government staff at all levels. The evidence-based innovations have helped to sharpen the implementation of the Programme Implementation Plan, with the government and the NGO partner contributing to demand-generation and quality improvement. Such mentorship should be taken forward to bring optimal returns on the investments made.

Experiences of Replication in Other Areas and Contexts

In the programme context, adolescent reproductive and sexual health is a new addition to the Reproductive and Child Health-II project. In terms of implementation, the experiences are only beginning to emerge. The Society for Women and Children's Health, in partnership with the State of Haryana and district authorities, has implemented most of the recommendations of the Ministry of Health and Family Welfare as articulated in the national strategy and Implementation Guide of the Government of India, with the addition of some innovations in programme implementation.

The experience can be replicated in other areas and contexts with greater

optimism since the intervention package, tools for capacity development, knowledge of what works, and tools for monitoring and evaluation have been developed, tried and tested. However, it would be wise to plan for a limited implementation initially rather than widespread rapid expansion. Carefully monitoring and reviewing the experience of implementation in selected areas of districts representing different geographical areas would also be crucial. Until the programme is widely implemented, partnership with a mentoring agency such as the Society for Women and Children's Health would be of critical importance.

Suggested Steps for Replication

Suggested steps for replication are as follows:

- conduct a mapping exercise to undertake a situational analysis and needs assessment of the adolescents and the community;
- plan and implement an adolescent reproductive and sexual health strategy (adolescent-friendly health and counselling services) in selected areas for at least one year before expanding it to other areas. Expansion should build on the experience and lessons learned;
- involve a mentoring agency for guidance, capacity development, close monitoring and evaluation to facilitate effective implementation, expansion and future planning;
- undertake an annual review of progress at the State level and a quarterly review at the district level based on the standards for quality assurance;
- incorporate quality assessment and quality improvement into the programme as an ongoing process and integrate them with the reproductive and child health programme;
- increase coverage progressively over a period of the next five years to ensure full coverage by the end of that period and undertake mid-course corrections on a yearly basis as guided by the experience.

Potential for Partnerships

Selected partnerships should be explored with the departments that already have high stakes in adolescent health. These include Education, Women and Child Development, Youth and Sports, and Media as well as Panchayati Raj institutions/elected leaders.

The following collaborating departments/institutions have also undertaken many related activities such as:

- conducting the annual school health examination: Education;
- *kishori shakti yojna*: Women and Child Development;
- mid-day meal programme: Education;
- cultural and other activities: Youth and Sports;
- media exposure: Media; and

- village health and sanitation committees: Panchayati Raj institutions.

These activities serve as building blocks for the sustainability of partnerships and further development of intersectoral coordination and networking. The Health Department should contribute to the capacity development of key persons in the above-mentioned departments by providing accurate information and essential health-related supplies and participate in the periodic review of progress.

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5

Indonesia

Importance of Community Participation in the Implementation of the Family Planning Programme

Mr. X. Sukamdi

Summary

The Family Planning Programme in Indonesia has evolved in two phases. First, during the New Order era (a term coined by former President Suharto to distinguish his regime from that of his predecessor when he came to power in 1966) and with strong support from the Government, the number of participants in the Programme increased significantly. The declining fertility rate has slowed population growth, which is turn has had a positive impact on the poverty alleviation programmes. Involvement of community leaders, non-governmental organizations (NGOs) and civil society organizations was key to the success of the Programme. Indonesia is the biggest Muslim country in the world. Working closely with Muslim organizations and key leaders to get their support, the Family Planning Programme was able to forestall any objections on the part of religious leaders or opposition parties.

The second phase unfolded following the Southeast Asian economic crisis, governmental change and decentralization at the end of the 1990s and early 2000s. In difficult economic circumstances and in a decentralized context, the Government was forced to scale back its commitment to family planning, which made it more difficult for people to obtain family

Summary (continued)

planning services. Today the Government has introduced the Income-generating Activities for Prosperous Families (Usaha Peningkatan Pendapatan Keluarga Sejahtera, UPPKS) Programme to increase participation in family planning across the board.

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Background

Population policy in developing countries has been influenced mostly by the conceptual framework that posits that a fertility decline would slow down population growth and thus reduce poverty. This view was influenced by neo-Malthusian thinking, which has become part of the global development debate since the 1950s and which gave birth to the term "population control". Even though this view was challenged by differing perspectives in the 1980s and 1990s, which claimed that demographic considerations are largely irrelevant to poverty reduction, research does show that there are potential benefits of slower population growth. However, the benefits depend on the timing and intensity of demographic change (Merrick, 2002).

The case of Indonesia might be the best example of how the concept became the driving force behind the development of population policies in the first 30 years after the collapse of the Old Order regime in which a family planning programme was implemented when there was lower population growth. The Old Order (in Bahasa Indonesian: *Orde Lama*) is the term that refers to the period 1945-1965 in which Sukarno ruled the country. The term was used by Suharto to contrast the previous administration with his administration, which was called the New Order era (1965-1998) after he succeeded Sukarno in 1965.

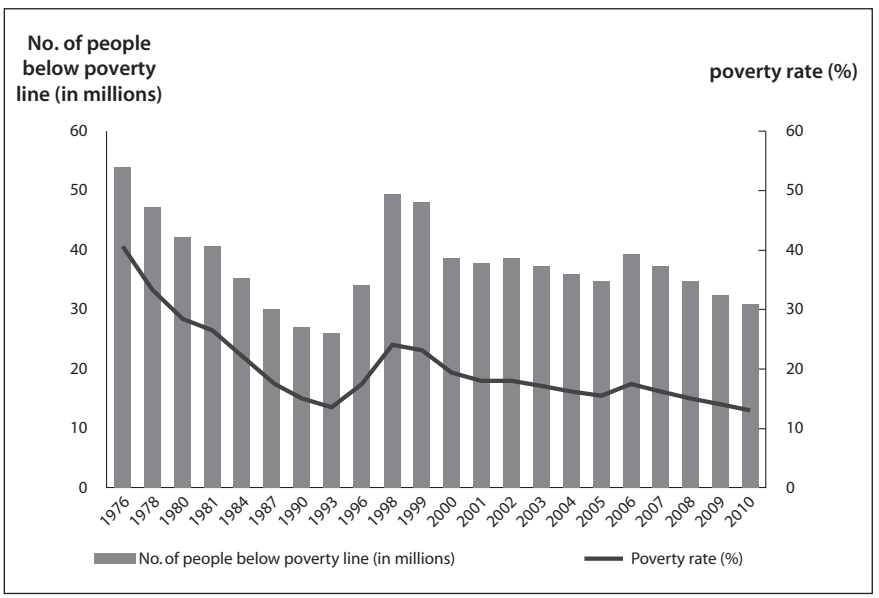
Despite an opposing view from some experts (Hull and Hull, 2005), the popular view sees population policy in Indonesia as being divided into two major types: pro-natalist during the Old Order and anti-natalist during the New Order. In the New Order era, economic development was the first priority, but President Suharto did not think that population concerns would take care of themselves (Neihof and Lubis, 2003, p. 6). The technocrats consider population to be an important variable in economic development and are convinced that

there is an inverse relationship between population growth and economic growth (Lubis, 2003, p. 32). Hence, the National Family Planning Programme was designed to lower population growth and was given high priority during the New Order. The Government heavily backed the Programme.

Since economic development is the priority to accelerate economic growth in order to improve people's welfare, the performance of development during the New Order era can be seen first from the declining poverty rate. As shown in graph 1, the poverty rate decreased significantly from 1970 to 1996 not only in terms of relative but also absolute value. In 1976, there were more than 50 million people (40.1 per cent) classified as poor; this number decreased to 34 million (13.3 per cent) in 2006. On average, the number of people living below the poverty line declined by more than one million. It is very clear that the poverty alleviation programme has played an important role in reducing the rate of poverty, but it cannot be denied that the declining population growth has also contributed to poverty reduction. At the very least, the declining population growth has made it easier to implement the poverty alleviation programme.

During the period 1971-1980, the annual population growth rate was 2.32 per cent and in the period 1990-2000, it was 1.44 per cent, the lowest level in

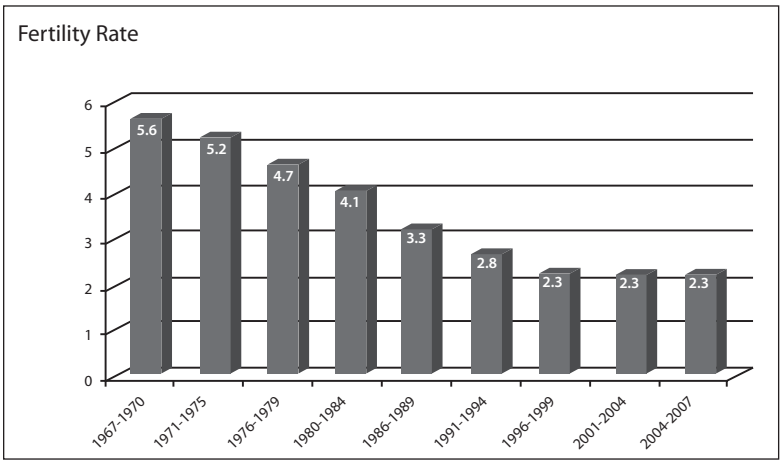
Graph 1 | Population living below the poverty line and the poverty rate in Indonesia, 1976-2010.



Note: The poverty rate is calculated based on the national poverty line.

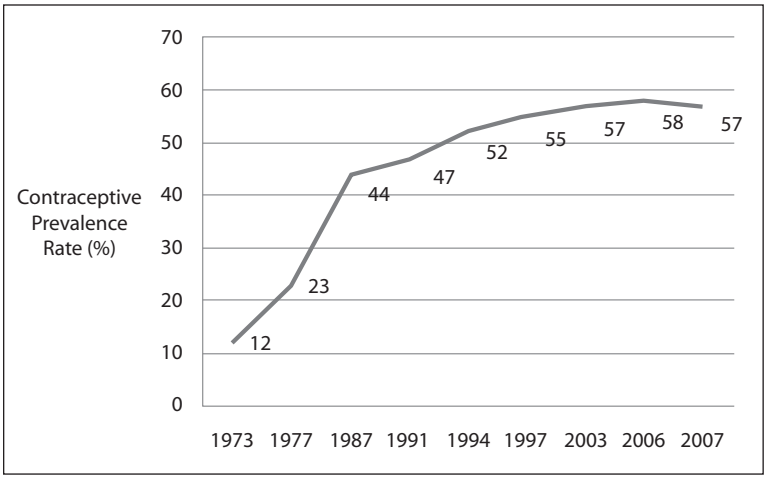
Sources: Central Body of Statistics (Badan Pusat Statistik, BPS) (2009), p. 2; BPS (2010), p. 3; and Yulaswati (2009).

Indonesian history. The decrease in population growth has been attributed to the family planning programmes that have been in place and that have been a government priority since the 1970s. Graph 2 shows clearly that the total fertility rate decreased by more than half, from 5.6 births per woman during the period 1967-1970 to 2.3 births per woman during the period 1996-1999. This decrease can be thought of as a revolution since the total fertility rate fell by more than half over a relatively short period (Hull, 2005). The drop in the fertility rate of the country is associated with the impressive performance of family planning. Contraceptive use (the contraceptive prevalence rate) increased nearly five-fold, from 12 per cent in 1973 to 55 per cent in 1997 (graph 2).



Graph 2 | Total fertility rate, 1967-2007.

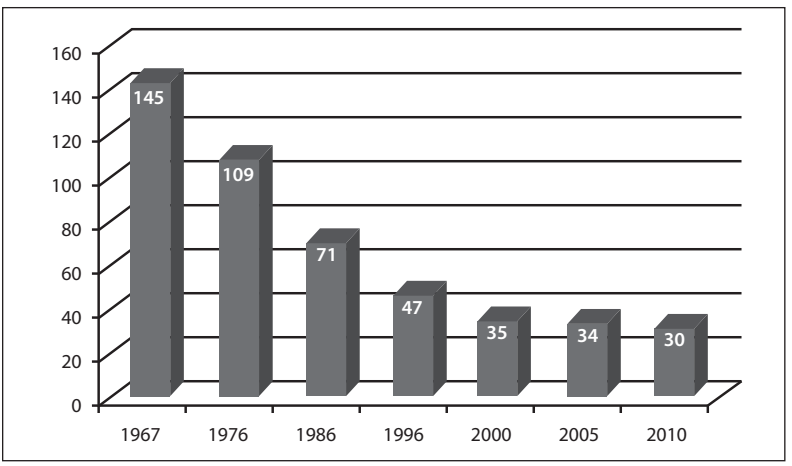
Sources: Central Body of Statistics (Badan Pusat Statistik, BPS) (2006), p. 37, and Hartanto and Hull (2009).



Graph 3 | Contraceptive prevalence rate (as a percentage), 1973–2007.

Sources: Mize and Robey (2006), p. 14; Adioetomo and Sarwiono (2009), p. 14; and the Central Body of Statistics (Badan Pusat Statistik, BPS), National Family Planning Coordinating Board (Badan Koordinasi Keluarga Berencana Nasional), Departemen Kesehatan, dan Macro International (2007), p. 72.

The decrease in the birth rate is meaningful because, at the same time, the infant mortality rate also declined significantly (graph 4). In 1967, the infant mortality rate in Indonesia was 145 per 1,000 live births. Over 30 years, that rate fell to 47 per 1,000 live births, a 70 per cent decrease in the rate. This can also be interpreted as another revolution outside the demographic revolution in fertility.



Graph 4 | Infant mortality rate, 1967-2010.

Notes: Data for 1967-1996 are based on the 1971, 1980, 1990 and 2000 population censuses; data for 2000 and 2005 are based on the 2002-2003 and 2007 Demographic and Health Survey; and data for 2010 are based on the *2010 World Population Data Sheet.*

Since the New Order era, population policy has been perceived to be integral to national development. It is therefore interesting to observe how this policy, especially the Family Planning Programme, has been implemented. This case study aims to increase the understanding of the implementation, challenges and achievements of the Family Planning Programme. From this understanding, lessons can be drawn for use in replicating or adapting the experience.

Implementation

The Family Planning Programme began when President Suharto, together with 30 other Heads of State, signed the United Nations Declaration on Population: World Leaders Statement in 1967. This was a milestone for national population policy and family planning in Indonesia and was supported fully by the Government.

In his address to Parliament in early 1968, President Suharto clearly stressed the need for community involvement in the Family Planning Programme. He stated that the Government would support family planning activities conducted by the community with aid and guidance from the Government. The commitment of the Government to implementing an effective family planning programme was signalled by the establishment of the National Family Planning Institute

(Lembaga Keluarga Berencana Nasional) created following the President's Instruction no. 26, in October 1968. The main tasks of the Institute were to promote family planning, to coordinate family planning activities, and to advise the Government on population issues (Sarwono, 2003, p. 29). Through Presidential Decree no. 8 of 1970, the Institute was invested with full responsibility for the Family Planning Programme. This decree transformed the mission of the Institute from advice, promotion and coordination of family planning activities to that of being fully responsible for coordinating the Family Planning Programme. The new initiative was named the National Family Planning Coordinating Board (Badan Koordinasi Keluarga Berencana Nasional, BKKBN).[1]

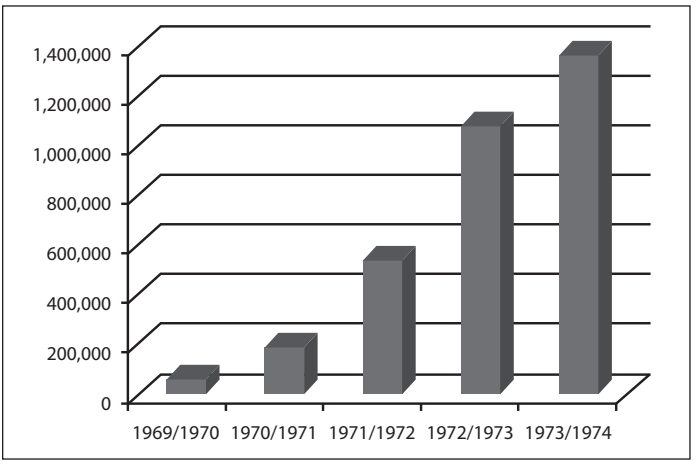
It is important to note, however, that the establishment of the National Family Planning Coordinating Board cannot be separated from the family planning pioneer, the Indonesian Planned Parenthood Association (Perkumpulan Keluarga Berencana Indonesia, PKBI), which was founded in December 1957. This organization obtained legal status in 1967 in the transition period from the Old Order to the New Order government. This implies that it was not the Government that first paid attention to the importance of family planning to control population but the NGOs. Thus, family planning as a movement existed long before the Government officially declared the Family Planning Programme to be a national programme. In the history of the Family Planning Programme in Indonesia, this pioneering period, 1950-1970 (Kantor Menteri Negara Kependudukan dan BKKBN, 1995, pp. 37-46), is the first phase.

The second phase was the development period (1970-1990) consisting of the first four periods of the Five Year Development Plans (*Rencana Pembangunan Lima Tahun*, REPELITA). During this phase, the Government committed to implementing the Family Planning Programme. This commitment can be seen from the inclusion of the Programme in the First Five Year Development Plan (1969/70-1973/74). Thus, the Family Planning Programme was an integral part of national development policy. The interesting point is that, as stated in the Plan, the Programme was not only important to lower population growth to support the economic development of the country but it was also beneficial for the health of mothers and the well-being of families. It had this dual objective from the start (Lubis, 2003).

During the initial phase, especially during the First Five Year Development Plan, the Family Planning Programme in Indonesia focused on the Java-Bali islands. Performance of the Programme during this period (1969/1970-1973/1974) was remarkable. In the first year of the Programme, there were only 53,103 participants but this number increased to 1,369,077 by the end of the period

[1]Hull (2003, p. 69) argues that the National Family Planning Coordinating Board (Badan Koordinasi Keluarga Berencana Nasional, BKKBN) was much more than a coordinating agency because it took on more implementation.

(graph 5). This means that in the first five years of the Programme, the number of participants increased by more than twenty-fold. During the whole period, the total number of family planning participants was 3,201,458, which was more than the targeted number of participants (3,025,000).



Graph 5 | Number of participants in the National Family Planning Programme, 1969/1970 to 1973/1974.

Source: Kantor Menteri Negara Kependudukan dan BKKBN (1995), p. 73.

Beginning in the period of the Second Five Year Development Plan, the Family Planning Programme expanded to the outer islands of Indonesia, including Aceh, North Sumatra, West Sumatra, South Sumatra, Lampung, West Nusa Tenggara, South Kalimantan, West Kalimantan, North Sulawesi and South Sulawesi. These 10 provinces were then known as the Outer Islands Group I. In the Second Five Year Development Plan, the Government also established the long-term goal of reducing fertility by 50 per cent from the 1971 figure by 2000. To achieve this goal as well as to cover a wider area, the Government introduced the community-based or village family planning programme. Piet (2003, p. 85) argues that the village family planning programme is the best example of the innovative approach of the National Family Planning Coordinating Board (BKKBN).

Community-based Family Planning Programme

The basic idea of the community-based family planning programme is to use villages as bases for the Family Planning Programme, to decentralize the Programme and to give responsibility to village officials and volunteers. As Piet (2003, p. 86) stated, "village family planning is an information, motivation and contraceptive services programme centred on the village (*desa*) level and run by village residents". The key element of the strategy is to make use of the trained family planning fieldworkers (*petugas lapangan keluarga berencana*, PLKB) and tra-

ditional village institutions to promote the concept of family planning and "small family norm" (Lubis, 2003). The best illustration of the strategy is explained by Lubis (2003, p. 38):

> *"In late 1974, BKKBN provincial authorities in Bali began a programme to promote family planning through the banjar[2] by training fieldworkers and banjar heads. As a result, contraception became a regular topic at banjar monthly meetings. Potential acceptors were identified in these meetings and a certain amount of peer group pressure encouraged non-acceptors to begin using some form of birth control.*
>
> *Since the introduction of this idea, increasing responsibility has been placed on the banjar to manage its own family planning efforts. For example, each head of household is required to publicly report the family planning and pregnancy status of every married woman of reproductive age in the household. Banjar registers are compiled, listing all eligible couples, their location in the hamlet and their use of contraception. The registers also contain logistic information on pill and condom supplies. The provision of supplies has largely become banjar responsibility and is another activity of the monthly meeting. Each banjar displays a map of all houses in the district, based on information collected from household heads. Houses of IUD users are outlined in blue, those of pill users in red and those of condom users in green, while houses of non-users are left blank".*

Further, Lubis (2003) explains that the strategy was applied differently in Java, where it was modified to match the character of the Javanese community, which is well known for its strong administrative hierarchy. The Family Planning Programme was then implemented through a bureaucratic mechanism. For example, officials were evaluated based on family planning performance at each administrative level. In addition, the existing village structure and institution were used as important vehicles of the Programme. Some of them include *arisan*[3] and the family welfare organization[4] (*pembinaan kesejahteraan keluarga*, PKK).

These examples clearly show the active participation of the community in the Family Planning Programme. This is a result of continuous efforts to encourage community participation through strong political commitment.

Piet (2003) explains that this model, used both in Java and Bali, did not fit the situation and condition in outer islands. The Programme was thus adapted to meet local needs, with the basic approach at the core of the Programme unchanged.

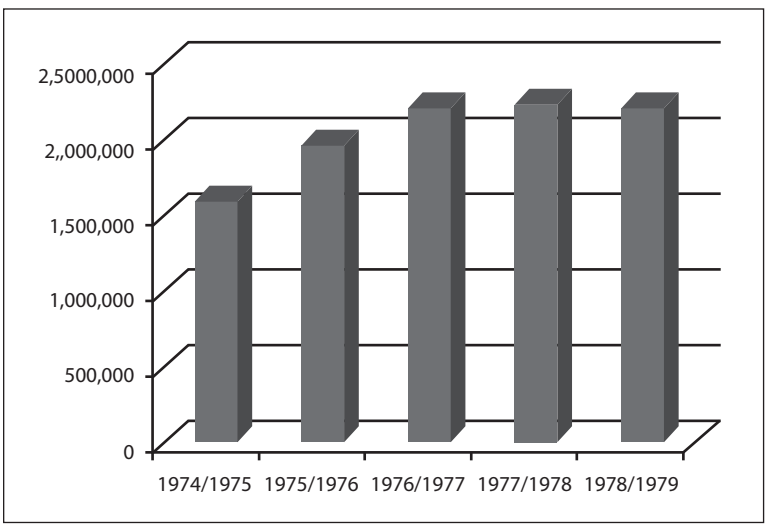
[2]Traditional hamlets in Bali are grouped into *banjar*, of which Bali has more than 3,500. The *banjar* is a unit for mutual aid and cooperative work and the gathering point for recreation and ceremony (see Lubis, 2003, p. 39).

[3]*Arisan* is a common word in Indonesia that refers to a unique social gathering in which a group of friends and relatives meets monthly for a private lottery similar to a betting pool.

[4]A family welfare organization (*pembinaan kesejahteraan keluarga*, PKK)) is a social organization established soon after the New Order took over the government. PKK chapters were set up at the village level to follow a ten-point programme aimed at promoting the welfare of women and families.

Another important programme focuses on village contraceptive distribution centres. This programme was set up to respond to the problem of discontinued use of contraceptives and the "drop out" problem. Distance was the main factor behind the problems of discontinuation and drop out. To tackle these problems, the Government established village contraceptive distribution centres in 1975 as "full-fledged community family planning posts, which enlisted local volunteers who would recruit and instruct participants as well as distribute pills and condoms" (Lubis, 2003, p. 40). In addition, the Government launched a mobile medical team (*tim medis keliling*, TMK), which later became the Mobile Family Planning Team (Kantor Menteri Negara Kependudukan dan BKKBN, 1995). This programme has helped participants to obtain contraceptives more easily and to prevent them from discontinuing contraceptive use and dropping out.

With these new strategies, achievements during the Second Five Year Development Plan (1974/75-1978/79) were much greater than during the previous period. The total number of participants in the Family Planning Programme reached 10.24 million over the whole period. This was more than three times as many as those who participated during the First Five Year Development Plan.



Graph 6 | Number of registered participants in the Family Planning Programme during 1974/1975-1978/1979.

Source: Kantor Menteri Negara Kependudukan dan BKKBN (1995), p. 73.

During the Third Five Year Development Plan, the Family Planning Programme expanded coverage to include all provinces in the country. The provinces included in this period were called the Outer Islands II to distinguish them from the Outer Islands I, the ten provinces included in the Second Five Year Development Plan. The basic strategy in this phase was similar to that during the Second Five Year Development Plan. A priority area for the Governement was

the need to educate people about population issues and increase people's participation in the Family Planning Programme.

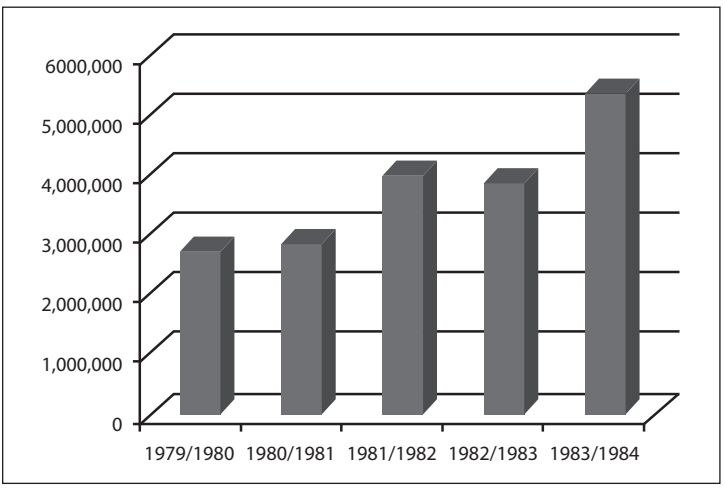
In the development phase (1970-1990), the Government intensified the Communication, Information and Education Programme (*Komunikasi, Informasi, Edukasi*, KIE). Activities under this Programme were meant to:

> *".. push for the achievement of the process of change transforming the knowledge, attitudes and behaviour of society concerning the national family planning programme toward self reliance in building small happy and properous family as the institutionalised and culturally accepted norm in society"* (Kantor Menteri Negara Kependudukan dan BKKBN, 1995, p. 47).

To acomplish these objectives, the Communication, Information and Education Programme was implemented in various ways. This included providing information to be distributed via the mass media, information that could be distributed to groups, and information that needed to be given face to face. The role of the fieldworker was very important. The fieldworkers travelled around the region, explaining the Family Planning Programme and persuading community and religious leaders to participate. This was vital because it was critical to have the support of religious leaders and avoid opposition from religious groups. It is important to note that the two largest Muslim organizations in Indonesia, Nahdlatul Ulama and Muhammandiyah, have supported the Family Planning Programme since its beginning. As Widyantoro (2003) mentions, Nahdlatul Ulama, through its national council declaration in 1969, accepted family planning as a means of spacing pregnancies, with the focus on the well-being of mother and child. Meanwhile, the national council of Muhammadiyah in 1971 ruled that family planning was allowed and could be practised to serve the well-being of families and society at large. However, opposition and questions concerning family planning practices were still undecided, with some religious leaders equating the use of intrauterine devices (IUDs) with "abortion" and prohibiting their use since to insert and control an IUD, one must look at a woman's genitals (Kantor Menteri Negara Kependudukan dan BKKBN, 1995, pp. 96-97).

During this period when the scope of the family planning movement was expanded to cover all provinces, the number of participants increased substantially. The Government claimed that, as before, the targets were surpassed (graph 7). The number of registered participants increased from about 2.2 million in fiscal year 1979/1980 to 5.3 million at the end of the period 1983/1984. Only in the 1982/1983 fiscal year were there slightly fewer participants than in the previous year.

In the Fourth Five Year Development Plan (1984/1985-1988/1989), the Government developed population policy in a more comprehensive way. The population programmes focusd on (a)

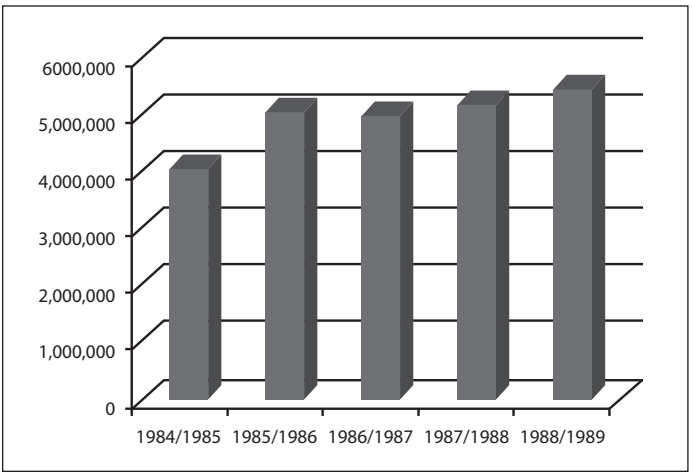


Graph 7 |
Number of registered acceptors of family planning during 1979/1980-1983/1984.

Source: Kantor Menteri Negara Kependudukan dan BKKBN (1995), p. 73.

decreasing the birth rate, (b) improving maternal and child welfare, (c) increasing life expectancy, and (d) decreasing mortality rates, particularly that of infants and children (Kantor Menteri Negara Kependudukan dan BKKBN, 1995). During this period, the Government focused on increasing the participation of women and young people in population affairs as well as the quality of human resources, both of which were introduced to strengthen and institutionalize the concept of "small and prosperous family norm" (*norma kelurga kecil, bahagia dan sejahtera*, NKKBS).

As can be observed in graph 8, the number of registered paricipants was more than that of the previous period. New participants totalled as many as 4 to 5 million each year. Only in fiscal year 1986/1987 were there fewer participants than in the previous fiscal year.



Graph 8 |
Number of registered participants in family planning during 1984/1985-1988/1989.

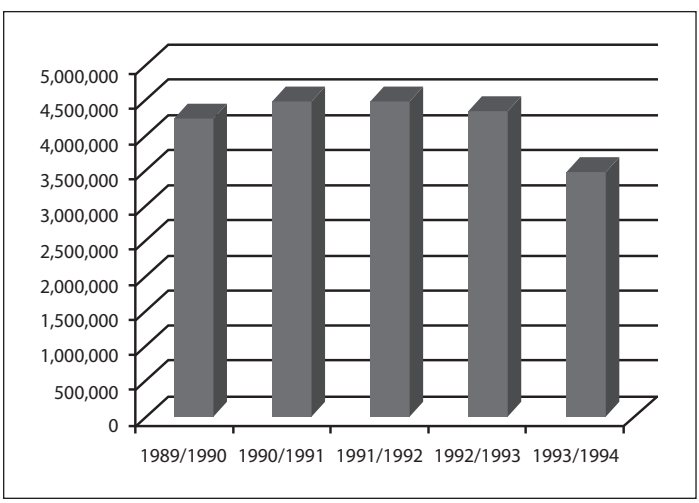
Source: Kantor Menteri Negara Kependudukan dan BKKBN (1995), p. 73.

The third stage, after the pioneering and development periods, was the institutionalization period, which begin in 1990. During this period, family planning was transformed from being a programme into a "movement". It became more complex and needed a new approach. During the Fifth Five Year Development Plan (1989/1990-1993/1994), the basic strategy was continued with the policies as follows (Kantor Menteri Negara Kependudukan dan BKKBN, 1995):

- restraining population growth to raise the quality of human resources;
- decreasing the rate of fertility directly through the family planning movement and indirectly by improving the welfare of the population;
- decreasing the rate of mortality, particularly infant, child and maternal mortality, and increasing life expectancy; and
- improving the quality of life of the population.

This period was marked by several new programmes, among them the Campaign for the Healthy Prosperous Mother (*Kampanye Ibu Sehat Sejahtera*, KISS), which later became *Gerakan Ibu Sehat Sejahtera* (GISS); the Campaign for the Prosperous Small Family (*Kampanye Keluarga Kecil Sejahtera*, KKS); and the Campaign for the Self-help Small Family (*Kampanye Keluarga Kecil Mandiri*, KKM).

The number of participants during the Fifth Five Year Development Plan was about the same as that of the previous period (graph 9). The last period, 1993/1994, was distinguished by fewer participants when compared to other periods. In the 1984/1985 to 1993/1994 period, the Government did not reach its target number of participants, save for 1988/1989, when 114.7 per cent of the target was realized.



Graph 9 | Number of registered participants during 1989/1990-1993/1994.

Note: Data for 1993/1994 were for the period up to December 1993.

Source: Kantor Menteri Negara Kependudukan dan BKKBN (1995), p. 73.

During the New Order era, population policy was transformed from a policy with demographic goals at its core to a policy with a more social and economic orientation. The happy, prosperous, small family programme (NKKBS) combined these two policies. The family planning movement is meant not only to lower population growth but also to support family welfare. The norm was set out in Law No. 10/1992 on Population Development and the Development of Happy and Prosperous Families, which states that a "prosperous family is based on the legal marriage which fulfils spiritual and material needs, devoted to God Almighty, having harmonious and balanced relations with the family members, the community and environment".

In addition, the family-planning terminology changed from "programme" to "movement". This implies that the Family Planning Programme has also been transformed from a government (programme) to a community responsibility. This is the reason why the involvement of religious leaders, civil society and NGOs is crucial.

Results and Achievement

Data on fertility, infant mortality and the poverty rate show that the population policy of Indonesia has successfully reduced these three important development indicators. Focusing on fertility decline, it could be argued that family planning has contributed to declining fertility. Adioetomo and Sarwiono (2009) stated that the declining fertility rate from 5.6 births per woman in the early 1970s to 2.3 births in the late 2000s was caused by more women using contraception. Other factors may also have contributed to lowering the population growth and should not be discounted.

The decreasing population growth has catalysed the poverty alleviation programme. Within this logical framework, it is reasonable to say that the decreasing fertility rate has also contributed to the declining poverty rate.

The success of the Family Planning Programme is attributable to the support of the community, NGOs and civil society. From the beginning, the two largest Muslim organizations in the country, Nahdlatul Ulama and Muhammadiyah, showed their support for the implementation of the Programme. Since Indonesia is also the world's largest Muslim country, their support has meant a great deal. However, their support does not mean that all opposition from Islamic organizations has been automatically removed. The contribution of NGOs is also important. The establishment of the National Family Planning Coordinating Board (BKKBN) cannot be separated from the role of the Indonesian Planned Parenthood Association (PKBI), which was founded earlier. PKBI continues to support the implementation of the Family Planning Programme even today (see Widyantoro, 2003). Civil society groups such as the family welfare organization (PKK) and the Indonesian Association for Secure Contraception (Perkumpulan Kontrasepsi Mantap Indonesia, PKMI), to

mention only two, are very active in promoting and providing family planning services.

The Family Planning Programme in Indonesia has shown how government has been successfully working hand in hand with the local community to implement the Programme. The change in terminology from "programme" to "movement" implies the transfer of responsibility from government to community. The success of self-reliance in family planning is also an example of how the community has already taken on more responsibility for the Family Planning Programme.

ASSESSMENT AND EVALUATION

Successful family planning and the programme to alleviate poverty were impacted by external factors: the economic crisis in 1997-1998 and political unrest that led to governmental change. This in turn affected two important aspects of the implementation of the Family Planning Programme: the weakened capacity of the Government to subsidize the Programme, and decentralization, which resulted in a gap between national and local (district) population policy. These two issues highlight the importance of community participation in the Family Planning Programme. The model must be adapted to take into account a new social, economic and political environment.

Graphs 2 and 3 show the effects of the economic crisis in 1997. For family planning programmes, the total fertility rate and the contraceptive prevalence rate are relatively constant. Since the economic crisis was followed by a multidimensional crisis that hit Indonesia in 1998, the capacity of the Government to subsidize contraceptives declined. The economic crisis also lowered the purchasing power of the population. At the same time, the price of goods, including contraceptives, skyrocketed. These factors working together increased the incidence of poverty (see graph 1). In terms of family planning, such conditions made it very difficult for the poor to afford contraceptives. In the end, the crisis reduced community participation in family planning.

Declining community participation was also caused by the shift of government from a centralized to a decentralized model. Originally, the central government had enormous power; after decentralization was implemented, these powers weakened. The National Family Planning Coordinating Board (BKKBN), which had been a very powerful organization under the New Order, was decentralized in 2003. It consequently lost much of its influence at the district level. As a result, the Government lost the ability to direct family planning policies as it had done in the New Order era. Decentralization also led to less government attention at the central and local levels to population issues in general and family planning in particular. This resulted in the implementation of family planning programmes that weakened existing family planning programmes.

To respond to this situation, the Government has revitalized the Income-

generating Activities for Prosperous Families (*Usaha Peningkatan Pendapatan Keluarga Sejahtera*, UPPKS) Programme, which was initiated in 1976. This Programme has been considered a successful programme, with a large number of families enrolled and about 13.5 million members involved in it (Ismawan, 2009). By Instruction of the President, trillions of dollars have been collected from a 5 per cent tax on company profit that is later used as a revolving fund for UPPKS groups. In this phase, the role of the private sector becomes stronger.

In the beginning, the Income-generating Activities for Prosperous Families Programme (UPPKS) had a very significant role in supporting the Family Planning Programme by increasing family income. However, owing to the economic crisis and the implementation of decentralization, the Programme tended to weaken. Similarly, other programmes relating to community participation, economic crisis and decentralization have led to the decline in its performance. Therefore, the revitalization of the Income-generating Activities for Prosperous Families Programme is important in family planning programmes in Indonesia.

The Medium Term Development Plan (RPJM) 2004-2009 states that there is a need to increase family incomes, especially of families in the categories of pre-prosperous and first prosperous family. In response, the National Family Planning Coordinating Board (BKKBN) has launched a more intensive economic empowerment programme for poor families by providing capital assistance to the Income-generating Activities for Prosperous Families (UPPKS) Programme. Capital assistance provided for these UPPKS groups ranges from 2.5 million to 5 million rupiah. However, the groups must meet predetermined criteria: they should be groups that are not able to provide collateral, that already have economically productive activities, and that participate in family planning. In 2006, the National Family Planning Coordinating Board (BKKBN) recorded 2,412 UPPKS groups that had received capital assistance amounting to 10 billion rupiah (see Dawam, 2008). According to Dawam (2008), in 2005, there were approximately 350,000 UPPKS groups. This was a significant drop from 557,942 groups in 2002 and 741,206 groups in 1999. In 2007, with the launch of the new policy, there were 30,410 UPPKS groups. This number increased dramatically by 2009 to 42,650 UPPKS groups with a total of 759,864 family members.

The Income-generating Activities for Prosperous Families (UPPKS) Programme played an important role when the influence of the Government declined in terms of ability to influence outcomes and to provide funding. It is becoming an alternative to help poor families afford contraception and, it is hoped, to increase the number of people participating in the Family Planning Programme.

Lessons Learned

The success of the Family Planning Programme in Indonesia in the New

Order era must be seen in the bureaucratic political context. The Programme is a national programme that is supported by strong government that has been able to develop political commitment to the Programme. This is reflected in the full backing of the Family Planning Programme by the President and the Parliament through the establishment of the National Family Planning Coordinating Board (BKKBN), a special body responsible for family planning implementation.

According to Piet (2003, p. 88), the success of the Programme is due to "the unusually effective administrative structure for a developing country that facilitates communication and mobilization of action at the grass root level for a wide range of development activities".

Piet (2003) has also pointed out that the flexible and innovative approaches are key elements of the success of the Programme. For example, village family planning is an innovation that was followed immediately by expansion without lengthy planning.

External factors such as the Southeast Asian economic crisis were unanticipated and became a threat to the continuation of the Programme. However, there was no immediate impact of the economic crisis in terms of withdrawal of the family planning acceptors, as evidenced by the high number of people participating in the Family Planning Programme.

Potential for Replication

The first and most important requirement for replication is the strong and sustained political commitment of the Government.

The problems surrounding community involvement in any family planning programme such as opposition based on religion or belief, misunderstanding of the programme, and low social and economic status exist in any country. The Indonesian model and approach can show other countries how to navigate these issues.

Population policy development together with strategic planning is needed.

The programme should include three important stakeholders: the State, the private sector and civil society, with a clear definition of responsibilities.

Acknowledgements

In preparing this case study, I received support from many parties. I would especially like to acknowledge the support of the National Family Planning Coordinating Board (Badan Koordinasi Keluarga Berencana Nasional, BKKBN). From BKKBN Jakarta, I would like to express my thanks to Dr. Sugiri Syarief, MPA; Dra. Kasmiati, MSc; and Drs. Eddy N. Hasmi, MSc, and M. Dawam, who provided valuable input as well as support for me to finish this work. I also wish to offer thanks to Dr. Samijo, MSc, from

UNFPA, who was willing to read and provide comments on my earlier draft.

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6

Kenya

An Innovative and Integrated Initiative to Reposition Intrauterine Contraceptive Devices in the National Family Planning Programmme

Dr. Lawrence D. E. Ikamari

Summary

The initiative described in the present case study was undertaken in order to reintroduce the intrauterine device (IUD) into the contraceptive method mix and to increase its uptake in Kenya. The use of IUDS was declining despite the safety, effectiveness, convenience and low cost of the device. At the same time, the use of expensive, modern family planning methods such as injectables was on the increase. The percentage of women in Kenya who used IUDs for contraception dropped from 21 per cent in 1989 to 15.4 per cent in 1993 and to 7.6 per cent in 2003. The underuse of IUDs and other long-acting and permanent methods became a cause of concern to the Government of Kenya and those who make health policy. Overreliance on relatively expensive methods burdened the National Family Planning Programme, which was already faced with budget cuts as resources were increasingly directed to HIV/AIDS programmes, and limited women's access to a full range of contraceptive options. At the same time, Kenya was undergoing serious challenges in ensuring family-planning commodity security, with recurrent stock-outs. HIV/AIDS was attracting all the focus of all the players, including the bilateral partners. It became necessary to reintroduce a method whose safety and cost benefits were well established even in the era of HIV/AIDS.

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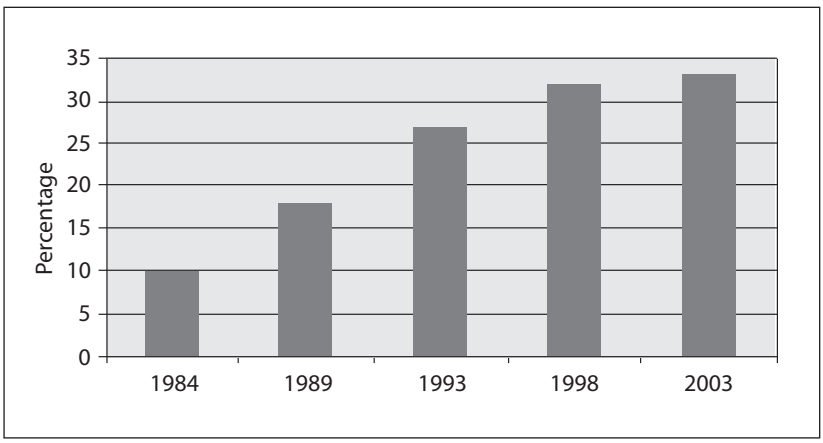
Introduction

The initiative described in the present case study was started to help to create demand for intrauterine devices (IUDs), enhance the quality of services, increase easy access to IUDs, reduce reliance on the relatively expensive methods that burdened the National Family Planning Programme, and increase women's access to a full range of contraception options.

Background: Origin, Design and Objectives of the Initiative

Origin and Growth

Since 1967, Kenya has been promoting and implementing an integrated maternal and child health/family planning programme to reduce its high population growth rate and to improve the welfare of women and children. The high population growth in the country was influenced mainly by high fertility and declining mortality. Until recently, the performance of the family planning components had been rather poor. For instance, between 1978 and 1998, the proportion of married Kenyan women using modern contraceptive methods rose from only 9 per cent to 39 per cent (graph 1). It reached a plateau between 1988 and 2003, indicating a significant unmet need for family planning. Contraceptive commodity stock-out was a serious challenge. Fertility remained relatively high at about 5 children per woman.



Graph 1 | Trends in the use of modern contraceptives in Kenya.

Source: Kenya Demographic and Health Survey 2003.

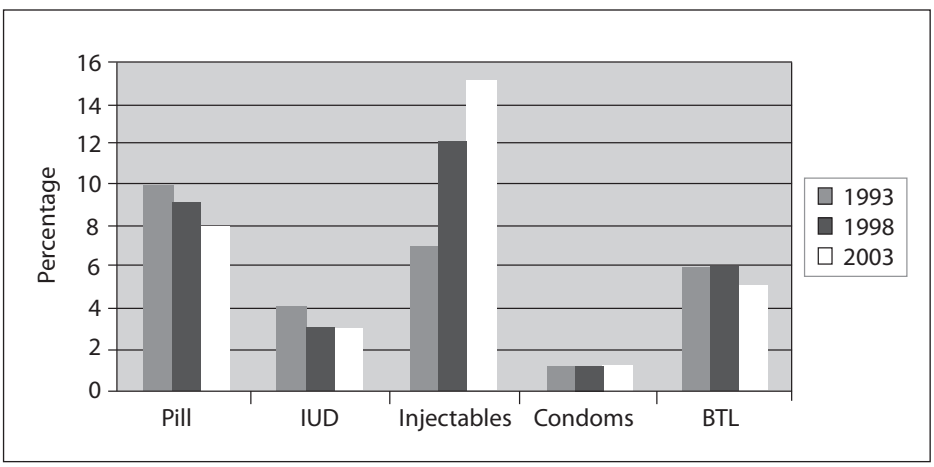
Moreover, the use of the IUD – one of the most reliable and cost-effective methods – dropped from 31 per cent of the modern method mix in 1984 to about 8 per cent in 2003 (graph 2). At the same time, Kenyan women began to rely almost exclusively on short-term methods, with more than 70 per cent of women who used modern contraception using injectables or pills, methods that are more costly than IUDs. In addition, IUDs have proven to be safe, effective, acceptable, and low in cost, and therefore suitable for most women in a resource setting such as Kenya. Also, the World Health Organization has shown that IUDs are also suitable for women with HIV/AIDS.

At the same time, the Ministry of Health was facing several challenges to its reproductive health programme. For example, it was facing serious challenges in ensuring family-planning commodity security, with recurrent stock-outs. Kenyan women did not have access to a full range of contraceptive methods. Kenya as a country was experiencing an increasing disease burden from the HIV/AIDS pandemic (graph 3), and the ability of the Ministry of Health to provide services was under a great deal of pressure. All the players, including the bilateral partners, were focusing only on HIV/AIDS. Amid all the challenges, an increased number of Kenyans were reaching reproductive age and requiring services, furthering demand for contraceptives.

In addition, research on IUD service delivery in Kenya showed that a combination of factors contributed to the decline in the uptake of the IUD. These included:

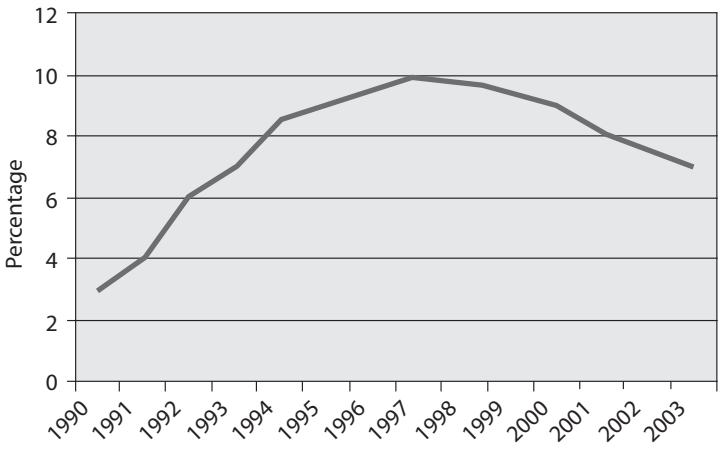
- poor quality of care;
- fear of HIV transmission;
- misconceptions and myths about IUDs;

Graph 2 | Trends in the contraceptive method mix in Kenya.



Note: BTL= bilateral tubal ligation.

Source: Kenya Demographic and Health Survey 2003.



Source: Adjusted from the Sentinel Surveillance System.

Graph 3 | HIV prevalence among adults in Kenya.

- provider bias or preference (e.g., concerns about the time and skill required to offer IUDs);
- shifting client preferences;
- lack of expendable commodities; and
- availability of Norplant and depot medroxyprogesterone acetate (DMPA).

Concerned about a contraceptive method mix skewed towards short-term methods (the most costly) and about providing a wide range of contraceptive options to Kenyan women and a more balanced and sustainable method mix, the Ministry of Health decided to reintroduce or rehabilitate the IUD. In 2001, the Ministry, in collaboration with several local and international partners, launched the initiative to promote a balanced and sustainable national family planning programme, increase client choice, and reintroduce the IUD into the Kenyan contraceptive method mix.

The initiative was phased in well. It started in two provinces – the Western and Coast provinces – and gradually some of the activities were extended to the six other provinces. The Ministry of Health AMKENI[1] Project, a service delivery project supported by the United States Agency for International Development (USAID), was already operating in these two provinces and thus integrated the IUD reintroduction efforts into its activities.

Based on the fact that the barriers to IUD use in Kenya were many, the initiative focused on and addressed four strategic areas: consensus-building and advocacy; building capacity and improving service delivery; creation of demand;

[1]A Swahili word meaning "awakening".

and monitoring and evaluation and operations research.

Objectives

The objectives of the initiative were to:

- increase support for the IUD among policymakers, service providers and clients;
- improve the quality of IUD services;
- enhance demand for IUDs; and
- monitor and evaluate programme performance.

Major Activities

Although the activities followed a developmental sequence, they were in reality carried out more or less simultaneously once the stakeholders had agreed on the importance of the project and the implementation mechanisms.

Consensus-building Activities

At the onset, the Ministry of Health undertook several activities to cultivate ownership and consensus among various groups, including researchers, trainers, programme mangers, service providers, professional associations, funding agencies and clients. This cluster of activities occurred in several steps over the course of approximately two years from late 2000 to 2002:

- In early 2001, the Ministry of Health and Family Health International hosted a panel session at the annual meeting of the Kenya Obstetrics and Gynecological Society to discuss IUD usage in Kenya. The members agreed that there was a need to convene a national stakeholders meeting to discuss matters relating to the IUD.
- Several months later, Family Health International organized a stakeholders meeting to bring together government leaders, representatives from non-governmental organizations (NGOs) and providers. The meeting served as a venue for presenting the most current IUD research and discussing a way forward. The stakeholders proposed the formation of the IUD Task Force, which the Ministry of Health adopted.
- In March 2002, the IUD Task Force, with the Ministry of Health as chair and Family Health International as secretariat, met to develop a revitalization strategy and work plan for the reintroduction of IUDs. In subsequent quarterly meetings, the group developed a work plan outlining goals, activities, indicators of success and a timeline.
- The national IUD revitalization strategy was launched at the annual conference of the East, Central and Southern Africa Association of Obstetrical and Gynaecological Societies (ECSAOGS).
- The IUD Task Force transitioned to a more streamlined implementing body under the chairmanship of the Department of

Reproductive Health in the Ministry of Health. The Department adopted a systematic approach of quarterly meetings and regular progress reports. The Ministry of Health led this group, which consisted of representatives of the Ministry, Family Health International, the AMKENI Project, Jhpiego (an international non-profit health organization) and several medical professional associations.

Advocacy and Sensitization Activities

Based on research findings about the causes of the decline in the use of IUDs in Kenya, the Task Force recognized that the revitalization strategy would require a strong advocacy component to combat provider bias and misinformation. Family Health International was responsible for developing the advocacy strategy. Throughout the process, it maintained strong partnerships with professional organizations and local NGOs whose members work closely with providers or are providers.

The advocacy activities included a review of Ministry of Health policies and the development of various communication efforts to raise awareness among providers, clients and the general public. As of 2004, over 2,600 advocacy briefs had been distributed, 400 programme managers and family planning service providers had been sensitized in meetings in all eight provinces in Kenya, and hundreds of others had been encouraged to take a new look at the IUD during radio programmes and presentations at regional reproductive health conferences.

In summary, the advocacy and sensitization activities included the following:

- A public call-in radio programme aired featuring IUD advocates, satisfied users and providers. During some of these programmes, professionals answered some of the frequently asked questions about IUDs. Some of the IUD clients shared their experiences with other potential clients.
- A package of IUD advocacy briefs targeting providers and policymakers was developed by the Ministry of Health, Family Health International and representatives from all the major medical professional associations in Kenya. In non-technical language, these briefs addressed the issues of concern identified in the IUD assessment and stakeholders meeting: safety, efficacy, cost, convenience for clients and providers, eligibility criteria and potential as a safe method for HIV-positive women.
- The Ministry of Health hosted district-level meetings of public-sector providers, health facility managers, and policymakers in all eight provinces. The purpose of the meetings was to disseminate the revitalization strategy and the briefs and to review information about the IUD.
- Private-sector providers across the country were invited to sensitization meetings as part of their continuing professional development.

Participants were certified and the sessions were recognized as part of their continuing medical education by their respective professional bodies. The materials for continuing professional development were adapted and used to train pre-service trainers from universities and medical training colleges.

Capacity-building and Service-delivery Activities

Capacity-building and service-delivery activities were implemented primarily by Ministry of Health teams and the Ministry of Health AMKENI Project, which was USAID-funded. Concerted efforts were made to improve the provision of quality IUD services by establishing a training system for IUD services and creating a cadre of trainers to reach IUD providers in the public and private sectors. The cluster of activities was carried out to enhance supervision capacities within the existing Ministry of Health structures, to ensure the provision of equipment and expendable supplies to AMKENI-supported clinics, to improve the infrastructure of facilities and to address infection-prevention techniques in clinics.

The AMKENI Project worked to improve reproductive health service delivery at 97 Ministry of Health-supported sites in the Coast and Western provinces. To fit the revitalization effort into the AMKENI work plan, pilot facilities in these two provinces were selected. Activities included the following:

- With leadership from the AMKENI Project, the Ministry of Health and the rest of the IUD Task Force revised the national reproductive health curriculum. Previous training materials were piecemeal and out of date. The new curriculum was standardized, with updated information about reproductive health and family planning.
- The AMKENI Project held facility-level orientation meetings to introduce IUD revitalization in 10 districts in the Coast and Western provinces. These meetings included the entire staff of the facilities, not just the providers. This gave all the staff an opportunity to understand the programme and their future roles in it.
- The AMKENI Project provided clinical, in-service training and refresher courses to public and private providers in eight districts on all aspects of IUD service provision.
- The AMKENI project also distributed nearly 600 kits for IUD insertion and removal to trained providers and it continues to work with the USAID-supported DELIVER PROJECT implemented by John Snow, Inc. to make sure that sufficient numbers of IUDs and related supplies are available at the facilities.
- Family Health International developed a checklist to help providers to determine if clients are medically eligible to use the IUD. The

checklist was partially field-tested in Kenya. During four focus-group discussions with providers, Kenyan providers reviewed and endorsed the use of the checklist.

The newly formed, decentralized, reproductive-health training and supervision teams of the Ministry of Health continue to provide supportive supervision. Their goal is to ensure that facilities have sufficient training, commodities and supplies to offer IUDs to their clients.

Demand-creation Activities

The IUD suffered from a poor reputation among family planning clients, who were rarely offered the method and often discouraged from using it by persistent rumors about its safety and by providers' attitudes. The providers' attitudes were influenced by many factors: lack of infrastructure, provider skills, equipment and supplies. The IUD Task Force (mostly implemented by AMKENI) undertook a campaign in the two focus provinces of AMKENI to dispel myths and to inform potential clients about the benefits of the IUD and all modern family planning methods.

Under Family Health International leadership, Task Force members developed two brochures (each produced in English and Swahili) for clients of reproductive health services. One brochure discusses the IUD, explaining what it is, who can use it, and its benefits and side effects. The other brochure provides information about all modern family planning methods, including the IUD.

AMKENI incorporated a new IUD emphasis into its existing behaviour change communication (BCC) programme. It trained more than 500 BCC agents, mostly volunteers who live in the communities that they serve, to provide information about the IUD and family planning in general. The BCC agents met with village health committees, women's groups, men at worksites, youth groups and families. They distributed the IUD and general contraception pamphlets.

The AMKENI behaviour change communication (BCC) strategy worked with communities around the targeted health facilities to increase demand for services, foster women's empowerment and participation in reproductive health/family planning decisions, and promote healthy behaviour. A hallmark of the AMKENI approach was to engage the community surrounding each facility to put people "in the driver's seat" for bringing about desired change. AMKENI mobilized 754 villages to form village health committees or health-facility management boards. More than 2,218 volunteer field agents were trained to provide information and mobilize community involvement in reproductive health/family planning. Approximately 51,000 members from over 2,700 community groups were engaged in regular BCC activities, reaching more than 2.8 million people.

In summary, clients' awareness of the existence and advantages of the IUD was a major determinant of demand. Research showed that often clients were not aware of the IUD as a contraceptive option or they had misconceptions about the

method. To raise awareness, the initiative developed information, education and communication materials and initiated public education campaigns through the extensive network of field agents of the AMKENI Project. As of March 2004, nearly 12,000 community members had been reached through educational sessions on the IUD.

Documentation

The process of documenting all the activities of the initiative was put in place as part of facilitative support supervision. Data and information were available in the implementing facilities. The documentation enabled participants to share programme information and made it easy to monitor and evaluate the progress and success of the programme based on the initial baseline survey.

Monitoring and Evaluation and Operations Research

From the start, monitoring and evaluation were considered vital to implementing the initiative and gauging its success. Family Health International was designated to lead the monitoring and evaluation process. During the monitoring and evaluation planning, it put measures in place to ensure appropriate documentation of all activities throughout the life of the project. These measures included the following:

- Family Health International developed a monitoring and evaluation plan that listed project objectives and the activities required to meet them, indicators to be measured, target goals and the partners responsible for collecting data on progress.
- Family Health International also coordinated and documented the IUD Task Force meetings and prepared quarterly reports with updates on progress and results. The AMKENI Project is collecting data in two provinces on the increase in IUD users, which will be an important indicator of success.

IMPLEMENTATION

The initiative was a collaborative effort that involved the Ministry of Health (prime mover), EnGender Health, Family Health International, IntraHealth International and the Program for Appropriate Technology in Health (PATH).

The Director of the Division of Reproductive Health had the overall coordination role and ensured that the resources needed for the various activities were made available to the implementers.

Involvement of professional health associations and training institutions in the project activities was ensured throughout the life of the project. In addition, private-sector providers across the country were invited to sensitization meetings as part of their continuing professional development. Participants were certified and the sessions were recognized as part of their continuing medical education by their respective professional bodies. The materials for continuing professional development were adapted

and used to train pre-service trainers from universities and medical training colleges.

Each partner had a clearly defined role based on its comparative advantage and was responsible for implementing the assigned project activities in close collaboration with other stakeholders.

Joint planning and review meetings were held by a representative task force. During these review meetings, progress was assessed, challenges were discussed, and, in certain instances, workplans were modified to reflect the reality on the ground.

Funding was provided by USAID and the Government.

Supervisory teams from the Division of Reproductive Health of the Ministry of Health were formed. As indicated earlier, these teams ensured that all the facilities had sufficiently trained staff, adequate IUDs and other contraceptive commodities to offer to clients. They also ensured that all the facilities had the checklists and that high standards were being followed and maintained.

Family Health International had developed a monitoring and evaluation plan that listed all the project objectives and the activities required to achieve them, indicators to be measured, target goals and the partners responsible for collecting data on progress. The implementation of the project activities was closely monitored and all the activities were documented throughout the life of the project.

Results and Achievements

The results described in the following sections are based on the project documents as well as assessment and evaluation.

Sustainability

The initiative was sustainable because it was mainstreamed into the Ministry of Health Family Planning Programme and into each partner's programme activities.

Increased Utilization of the IUD

Under the Ministry of Health AMKENI Project, which ended in 2005, the number of new users in the 97 facilities supported by AMKENI increased from 151 per quarter at the baseline in early 2003 to 373 per quarter in early 2005. The cumulative number of IUD users in AMKENI Project sites over the two-year intervention period was approximately 2,800 women.

AMKENI Project achievements have had a significant impact on the access to, quality of, and use of reproductive health services in the Coast and Western provinces. People now can choose from an increased range of family planning methods, and more people are using more methods. At the baseline, most facilities could offer only short-term methods, such as the pill, injectables and condoms, and the number of clients was low.

Increased Access to Quality Family Planning Services

AMKENI enabled the facilities to provide a range of methods, strengthening the capacity to provide long-acting and permanent methods in particular. For example, the number of facilities that could provide IUDs rose from 5 per cent at the baseline (2001) to 35 per cent by the end of 2005, and reported IUD insertions rose from 510 in 2001 to 1,169 in 2005. During the same period, acceptance of all long-acting and permanent methods rose by 152 per cent, and the number of new family planning users increased by 65 per cent.

AMKENI Project staff formed a true partnership with Ministry of Health staff, jointly planning and implementing projects in eight provinces, and this was piloted successfully down to the health-facility level in two districts. The Ministry of Health intends to roll out the system nationwide.

Effective Supervision of Service Delivery

By the end of the project in 2005, each of the eight provinces in Kenya and the 10 districts within the AMKENI Project area had members of the reproductive-health training and supervision team who had been updated in their clinical skills, exposed to supportive supervision procedures, and instructed in clinical training skills and on-the-job training techniques.

Standardization of Reproductive-health Training Materials and Their Use in Training Staff

The staff had their knowledge and skills updated using standardized training manuals. The project also included pre-service trainers from various Kenyan medical training colleges in its training support. This assistance created a large reserve of high-quality, local experts in training and in supervision.

Lessons Learned

The following lessons were learned in the course of implementing the project:

- High-level political commitment is crucial for successful programme implementation. Programme commitment to intervention by the Ministry of Health and all the partners is essential for successful implementation and its sustainability. In addition, leadership by the Ministry ensured a commitment by all involved to undertake necessary policy and programmatic changes.
- Building activities on evidence (especially synthesis and discussion of local evidence) is more effective than not using an evidence-based approach. Synthesis and incorporation of valid research

findings are required to inform action. Succinct and accessible evidence makes busy policymakers, programme managers and service providers take notice.

- A review of existing policy and guidelines to ensure appropriate content is necessary. For instance, the guidelines on family planning were revised and a new *Kenya Family Planning Guidelines for Service Providers* was issued, which now includes the new medical eligibility criteria for the IUD and all other contraceptive methods.
- Partnerships with key stakeholders at all levels of implementation are critical. Each partner should be assigned responsibilities based on its comparative advantage and track record. The assignment of responsibilities should be done in a democratic and transparent manner. Collaboration leads to ownership and more effective project implementation.
- Community initiatives and partnerships are key to service and commodity uptake. Village-based health structures such as village health committees are essential for reaching people with appropriate information and for creating demand for health services and are critical for ownership and sustainability of health initiatives.
- Collaboration and leveraging of resources by implementing agencies are feasible. Organizations can effectively cooperate and contribute resources when they share common goals, are coordinated and bring a variety of skills to the project.
- Credible spokespeople are important advocates in that they can help to bridge the worlds of research, policy and programmes.

Challenges

During the course of implementing the programme, several challenges were encountered:

- weak health infrastructure;
- bureaucracy in the decision-making process of government agencies;
- inadequate and erratic supplies of contraceptive commodities;
- inadequate support by service providers;
- competition from other short-acting contraceptives (e.g., DMPA);
- lack of continuity in facilities' commitment to the IUD and the provision of IUD services; and
- insecurity among clients as to whether the services would be maintained.

Suitability and Possibility of Scaling Up (Replicability)

The model according to which the initiative was executed has been replicated both locally (in the country) and internationally.

- The initiative has been scaled up and is being implemented in all eight provinces of Kenya. As was indicated earlier, the Ministry of Health teams trained family planning staff of all the major health facilities in the eight provinces to provide IUDs among other family planning methods. A number of health facilities have also been upgraded and strengthened to provide a variety of family planning methods including IUDs. IUDs are now routinely included in the contraceptive commodities supplied to all the health facilities in the country. This is clear evidence that the initiative has been incorporated into national health decision-making and planning processes.
- The implementation of project activities was closely monitored and all the activities were documented throughout the life of the project. The lessons learned in the project have been used in the AMUA and ACQUIRE Projects to increase the usage of IUDs. In Kisii District, with support from ACQUIRE[2] and using lessons learned from the AMKENI Project, the Ministry of Health held community linkage meetings to bring together providers and community members. These meetings provided an opportunity for community members to express their concerns regarding family planning services and for providers to meet. They resulted in increased use of IUDs between 2005 and 2006 in Kisii District.

  Remarkable progress in IUD insertions was recorded by the AMUA[3] Project. This social franchising project targeting the rural private sector with particular emphasis on long-acting and permanent methods was conducted in Rift Valley Province from 2004 to 2007 using some of the lessons from the AMKENI Project.
- The Population Council adopted and produced 500 copies of the IUD advocacy kit for Ghana Health Services (i.e., the Ghana Ministry of Health) at a cost of approximately US$1,500.
- Ghana Health Services used advocacy kits to help to sensitize 153 Family Planning Programme managers and service providers.

RECOMMENDATIONS

The recommendations listed below should be followed to successfully reposition the IUD or any similar initiative in Kenya or in countries with similar conditions:

- Partners and stakeholders who support the Ministry of Health of

[2]The ACQUIRE Project (Access, Quality, and Use in Reproductive Health) is a global initiative supported by USAID and managed by EngenderHealth in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA).

[3]Meaning "decide" in Swahili.

Kenya should work within the existing structures of the Ministry.

- Stakeholders on a project should consult with one another regularly.
- Advocacy, sensitization and consensus-building should be encouraged.
- Regular supportive supervision should be maintained.
- Advocacy should be undertaken for inclusion of the project in the annual operating plan of the Ministry of Health.
- Advocacy should also be undertaken for a line in the Ministry of Health budget covering all the components of IUD services to ensure that they will be continuous.

The initiative worked well because of the innovative design and strategy implementation that entailed wide consultation among key stakeholder, use of research, consensus-building and advocacy, strong government commitment and leadership, capacity-building, involvement of carefully selected implementing partners that were assigned responsibilities democratically and on the basis of comparative advantage and proven track record, and well-thought-out monitoring and evaluation arrangements. It further involved a well-coordinated flow of resources from USAID, the Government of Kenya and a variety of other development partners and integration of the initiative activities into ongoing activities of the implementing partners.

Conclusion

This initiative was a best practice because it increased the uptake of IUDs in the project provinces as shown by the service statistics; it contributed to the strengthening of the capacity of various stakeholders and health facilities; it built strong partnerships; and it was sustainable (use of existing health facilities and local resources, community participation). In addition, it is replicable (it has already be used to reintroduce the IUD in all eight provinces of Kenya and has been used in Ghana). Furthermore, the initiative was based on research and it integrated operations research and involved professional associations in a very innovative way.

Acknowledgements

I wish to express my profound appreciation and gratitude to the Division of Reproductive Health of the Ministry of Health and Family Health International (Kenya) for allowing me to have access to the documents of the initiative. Second, I would like to thank the National Coordinating Agency for Population and Development for nominating me to undertake this assignment for Partners in Population and Development (PPD). Finally, I wish to thank the PPD secretariat for the invaluable assistance that I received during the exercise.

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7

South Africa

A System Approach to Training in Population, Environment and Development

Prof. Cornelius J. Groenewald

Summary

Population trends are intimately interacting with environmental sustainability and the need for development in order to sustain or increase people's quality of life. This interaction has become a major factor in the process of development planning and implementation on all levels: global, regional, national and local. The multiple interactions among the three primary fields – population, environment and development – may be described as a nexus of interrelationships. Few development policymakers and planners have a solid understanding of this nexus and are therefore inclined to neglect or underestimate the systemic effect of their accumulated interactions when crafting development policies, plans and programmes. As a result, sustainable human development is not achieved. The need, therefore, is to build the capacity among policymakers, managers and planners to engage on an intellectual level (i.e., in addition to technical competencies) with the population, environment and development nexus, which has become an imperative for attaining sustainable human development.

Due to the fact that leaders, policymakers, managers and planners are not available to attend lengthy training courses, the Government of South Africa, in line with the mandate of its Population Policy, crafted a short course that varies between five and eight days, depending on the specific need, to address this capacity gap and accelerate the mastering

Summary (continued)

of an intellectual understanding of the systemic nature and implications of the population, environment and development nexus for development planning and implementation. This understanding would strengthen personal and institutional leadership in guiding policies, plans and programmes towards sustainable human development. According to the human development index (HDI), South Africa is not currently making strong inroads in attaining sustainable human development.

This case study introduces a short-course training programme, "Leadership Training in Sustainable Development: The Population, Environment and Development Nexus" (in short, the "LEAD-PED Nexus Training Programme") that has been implemented since 2005 to this effect and reviews its outcomes, impact and future potential.

Due to its focus and approach (the application of a systemic understanding of the interactions among the key population, environment and development components in sustainable human development and a unique adult learning methodology), the "LEAD-PED Nexus Training Programme" is assessed to be an innovative practice that is portable, replicable and successful in addressing local development planning and implementation.

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Introduction

"Our environment provides us with a range of goods and services that are essential for human survival, well-being, cultural diversity, and economic prosperity. Human activities are, however, having significant impacts on the environment, ranging from the local to the global scale. For example, growing human populations are consuming resources and discarding wastes at rates that we have not experienced in the past. The ability of the earth to sustain us is therefore diminished by, for example, accelerated rates of deforestation, soil erosion, desertification, and increasing levels of air and water pollution. In other words, the increasing pace of human-induced environmental change is altering the ability of the environment to provide essential goods and services, which in turn impedes progress towards sustainable development."

These words are the opening sentences of the *South Africa Environment Outlook* (Government of South Africa, 2006, p. xv), a comprehensive report on the state of the environment in the country. They provide a concise description of how population trends are intimately interacting with environmental

sustainability and the need for development in order to sustain or increase the quality of life of people. This interaction – the interplay among population, environment and development – has become a major factor in the process of development planning and implementation on all levels: global, regional, national and local. The intricacies involved in the multiple interactions among the three primary fields may be described as a complex of links and connections, tied into a connected series of bonds that may be called a nexus (Barnhart and Barnhart, 1982, p. 1401). The experience is, however, that few development policymakers and planners have a solid understanding of this nexus sufficient for translating their knowledge and skills regarding the three primary aspects of sustainable human development (i.e., population, environment and development) into effective development policies, plans and programmes. Therefore, the need is, among others, to build the capacity to engage with the population, environment and development nexus on an intellectual level (i.e., in addition to technical competencies). As a result, government agencies (but also non-governmental organizations (NGOs) and businesses) are challenged to equip managers and planners, in the shortest time possible, with the necessary knowledge and skills to understand this nexus and to guide and direct policymakers and implementers to increase the potential for sustainable human development.

The problem addressed in this case study is, therefore, the need to understand the population, environment and development nexus as an essential aspect in development planning and implementation in order to provide leadership in the process of attaining sustainable human development.

Published figures of the South Africa human development index (HDI) (*Human Development Report 1997, 1998, 1999,* 2002, 2007/2008) show a decrease in the health indicators of the HDI despite progress in the economic and education indicators of the index (table 1). This means that the

Table 1 | Yearly human development index (HDI) values for South Africa, 1994 to 2005, selected years.

Year	Rank/Total No. of Countries	HDI	Life Expectancy Index	Education Index	GDP Index	GDP Per Capita Rank Minus HDI Rank
1994	90 / 175	0.716	0.64	0.81	0.69	-10
1995	89 / 174	0.717	0.65	0.82	0.68	-9
1997	101 / 174	0.695	0.50	0.87	0.72	-47
2000	107 / 173	0.695	0.45	0.88	0.76	-56
2005	121 / 177	0.674	0.43	0.806	0.786	-65

Sources: Human Development Report 1997, 1998, 1999, 2002, 2007/2008.

Table 2 | Human development index (HDI) values for South Africa at 5-year intervals, 1975-2005.

1975	1980	1985	1990	1995	2000	2005
0.650	0.670	0.699	0.731	0.745	0.707	0.674

Source: Human Development Report 2007/2008.

overall value of the index has been decreasing since 1995 (table 2).

In the case of South Africa, the quality of life of the population, as measured by the HDI, is affected significantly by major health challenges such as HIV/AIDS, tuberculosis, cholera and malaria that are all diseases intimately affected by environmental, developmental and socio-cultural factors. Understanding how these different sets of factors interrelate, apart from their individual effects, has become a major challenge in producing successful human development policies, plans and programmes.

This case study introduces a short-course training programme as a fast-tracking mechanism for building intellectual capacity in systemic understanding of this nexus: "Leadership Training in Sustainable Development: The Population, Environment and Development Nexus" (in short, the "LEAD-PED Nexus Training Programme") that was initiated in 2005. Based on its sustained, growing and successful track record, its innovative and distinctive features, and its proven impact, the programme may be regarded as a best practice that is portable and replicable.

Background, Justification, Origin and History of the Programme

Background and Justification

The interplay between population and environment has been a challenge since long before Thomas Malthus, in the eighteenth century, explained the striking difference between arithmetic and exponential growth in food production and population growth, respectively (Malthus, 1976/1798). Sam Gaisie (2008), in an essay on population and development interrelationships, highlights the ways in which ancient Chinese, Greek and Roman philosophers grappled with these issues, recommending policy positions on population growth and size, sometimes arguing for population increase in support of military or political considerations. Debates in the 1960s and 1970s took an alarmist view of population growth (e.g., Erhlich, 1968), arguing strongly for strict population control.

A turning point was forthcoming at the United Nations Conference on Environment and Development in Rio de Janeiro in 1992 when the international community agreed on objectives and

actions aimed at integrating environment and development in pursuit of the idea of sustainable development, i.e., development that generates an increase in human productivity that is sustainable and enhances, rather than damages, the quality of life of both humans and the environment (Gaisie, 2008, p. 224). The linkage among population, environment and development was explored in more depth at the International Conference on Population and Development of 1994 in Cairo, leading to the acceptance of resolutions and a plan of action regarding sustainable human development (United Nations, 1994a, 1994b).

Following these resolutions and the plan of action, the Government of South Africa in 1998 adopted the Population Policy for South Africa (Government of South Africa, 1998). This Policy envisages a society that provides a high and equitable quality of life for all South Africans and in which population trends are commensurate with sustainable socio-economic and environmental development. The goal of the Policy is, therefore, to bring about changes in the determinants of the population trends of the country so that these trends are consistent with the achievement of sustainable human development. The Government has thus accepted that it is of strategic importance for the future of its population to attend to the interrelationship between population, environment and development (Government of South Africa, 2004b). The Population Policy mandated such a focus in terms of its central goal, the population concerns that it raised and the population strategies that it proposed.

To give focused expression to this strategic area, the Chief Directorate: Population and Development of the Department of Social Development draws attention to the strategic importance of the area and performs relevant activities within the field (Government of South Africa, 2004b). It defines the interplay of the three principal factors – population, environment and development – as a nexus, in the sense explained earlier. Population, environment and development comprise a complex field that needs proper multi- and intersectoral understanding, cooperation and planning among all relevant stakeholders across departments, programmes, plans and projects. It requires so-called triple-bottom-line accounting, which means that development includes social and environmental factors in addition to economic considerations. This triple bottom line is needed to attain sustainable development (Mpumalanga Provincial Government, n.d.). One of the programmatic activities in this area is the "LEAD-PED Nexus Training Programme".

Origin and History of the Programme

The "LEAD-PED Nexus Training Programme" originated from a partnership between the Department of Social Development of the Government of South Africa, represented by its Chief Directorate: Population and Development,

with its base in Pretoria, and Leadership for Environment and Development (LEAD) Southern and Eastern Africa (SEA), based at the University of Malawi.[1] These two parties piloted the first concept of the programme during March 2005 in Kempton Park, South Africa. Six months later during September 2005, the Programme was officially launched in Mohale, Lesotho, to serve as a regional Southern African project driven by the Government partnership with LEAD SEA. The "LEAD-PED Nexus Programme" training is accredited with LEAD, and participants can continue to attend other courses of the LEAD Associate Programmes at any of the LEAD member programmes worldwide to qualify for fellowship training.[2]

Since the launch, the Programme has been implemented initially as an eleven-day[3] training course in various parts of South Africa governed by a Project Document (2005) between the Government of South Africa and the United Nations Population Fund (UNFPA), which became the third partner in the Programme according to the mandate of its Second Country Programme for South Africa (2002-2005).

A number of South African universities are involved in the "LEAD-PED Nexus Training Programme", including the University of the Free State, the University of Cape Town and Nelson Mandela Metropolitan University. A Memorandum of Understanding with each university regulates its participation in the Programme. In practice, the university provides the venue, the main intellectual input and logistical infrastructure for the training course while the other partners assist financially and intellectually. Although the Programme has a general theme and framework – sustainable human development within the context of population, environment and development – universities bring a specialized focus according to their field of expertise. For instance, Nelson Mandela Metropolitan University focuses on the integration of population, environment and development within the context of the municipal integrated development planning processes in order to serve the need at the local community and district levels where expertise is lacking. The course title is "Population, Environment and Development in Integrated Development Planning Processes".

Goals and Principles and Description of the Programme

Outcomes and Impact

The "LEAD-PED Nexus Training

[1]LEAD SEA is a subsidiary of LEAD (Leadership for Environment and Development), which is an international NGO that focuses on capacity-building in leadership and sustainable development. References below to LEAD are to the worldwide NGO while LEAD SEA will refer to the Southern and Eastern African initiative of this NGO.

[2]In 2010, LEAD is bringing its International Training Session to Nelson Mandela Bay Municipality in Port Elizabeth, Eastern Cape Province, South Africa, as the final training of 210 Associates from about 50 countries to qualify as Fellows. The theme is "Leadership and Climate Change: Population, Environment and Development".

[3]The length of the course is adapted according to the needs and circumstances of specific target groups. It varies between five and eight days, as will be explained later, but can vary even more.

Programme" envisages a number of outcomes for course participants (Government of South Africa, n.d. c, p. 6):

- an understanding of the concept of "sustainable development" and the role that participants can play in their work individually and within organizations in achieving sustainable development;
- an understanding of the key sustainable development challenges and their potential solutions at the global, regional and local levels;
- needed skills to analyse and address global, regional and national population, environment and development issues;
- solid knowledge of the population, environment and development interrelationships;
- improved skills in policy analysis, including multisectoral policy analysis, and in programme management, including programme formulation, implementation, monitoring and evaluation;
- enhanced leadership skills in conflict resolution, systems thinking, change management and communication, especially as they relate to population, environment and development interrelationships;
- the ability to develop solutions that are both environmentally sustainable and socially equitable within the workplace and communities; and
- the initiation of a network of professionals involved in population, environment and development to share information and experience.

Furthermore, as far as impact is concerned, it is expected that the training will raise awareness and build capacity to make valuable contributions in the process leading to decisions on planning, development, implementation, monitoring and evaluation of policies on population, environment and development in order to improve the living conditions and the quality of life of all South Africans. It is envisaged that participants will develop and increase interest in population, environment and development issues to pursue careers that centre on the population, environment and development nexus. Participants will increase their capacity to identify key population, environment and development interrelationships and integrate them into policies and programmes on sustainable development (Government of South Africa, n.d. c, p. 6).

These outcomes and the expected impact assume fairly sophisticated learning results. They contain three major categories of outcomes in comprehensive learning: (a) a change towards a positive attitude and values regarding sustainable development; (b) an increase in knowledge that will lead to critical understanding of abstract concepts and complex relationships and processes; and (c) the acquisition of sophisticated skills in leadership, awareness-raising, and direction-giving and decision-making regarding policies, programmes and projects. Understanding population, environment

and development interrelationships and their integration into policies and programmes on sustainable development would require training in mastering highly sophisticated intellectual tools (Government of South Africa, n.d. c, p. 5). One of these intellectual tools refers to systems thinking, which is described in the following section.

Systems Perspective

Since the International Conference on Population and Development of 1994, the challenge of sustainable human development has become a globally recognized problem for all levels of policy design and implementation. This challenge is also recognized in the Population Policy for South Africa (Government of South Africa, 1998) that was adopted in 1998. The challenge can be stated as follows: How can sustainable human development be achieved and maintained given the reigning population and environmental realities of the country?

The answer to this challenge is to be found in the acceptance of the fact that population dynamics need to be factored into all development planning and implementation in order to conserve natural resources for use by future generations, to restore the degraded environment, to stop further environmental degradation, to modify destructive consumption patterns to manageable levels for both developed and less developed communities, to temper the demand on natural nonrenewable resources, and to increase the quality of life of all and the standard of living of the poor. To achieve this dynamic and complex condition, it is necessary to understand the interrelationships among the constituent factors of the nexus of population, environment and development and to acquire and apply the knowledge and skills that this understanding must bring to design and manage new complex eco-social systems. It should be understood that once a new eco-social system has been designed and implemented, it will need to be redesigned and adapted continuously to remain sustainable. This means that information systems, including monitoring and evaluation systems, will need to be designed and implemented as an ongoing activity to feed population, environment and development and related data into the decision-making systems in order to redesign and implement updated and upgraded models of sustainable human development.

The key concept describing this extremely dynamic and complex situation is integration. "Integration" refers to a process and ongoing activity that link various elements to achieve higher levels of synergism or interrelationships that create new combinations and, accordingly, new types of outcomes. In the present context, this refers to the integration of population and environment in such a way that sustainable development would be possible and in fact materialize.

Integration is a process that regulates the functioning of systems by recombining existing and new units and functions to create even higher-order functions. In human systems, this process is assumed to be driven by human values, or value

generalization. "Value generalization" refers to the process of the evolution of values to a higher order, i.e., of having a more generalized authority that will function as new forces of (more effective) integration of the units within the overall system.[4] Globalization is an example in the sense that it refers to universal (transnational) values in human development, such as the Bill of Human Rights.[5] In the South African system, this is embodied in the Constitution of South Africa (Government of South Africa, 1996), which is one of the major results of incorporating South Africa after 1994 (i.e., since the abolition of apartheid) into the world system. The Mafikeng Declaration on Population and Development in Africa of 2007 subscribes to general values and principles in topics pertaining to population, environment and development.

A simple description of a system depicts it as a unit where its elements are interrelated and where this interrelatedness has the effect that the whole (the system unit) is more than the sum of its parts. The parts synergized to create a higher energy output than the sum of each one's individual output.[6]

Understanding the population, environment and development nexus requires a sophisticated knowledge of systems thinking. Training initiatives by the Department of Social Development and the United Nations Population Fund (UNFPA) in South Africa that attempted to develop insight into the integration of population and development factors did not make this explicit up until 2005. Laudable attempts have been put in place to develop an increased understanding of the relevant interrelationships but the "LEAD-PED Nexus Training Programme" is the first to claim explicit training in systems thinking and the first that attempts to apply systems-thinking skills to the topic. In this respect, the Programme is a unique and innovative venture.

The training in and application of systems thinking in various fields generally has had the result that participants developed an enhanced insight into the relevant field. Systems-thinking applications are, of course, without boundary or restriction. Systems thinking is exceptionally suitable for applications where one needs to think and work in a transdisciplinary and interdisciplinary way. It is furthermore essential as a tool in problem-solving.

It is important that managers and leaders acquire these competencies to be able to design scenarios for alternative futures and to nurture vision. The leadership qualities that are critical in this regard include capacity in interpretation, envisioning, explicating new values,

[4]Insights used here were drawn, inter alia, from the following sources: Parsons (1966, 1971) and Laszlo (2001).

[5]Other relevant examples are international declarations on topics relating to population, environment and development such as the Dakar/Ngor Declaration on Population, Family and Sustainable Development (1992), the Plan of Action of the ICPD (1994), and the United Nations Millennium Declaration and its eight Millennium Development Goals (2000).

[6]This is, of course, true only of dynamic (open) organic systems; in closed mechanical (e.g., a petrol engine) or steady-state systems, this is not true. See also Bailey (1998).

building synergy, and mobilizing resources and people towards reaching new ends.

Description of the Programme

The core activity of the "LEAD-PED Nexus Training Programme" is, of course, training. The initial design of the Programme is written up in a prospectus, called the Course Outline, which specifies the curriculum, the teaching and learning approach, pre- and post-course activities, selection of participants and related topics (Government of South Africa, n.d. c). These aspects are to be considered as the planned Programme content and activities. However, in view of experience gained and the differential needs of target groups, amendments are made along the way. The Course Outline serves as a framework according to which needs of specific institutions and target groups are addressed in line with the basic design. This design is introduced in table 3.

The main theme is population, environment and development for sustainable development. The accompanying themes are: environment and development; population and development; population and environment; and competencies in leadership and management. Site visits and/or local case studies are important learning tools, and discussions and group work are essential elements in the presentations. A variety of themes is addressed according to the following topics although amendments and adaptations are made at each university.

The three partner universities follow this outline to a large extent but amend it according to their own individual emphasis and special strengths.

As noted earlier, the course initially lasted 11 days and consisted of a series of active and intensive learning activities preceded by a pre-course phase. The duration of the course is now shorter: in the case of the University of Cape Town, it is six and a half days; for the University of the Free State, it is eight days; and for Nelson Mandela Metropolitan University, it is five days.

None of the universities are using the pre-course phase that was initially provided in the Course Outline. According to the Course Outline, the pre-course phase was to be used to select the participants and to provide them with pre-course reading work that they were supposed to study and on which they would be tested. This would have had two important functions: to introduce the participants to the field of study and to ensure that they would be on an equal footing when entering the active lecturing part of the course (Government of South Africa, n.d. c, pp. 9-10). Apparently, owing to late registrations, none of this is possible at present, which is a pity particularly because facilitators observe different levels of pre-course knowledge among participants and the need to introduce baseline material during the course. Provision should be made for correcting this practice by going back to the original idea or providing pre-study time to participants.

A facilitator conducts daily monitoring of course activities. Presentations and learning activities vary. Some topics are introduced and discussed according to a conventional lecturing style while others are addressed in a workshop. Case studies

Table 3 | Population, environment and development topics as per the Course Outline.

Population, Environment and Development for Sustainable Development

- Overview of key population, environment and development concepts and indicators; international agreements;
- Systems thinking;
- Simulations;
- The role of indigenous knowledge systems in sustainable development; public participation;
- Globalization, trade and sustainable development; and
- Provincial growth and development strategies.

Environment and Development

- Ecosystems and global change;
- Ecological footprint;
- Resource utilization;
- Health and environment;
- Environmental policies and tools.

Population and Development

- Population, gender and development;
- Reproductive health and development;
- Social and economic impact of HIV and AIDS; and
- Migration and urbanization.

Population and Environment

- Land tenure and human settlements;
- Agriculture and food security; and
- Disasters and vulnerability.

Competencies in Leadership and Management

- Communication skills;
- Conflict-resolution negotiation and decision-making; and
- Change management.

Site Visits and/or Local Case Studies

These may include:

- Sustainable commonage management;
- Poverty alleviation and Working-for-Water/Working-for-Wetlands initiatives; and
- Sustainable human settlements and land reform.

Source: Government of South Africa, n.d. c, pp. 11-22.

and simulations are used to ensure practical and applied learning and group work is encouraged and implemented.

After the course, participants are expected to develop networks among themselves, the facilitators and the presenters. This networking is used as a means of mentoring among individuals to assist one another at work. This is regarded as a long-term benefit of attending the course.

The in-class training course content focuses on a number of topics including awareness creation and capacity-building regarding the population, environment and development nexus in sustainable development, and leadership and management of population, environment and development issues in sustainable development.

Implementation of the Programme

Altogether 17 courses with a total enrolment of 452 participants were conducted from April 2005 to April 2010 under the Programme. The second course, in Lesotho, was much shorter than other courses as it served as the launching event of the Programme. "Population, Environment and Development in Integrated Development Planning Processes" was first presented in October 2008; since then, another two courses have been given. Most of the courses were presented by the University of the Free State (7 courses) and the University of Cape Town (3 courses).

The courses targeted professionals and managers who work in a sector that is concerned with development, such as international, national, provincial and local government, NGOs, trade unions and the private sector, and high-level policymakers.

The courses drew more participants from national and provincial government departments than from local government. The "Population, Environment and Development in Integrated Development Planning Processes" course did not succeed in drawing majority numbers from local governments. Up until 2009, 85 local government officials had attended, which represents less than a third of the total number of municipalities (local governments) in South Africa.

On the other hand, some municipalities sent more than one trainee and in some cases quite a number of them. It is a fact, however, that while local government managers and planners, especially those responsible for the integrated devel-

Unemployed youths have become a target for the Programme. Principles of systems thinking are being introduced by Prof. Sosten Chiota from LEAD SEA.

Table 4 | Courses given and distribution of course participants.

Course Presented	Course Participants					Total
	South Africa Nat. Govt.	South Africa Prov. Govt.	South Africa Local Govt.	Non-South Africa (Africa)	South Africa Other (NGOs)	
03-15 Apr. 2005, Kempton Park	2	13	4	4	1	**24**
26-27 Sept. 2005, Lesotho	0	1	2	10	0	**13**
21 Nov.-02 Dec. 2005, Africa Centre, KZN	10	7	1	0	0	**18**
05-17 March 2006, Cape Town	9	7	12	0	0	**28**
03-14 July 2006, Bloemfontein	8	11	7	2	0	**28**
16-27 Oct. 2006, Port Elizabeth	5	4	8	3	5	**25**
11-22 Feb. 2007, Kimberley	6	6	0	3	3	**18**
13-21 Sept. 2007, Bloemfontein	11	4	2	17	0	**34**
25-31 Aug. 2008, Cape Town	15	2	6	1	12	**36**
13-17 Oct. 2008, Port Elizabeth ("Population, Environment and Development in Integrated Development Planning Processes")	12	2	6	0	0	**20**
11-19 Sept. 2008, Bloemfontein	4	18	9	14	2	**47**
17-21 Nov. 2008, Port Elizabeth ("Population, Environment and Development in Integrated Development Planning Processes")	9	1	2	0	5	**17**
04-12 June 2009, Bloemfontein	7	6	2	3	0	**18**
15-23 Sept. 2009, University of the Free State, Bloemfontein	8	11	8	2	1	**30**
01-07 Nov. 2009, Cape Town	4	11	7	5	0	**27**
07-12 Dec. 2009, Port Elizabeth ("Population, Environment and Development in Integrated Development Planning Processes")	6	14	5	0	3	**28**
15-23 Apr. 2010, Bloemfontein/Golden Gate	20	6	4	11	0	**41**
Total	**136**	**124**	**85**	**75**	**32**	**452**
% per government sphere, etc.	**30.1**	**27.4**	**18.8**	**16.6**	**7.1**	**100**

Sources: Government of South Africa, 2009a; Government of South Africa, 2010.

opment planning process, are the target for the Programme, it is not succeeding in attracting a majority to attend from this source. It should be noted that departments in national and provincial governments responsible for servicing local government needs did respond favourably in attending the Programme and were in that sense answering the call to attend to local planning and development needs.

Post-training Opportunities

One of the major features of the "LEAD-PED Nexus Training Programme" is the post-training opportunities that offer unique possibilities for the further development of selected participants.

The available options include the completion of the entire LEAD Associate programme, internships at relevant United Nations agencies, exchange programmes between countries and progression to a post-graduate programme. Post-training support is provided through a network of participants with a tutor. This means that participants, on their return from the course to their workplace, may discuss questions among themselves with technical support from tutors. Participants will also be subscribed to the Population and Environment Research Network of the International Union for the Scientific Study of Population.

All the participants will become LEAD Associates. In addition, a limited number of participants have an opportunity to join LEAD training to receive detailed training in leadership in sustainable development. This would enable participants to become LEAD Fellows.

The "LEAD-PED Nexus Training Programme" produced more than 40 LEAD Fellows until the end of 2009 and doubled the number of LEAD Fellows in South Africa. LEAD Fellows act as change agents globally and within their own countries and regions. One expects, therefore, a continued impact among management and leaders regarding population, environment and development issues due to the increased awareness and knowledge improvement gained in the course.

Support was provided to four local government participants to undergo United Nations Economic Commission for Africa internships with a focus on population, environment and development in the work place and on gaining a population, environment and development orientation to plough back into their local situation.

Some evidence was forthcoming that exposure to training according to the model of the "LEAD-PED Nexus Training Programme" might be beneficial for finding job opportunities among unemployed youth. At least one such pilot was conducted with a measure of success.[7] As this example demonstrates, the Programme is showing potential for vertical portability by including and benefiting a variety of target groups.

Finally, participants have an opportunity to continue post-graduate population, environment and development studies at partner universities depending on the requirements of the universities. One of the partner universities (University of the Free State) is recognizing LEAD population, environment and development

[7]In this case, the Department of Environmental Affairs and Tourism requested a pilot LEAD population, environment and development course among unemployed youth, which was presented by Dr. Anton de Wit from Nelson Mandela Metropolitan University, with the result that participants received job placements within six months after completing the course. The roll-out of this version of the course on a larger scale is now under consideration (Government of South Africa, 2010).

training in its master's degree programme in Development Studies.

Networking and Support

There is a need for networking and mutual support in the post-training phase as indicated earlier. Various mechanisms have been created for this purpose, notably the printed *Population, Environment and Development News* and an e-driven information service run by the Department of Social Development.

Population, Environment and Development News is a collaborative venture by the Department of Social Development and an NGO, Bethelsdorp Development Trust (BDT). The aim is to provide a communication channel for population, environment and development (PED) trainees to share information, news and ideas about, within and among communities within South Africa and the region. The information is generated from a community base and is not moderated by the Government although the Government acts as a facilitator. In its first edition, December 2006, the lead-in article states that "This newsletter should always have a distinctly local 'flavour'. It must contain news and stories of local community activities from across Africa, like those of the BDT. You, the reader, have an important role to play to ensure that your own PED stories also get told herein, so that others can read them." The Bethelsdorp Development Trust is regarded as a successful population, environment and development initiative. It is operating in the Nelson Mandela Bay municipal area and hosting the newsletter. People responsible for the publication have been trained in the "LEAD-PED Nexus Training Programme". The newsletter serves as an advocacy instrument, appears twice a year and has a circulation of about 5,000 (Government of South Africa, 2010).

The Department of Social Development maintains a Population and Development Information and Knowledge Centre, which serves the population and development community, among others, through an e-driven subscribers' information service. The service includes an environment list with subscribers to whom information messages (about publications, conferences, courses, etc.) are sent. Items are linked or can be requested directly from the service. Items are also added to the *population.gov.za* website where they are downloadable. The service provides a rich and up-to-date source of data and information on issues relating to population and the environment.

Population, Environment and Development Research and Case Studies

Information on population, environment and development issues serves to enhance interest in as well as the level of insight into the interrelationships among the core components of the nexus and how they are affecting not only the constituent parts and system but also the wider and outer systems. Often these intricate systems are best understood by having access to in-depth case material that demonstrates the dynamic processes in real-life situations. The "LEAD-PED

Nexus Training Programme" stimulates not only a need for case studies but also initiatives to conduct such studies. Two unpublished volumes contain the result of these studies, which are collaborative efforts by individual researchers and research institutions with the Department of Social Development. The first volume includes papers that provide information on the policy and legal framework of population, environment and development interrelationships; the theoretical and international debates on this topic; the various thematic aspects of the interrelationships; women and population, environment and development; technology; economics; and training and partnerships. This volume may serve as a theoretical and contextual introduction in population, environment and development training (Government of South Africa, n.d. a). The second volume includes six real-life case studies on population, environment and development interrelationships in South Africa (Government of South Africa, n.d. b).

The "LEAD-PED Nexus Training Programme" has therefore stimulated in-depth research into population, environment and development interrelationships. Further research, training and regional networking are encouraged by the fact that LEAD is conducting its Cohort 15 International Training Session in Eastern Cape (Nelson Mandela Bay Municipality, Port Elizabeth), South Africa, during 2010. Participants in this training qualify as LEAD Fellows. In order to qualify for enrolment, pre-courses must be completed, one of which may be from the "LEAD-PED Nexus Training Programme". Pre-courses are offered in South Africa, the United Republic of Tanzania and Malawi, which creates a basis for a regional network in PED training. The LEAD International Training Session is held in one of the poorest provinces of South Africa, which is providing financial, intellectual and networking inputs to the province and city. Six areas are identified for continuation of case study research, with consideration of the theme of the international session, namely, "Population, Climate Change and Development".

Climate Change

Climate change is the most significant emerging issue in international population and development discussions, as reflected in resolutions adopted by the United Nations Commission on Population and Development in 2008 and 2009 and in the Kampala Declaration of the Partners in Population and Development (PPD) (Government of South Africa, 2010).

Climate change as an acute environmental issue in relation to population and development has therefore become an urgent challenge. In the 15-year review of the International Conference on Population and Development within the Southern African Development Community (SADC) region, it is recommended that the impact of environmental degradation and climate change on sustainable development and the need to strengthen capacity to address this impact be recognized (Government of South Africa, 2009b, pp. 18 and 58). The above-

mentioned International Session on Population, Climate Change and Development and its associated activities therefore seem to be a timely response to this call. The "LEAD-PED Nexus Training Programme" has provided the necessary institutional link for bringing this input to the country.

Assessment and Evaluation

Innovative and Distinctive Aspects

The "LEAD-PED Nexus Training Programme" may be regarded as a bold innovation in teaching a complex topic, distinguishing itself from other programmes in the population capacity-building field. Programme facilitators and past participants testify to the extent to which they have experienced the Programme as an innovation and distinctive venture.[8] This section provides perspectives and findings on this question.

From a general perspective, the topic of population, environment and development interrelationships itself is multifaceted and complex and therefore extremely challenging to teach. It requires a multi- and inter-disciplinary approach, explaining the theoretical concepts and models for understanding this complexity and providing hands-on illustrations in practical situations to grasp the theoretical underpinnings. From a teaching point of view, in an adult learning setting, with time restricted, it is imperative that learning situations be well planned, well resourced and facilitated by well-prepared, knowledgeable and experienced instructors. It should furthermore be understood that the trainee audience is mixed and varied in terms of academic background, professional experience, and cultural, age and gender composition. The minimum academic entrance qualification is a bachelor's degree. Given this background as a description of the teaching challenge, participants have observed the following as innovative and distinctive aspects of their learning experience in the Programme.

First of all, one participant observed that "it is the interrelatedness of the three topics that makes it both a challenge and the key for human prosperity". It seems that this participant recognizes the systemic nature of the study topic and gained insight from this fact. Other participants concur by pointing out how well the Programme succeeds in making the complexity understandable through well-designed teaching and demonstration settings, well-prepared facilitators, bringing theory and practice into immediate relationship with one another, and using cases studies, field trips, the natural environment and practitioners.

In addition, participants mentioned that they found the coverage of a rather wide range of topics from different angles and vantage points to demonstrate the

[8] A special investigation to this effect was conducted by the author of this case study.

linkages among population, environment and development as a distinctive aspect. It is not only different approaches that are making the distinction but also the fact that the Programme draws from different countries, cultures, professions and age groups. "This makes for a great learning experience", said one participant. Another participant appreciated the multidisciplinary approach: "So many disciplines form part of the course, which means that your horizons are broadened."

The methodology of teaching was also experienced as innovative and distinctive. Case studies, group projects and group presentations were appreciated in this regard. A participant testified that "The interactive setting highlighted key concerns and challenges. Issues that I had read and studied before and during the session from books were brought to life through carefully crafted and finely observed practical applications." The distinctive element therefore was "the focus on interactive learning and practical application in group context and using case studies".

An example of how one university (University of the Free State) attempted to bring a real-life situation into the teaching setting was the bringing on board of South African National Parks (SANParks) as a partner. The innovative aspect was the involvement of a secondary partner, SANParks, which "has ensured the programme of a sustainable case study and the incorporation of inputs of practitioners working in the PED context. Participants were given practical exposure to the PED linkages in a real-life context. The field visit enables participants to integrate theoretical concepts and practical experience within a natural environment."

The total mix of the various elements of the teaching experience was also valued: "The balanced use of a variety of adult learning methods including the emphasis on cross-cultural experience and exchange of expertise" is a distinctive feature.

The creation of networks also was seen as a special feature. As a participant stated, "The programme teaches a philosophy and approach to sustainable development rather than mere facts that will be reinforced for many years to come by strong networks and support for further learning. I have found the interaction with fellow group members helps to keep me motivated and involved."

Some participants and even Programme facilitators alluded to the fact that they were not aware of other programmes in this particular field and therefore regarded this Programme as unique in itself: "The venture itself and the topic are a unique intervention within the South African context."

Finally, the University of Cape Town saw the innovative aspect of this Programme as the fact that the nexus of population, environment and development is regarded as a teaching topic. Furthermore, it found the partnership between the public sector, civil society and particular academic organizations to be innovative.

Strengths and Weaknesses

A mid-term evaluation of the "LEAD-PED Nexus Training Programme" was commissioned by UNFPA and the Department of Social Development and conducted in 2006 to assess the first group of courses and the experience of participants and to make recommendations for future application (Gaisie and Groenewald, 2006).

This evaluation found that most participants viewed the Programme as a success. The apparent reason for its value lay in the mix of the course elements and the foundational value of systems thinking to which participants had been introduced. The evaluation concluded that to maintain a lasting effect, the course module needed to be followed up by further similar but reinforcing modules and accredited with the South African Qualifications Authority so as to affirm its high standard. The course could be redesigned to cater to homogenous levels of seniority groupings of participants to facilitate the institutionalization of the course on postgraduate levels where the need might arise. The course needed to be seen as a template for developing a series of short courses on different levels that all fit the population and development interaction framework.

This recommendation by the mid-term evaluation of the "LEAD-PED Nexus Training Programme" received a positive response by the Government's Directorate for Population and Development. Various training initiatives of different kinds and formats, all related to the population, environment and development nexus, have since been identified and developed (Government of South Africa, 2009a).

Although no further evaluation was subsequently undertaken on the same scale as the mid-term review of 2006, post-course assessments were conducted by the various universities. These assessments covered all sessions/presentations/exercises in each course. The findings from these assessments do not differ significantly from those of earlier assessments and the mid-term evaluation and in fact support the findings of those assessments. With respect to one university (University of the Free State), a significant improvement in the participants' ratings was observed over the period from 2006 to 2008. Participants were responding generally positively to the Programme. At another university (University of Cape Town), nearly all participants confirmed consistently over three courses that they felt that the course contributed to their capacity to do work and that they had gained new knowledge and skills.

Weaknesses noted in the mid-term evaluation (Gaisie and Groenewald, 2006) include the following:

- No pre-course learning activity seems to be required, which has a negative effect on starting the course on an equal footing.
- Some course attendants are diverse in terms of their level of knowledge and experience and seniority level, which slows down the pace of group exercises and contributes

to increased frustration among participants.

- Apart from the accreditation by the LEAD fellowship programme, there seems to be a need to have the Programme registered with the South African Qualifications Authority. One university has accredited the Programme within a post-graduate Programme.
- Targeted selection of prospective trainees should receive more attention, particularly among groups where the need for population, environment and development knowledge is apparent, such as among local government managers and planners.

Enhancement of Participants' Capacity

The partnership of the Programme with LEAD brings numerous advantages, as has become clear from the overview above. Using case studies as a learning strategy has proven to be highly successful. LEAD has applied a case-study approach worldwide for the past 18 years. The LEAD Network has 14 regional offices that each provides capacity development courses and activities. The "LEAD-PED Nexus Training Programme" in South Africa is already linked regionally to the LEAD Network. The concept has been applied elsewhere in Africa, which is an indication of the portability of the Programme also into countries of Francophone Africa. As mentioned earlier, the local courses are accredited with the international LEAD programme (LEAD, 2010).

On the level of the individual participant, trainees provided generally positive responses about the course, as already indicated. Numerous comments listed in the formal evaluation by the universities confirmed this. Participants grasped the idea and an understanding of key population, environment and development interrelationships and developed the skill to integrate them into policies and programmes on sustainable development (Gaisie and Groenewald, 2006). Generally, it seems that this outcome has been accomplished.

Some participants were encountered who did not acquire the desired knowledge and skills but the evaluation concluded that the courses were successful in accomplishing the main objective of acquiring integrative skills.

In the recent inquiry,[9] participants were asked to indicate whether in their experience the course had enhanced the capacity to do their work. Nine out of ten participants answered in the affirmative.

The participants were also requested to provide examples of how, or where, they had applied, with a measure of success, insights, knowledge or skills acquired in the course. Examples of applications include the following:

- A participant was able to run a programme on the social and

[9]As noted earlier, the inquiry was specifically conducted by the author for the purposes of this case study.

economic impact of HIV/AIDS.

- A participant used the Gender and Access to Resources module to manage a poverty-relief project and to recognize the role that gender is playing in this regard.
- A participant had to compile socio-economic profiles for the municipalities in the province and was able to link local government policies and accompanying budgetary documentation to the exercise.
- A participant worked with engineers from Infrastructure Development (which, according to his/her perception was "always developmental") as well as the Social Facilitation section. With the population, environment and development knowledge, he/she could now ensure "that a balance is achieved between development, people and environment".
- A participant said that he/she had the opportunity to use knowledge gained from the course in advocacy and capacity-building sessions that the office was conducting with district and local municipalities.
- A participant used the acquired knowledge and skills in running a campaign of early childhood immunization against measles and other diseases.
- A participant used insights and knowledge from the course when writing a synthesis report on the implementation of the Population Policy between 1998 and 2008.
- A participant was involved in course designs regarding a training manual on integrating population issues into development policies and plans and the Allied Population Sciences Training and Research (APSTAR) manual. The participant was able to give inputs regarding the importance and need to address the integration of population, environment and development in both the courses.
- A participant had to critique a paper on population, environment and development linkages in addressing environmental sustainability. The training made it possible to review the author's views and perspectives and to (re-)shape policy perspectives in this respect.

These examples show that a wide variety of applications is indeed possible for participants who have acquired knowledge and skills as intended through the training. It can therefore be concluded that the Programme succeeds in providing the desired outcomes.

Impact

The course outcomes are important and critical in establishing impact among participants, in society and on the physical environment.

With respect to the participants, their capacity to perform their work and duties, and their work situation, evidence has been provided to reach the following conclusions in line with the expected outcomes, that is, the majority of participants:

- seem to have an understanding of the concept of "sustainable human development" and the role that they can play in their work individually and within organizations;
- seem to have an understanding of key sustainable development challenges and of how to address them at global, regional and local levels in so far as this is related to their work situation;
- have developed insight into the skills needed to analyse and address global, regional and national population, environment and development issues;
- have acquired improved knowledge of population, environment and development interrelationships;
- have developed insight into the skills needed to perform policy analysis and undertake programme management, formulation, implementation, and monitoring and evaluation;
- have developed insight into the skills needed in conflict resolution, systems thinking, change management and communication as they relate to population, environment and development interrelationships;
- have enhanced their ability to develop solutions that are both environmentally sustainable and socially equitable within the workplace and communities; and
- have formed networks with professionals involved in population, environment and development to share information and experience.

It could be expected that the major overall societal impacts to follow from these outcomes would be enhanced sustainable human development, a more equitable and harmonious society, improved quality of life, a population less vulnerable to natural and man-made disasters, and informed and empowered leadership. Because it would be impossible to measure and demonstrate empirically links between these expected impacts and the specific inputs of a singular programme, one may only assume, on reasonable grounds, that the "LEAD-PED Nexus Training Programme" does have a contributing effect in the above-mentioned respects.

The impact on the physical environment, for example, may result from changes in individual behaviour, which will only have a significant impact when a large enough number of individuals change their behaviour to environmentally friendly patterns. This means that impact from the Programme possibly will only be significant as a result of awareness and advocacy, making use of suitable information, communication and educational action. On the assumption that the Programme is reaching leaders and managers who have a wide range of influence, one can expect measureable impact although demonstrating causal linkages will remain a difficult methodological task. One therefore must opt for an impact argument that assumes causality as a result of critical mass, perhaps resulting in public measures (e.g., policy and legislation) and public opinion that promote environmental rehabilitation and

conservation in the broadest sense of the word. In this respect, the Programme is assumed to be on the right track.

The final question regarding impact is whether the Programme has in fact resulted in changes in public policy measures and public opinion that would promote sustainable human development based on a sound understanding and resolution of population, environment and development issues.

In this regard, it should be noted that the Programme is a result of such public measures and public opinion in so far as these measures and opinions are already in existence. It has been argued extensively in this case study that there is a global consensus regarding the strategic importance of the population, environment and development interrelationships and about the critical nature of population, environment and development issues (for example, climate change being a particularly important issue at present). The case study has indicated that South Africa has indeed bought into this argument, among others, by endorsing the global consensus and concerns and by adopting a Population Policy that underscores the concerns and issues. In this case study, the route has been traced by which the "LEAD-PED Nexus Training Programme" has come about as a specific venture, among others, to address (some of) these concerns and issues. The case study has also shown how the Programme has expanded in terms of participant numbers and institutional response. It may therefore be correct to assert that the Programme is already part and parcel of the existing development policy (in this case, the Population Policy) of South Africa.

On the other hand, because of the status of the Programme as a development measure, it has been considered as a special tool in facilitating local development planning. Local development planning is a formal, legally sanctioned process, under the auspices of local government, which, according to the Constitution of South Africa (Government of South Africa, 1996), has full responsibility as well as the obligation to take care of local community development.

The Municipal Systems Act (32/2000) provides the legal provisions for local government to fulfil its Constitutional obligations and responsibilities. In this regard, development at the community level must answer to so-called "triple bottom-line accounting", which refers to the need to incorporate population (the social component), environment and development into local development (Mpumalanga Provincial Government, n.d.).

Government, through the Chief Directorate: Population and Development, identified the need to build capacity among local government institutions (municipalities) and personnel to perform their responsibilities in formulating and implementing integrated develop plans. These plans, once adopted, will become the legally binding instrument for performing the development process for the local government area of jurisdiction. By training integrated-development-plan and

related managers of local government, the "LEAD-PED Nexus Training Programme" is becoming a real, direct influence in the integrated-development-plan process, as examples of the application of knowledge and skills acquired in the training have demonstrated.

A specific instrument has been designed to assist the "LEAD-PED Nexus Training Programme" in fulfilling this task. This instrument is a guideline titled *Taking Population Seriously in Your IDP: A Guide for Integrating Population Information into Integrated Development Planning*. This guideline has been submitted to the Chief Directorate: Population and Development and has been used already in the training of participants in the Programme on two occasions (Groenewald, 2010).[10] In this way, the "LEAD-PED Nexus Training Programme" has become institutionally integrated into the development policy and planning process at the local level of governance. It may therefore be concluded that the Programme is impacting on development policy, planning and implementation.

Lessons Learned and Replication

An important question remains whether the Programme has the potential to be replicated in another country. What would be the requirements for and potential stumbling blocks in such a move? The experience in establishing the "LEAD-PED Nexus Training Programme" is providing some lessons learned and guidelines in considering these issues.

- The implementation of the Programme in South Africa was informed and supported by training sessions conducted by LEAD elsewhere in Africa and developed in close collaboration with LEAD. In fact, some academic content used in the present implementation was developed by LEAD and is still applied in sessions by LEAD locally and elsewhere. Some presentations are made by LEAD personnel. This points to an important principle and in fact a requirement for the successful transfer of a programme such as this, namely, that close collaboration is maintained between the sending agent and the receiving agent. Part of the success of the Programme in South Africa can be ascribed to the adherence to this principle.
- The Programme has the potential for portability. Transference geographically from one region/country to the next has taken place successfully and is an example of horizontal transference. In this case study, it has also been shown that vertical transference is possible, namely, from one target group to another. In both cases, adaptation to the needs of the new environment/target group is necessary

[10] The research and writing of the guideline were commissioned by the Department of Social Development and introduced on two occasions to participants at the University of Cape Town course in November 2009 and the Nelson Mandela Metropolitan University course in December 2009.

and changes should initially be piloted before new content, structures and practices are established.

- Institutionalization is a strong if not essential principle and process to ensure sustainability in the venture. This is valid for the present Programme as well as new programmes. "Institutionalization" means that the programme can be seen as a function of the relevant organization or organizations within a framework of agreed partnerships. A strong institutional foundation, with partnerships as the basis, is therefore recommended. The relationship among partners and their individual roles and obligations should be regulated according to memorandums of understanding and agreement.
- Implementing agencies should have a clear understanding of what is involved in implementing the Programme. In other words, they should know the requirements, both scientifically and logistically, and preferably have hands-on experience in the implementation of projects.
- From the point of view of implementation, there is a need for a champion of the Programme, i.e., someone to drive the Programme at each of the home institutions (programme coordinator); this also and particularly applies to government. Without key champions at key partner institutions, the Programme is doomed to failure. To act as a champion implies that there is sufficient capacity, interest and enthusiasm on the part of the local academic partner. Home institutions should have at their disposal adequate and suitable resources and infrastructure for implementing the Programme.
- A dedicated and experienced group of presenters should be recruited and maintained to present a series of courses that are committed to the population, environment and development idea and the Programme.
- Financial responsibility should be shared among the partners. Dependency on single-party funding is risky and unsustainable. Each partner should be clear on its financial input into the running of the Programme. In this respect, the South African Programme sees the UNFPA role as that of an incubator that enables the start-up of the Programme (memorandums of understanding for funding, curriculum writing, pilot courses, etc.) and not as responsible for subsidizing the Programme as a whole. The Chief Directorate: Population and Development claims that this is an innovative engagement of UNFPA that is actually making the Programme more self-sustaining owing to the institutionalization of role expectations at the partner level (Government of South Africa, 2010).
- The Programme would need a fully designed curriculum including a course outline and study

guide together with suitable study material. Standards and norms should be specified.

- The most suitable replication model should be investigated. The following are options but combinations would also be possible:
  - the course may be transferred as a package deal;
  - participants are transferred from the area of need to the site of presentation;
  - presenters are shared between the existing and the new Programme;
  - existing implementing agents are shared with the new Programme;
  - capacity is built in the new environment in order to enable the new presenters to become equipped for their task. This will stimulate self-sufficiency in the long run.

THE FUTURE: CONDITIONS FOR DEVELOPING AND EXPANDING THE PROGRAMME

The process of crafting this Programme was elaborated earlier. In South Africa, the Population Policy for South Africa (Government of South Africa, 1998) served as a major rationale for the idea of a training and capacity-building programme to deal with population, environment and development issues. The country programme of UNFPA, especially its Population Development Strategy, added to this and was a key in the forging of the partnership between the Government of South Africa and UNFPA. The involvement of LEAD may have been motivated by the fact that key role players were LEAD Fellows who upheld the values of leadership and environmental sustainability. The inclusion of universities should be regarded as a deliberate policy directive to involve stakeholder communities in planning and development.

The role players mentioned above progressively plan and execute the institutionalization of the Programme. First, there was an agreement between the Government of South Africa and UNFPA to collaborate on this venture. This was followed by a Project Document with expanded agreement conditions and parties, involving LEAD. Universities were consulted and formally included through memorandums of understanding. Secondary and other partners were included along the way. The following partners may be mentioned: SANParks (Golden Gate Highlands National Park in Free State, Addo Elephant National Park in the Eastern Cape), the Africa Centre in KwaZulu-Natal, Coega Industrial Development Zone in the Eastern Cape, Bethelsdorp Development Trust in the Eastern Cape, Nelson Mandela Bay Municipality in the Eastern Cape and the Bus Rapid Transport System.

The role players represent a wide spectrum of stakeholders and interests ranging from international (UNFPA, LEAD), regional (Southern African Development Community, Southern

African Ministers' Conference on Population and Development), national (Government of South Africa, Department of Social Development, Chief Directorate: Population and Development) and provincial (Provincial Population Units) to local players (e.g., Nelson Mandela Bay Municipality) as well as various universities (University of Cape Town, University of the Free State, Nelson Mandela Metropolitan University) and specialist organizations and businesses, as listed above. The active engagement of the various institutional spheres through the mechanism of the memorandums of understanding and the sustained involvement of participants in the post-training phase through the LEAD Associate and Fellowship Programmes ensured a high level of community engagement.

However, in a recent follow-up inquiry by the author,[11] it was observed that a substantial number of participants could not be traced through the address system on record. This shows that the alumni system could be upgraded and kept in better condition than it is at present. By keeping alumni on an active and up-to-date circulation list, networking could be more effective and the circulation of *Population, Environment and Development News* could be better targeted.

Attempts are made to build and strengthen local institutions. One example is strengthening and supporting Nelson Mandela Bay Municipality. The process started when leaders from the Municipality were trained in the "LEAD-PED Nexus Training Programme". These leaders encouraged colleagues to be trained and, as a result, the awareness and knowledge level regarding population, environment and development issues increased significantly and a centre of gravity started to develop regarding population, environment and development interrelationships. For example, a local municipal policy and implementation process began with respect to the so-called "green economy". It provided for hosting the LEAD International Session on Population, Climate Change and Development, which spurred a range of activities relating to population, environment and development interrelationships: public seminars; a university course; scholarships for training in population, environment and development issues; network-building, etc.

Local institution-building is one of the prerequisites for sustainability in programmes. It depends on visionary leadership. It is therefore extremely important to nurture leadership through the training and capacity-building processes of the Programme, to develop and build effective communication processes to spread the message and to anchor these efforts within an institutional framework. A good example is the development of *Population, Environment and Development News* and its anchoring in the Bethelsdorp Development Trust. This venture is nurturing leadership (an editor from the Trust), a communication channel and

[11] The inquiry for this case study.

mechanism (*Population, Environment and Development News*) and institution-building (the Trust has become a platform for news, information and interpretation).

The training programme and the sessions are accredited with the international LEAD Programme. Participants can continue to attend other courses of the LEAD Associate Programme at any of the 14 LEAD member programmes worldwide. The various universities involved are in the process of gaining recognition for the course within the various university structures according to the procedures for accreditation by the South African Qualifications Authority or the South African Council on Higher Education. Such accreditation will carry recognition throughout the university system of South Africa. This will enhance the credibility and sustainability of the Programme.

Conclusion

This case study on the "LEAD-PED Nexus Training Programme" has shown that understanding interrelationships between population, environment and development is an urgent and important issue for South Africa and beyond, as confirmed in international and national discourse. In particular, climate change has become a matter of grave concern regarding the future quality of life of people and in poverty alleviation. Awareness-raising, knowledge enhancement and skills development are measures necessary to address the issue. The Programme introduced in this case study aims to build capacity in this regard that may impact constructively on development policy, planning and implementation.

The case study provides evidence of a best practice and innovative and distinctive approaches in the implementation of this Programme in terms of its design, development and expansion. It has been argued that the topic itself, the inputs into the implementation of the Programme, the methodologies followed, the quality of the facilitators, the management of the Programme, the target group, the partnerships, and the follow-up networking of participants all contributed to its best-practice status. The case study shows that the Programme has strong portability potential and that it should be possible to replicate the model in other environments. A list of requirements, based on lessons learned, is provided for this purpose.

Finally, the Programme is considered as a product of development policy and planning and a contributor to the more effective implementation thereof as well as a direct stimulus for the further advancement of development policy and planning, particularly in the area of integrated development planning in South Africa.

Acknowledgements

I would like thank the following people who assisted in providing information: Prof. Sosten Chiota, Director, LEAD Southern and Eastern Africa, University of Malawi, Zomba, Malawi; Dr. Anton de

Wit, Department of Geography, Nelson Mandela Metropolitan University, Port Elizabeth; Prof. Ralph Hamann, Associate Professor and Research Director, Graduate School of Business, University of Cape Town, Cape Town; Ms. Carol Lombard, Population and Development Information Centre, Chief Directorate: Population and Development, Department of Social Development, Pretoria; Ms. Eunice Nchoe, Chief Directorate: Population and Development, Department of Social Development, Pretoria; Ms. Lynn O'Neill, University of Cape Town, Cape Town; Prof. André Pelser, Department of Sociology, University of the Free State, Bloemfontein; Ms. Nola Redelinghuys, Department of Sociology, University of the Free State, Bloemfontein; and Mr. Jacques van Zuydam, Chief Director, Population and Development, Department of Social Development, Pretoria.

I would also like to express my appreciation to the trainees who responded to my inquiries and provided qualitative answers to the questions.

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8

Thailand

Experience in Addressing Mother-to-child Transmission of HIV/AIDS within a Community Framework

Mrs. Nareeluck Kullurk

Summary

In 2000, the Ministry of Public Health of Thailand issued a policy that aimed to prevent the transmission of the human immunodeficiency virus (HIV) from mothers to their children. The national policy combined core services in preventing mother-to-child HIV transmission with existing care for mothers seeking prenatal care at all government and some private hospitals. These services should have included general care and psychosocial help and they should have stressed the linkages between hospitals and communities. The national policy and guideline did state, however, that HIV-infected mothers and their children should receive a continuum of HIV care to improve their health and receive other appropriate treatment and care whenever needed.

The medical and related health services for mothers and children are part of the government mainstream health service facilities, which are found at all levels of administration and in all geographical areas. Government health-service providers in these facilities are often overburdened with a heavy workload and might not always have been able to spend sufficient time with patients, in particular with HIV-infected patients who require psychological support in addition to medical services. As a result, peer leaders of people living with HIV/acquired immune deficiency syndrome (AIDS) were called upon to provide assistance to the health-service providers in the government hospitals. In Thailand, the people living

Summary (continued)

with HIV/AIDS have played an important role and have been active in self-help groups for people living with HIV/AIDS. Many of these people have become peer leaders and have been recruited and trained by non-governmental organizations to work closely with the staff in the communities. The community network is yet another important mechanism that has helped and encouraged HIV-infected mothers to bring their children for follow-up. Coordination among health-service providers in hospitals, peer leaders of people living with HIV/AIDS and the community network needed to be strengthened in order to increase the access to support and help.

In 2005, a project to provide care and support for HIV-infected mothers, their partners and children was developed and set up in 41 provinces. The project was implemented by the Department of Health with collaboration and coordination from the Thai National AIDS Foundation. The Foundation brought in its network of peer leaders of people living with HIV/AIDS to work closely with the government service providers in clinics for maternal and child health/prevention of mother-to-child HIV transmission. The project offered HIV treatment and care for infected mothers, their children and spouses; follow-up of HIV testing and antiretroviral treatment (ART); supportive ongoing counselling; and psychological support for children infected with or affected by HIV. It organized peer support groups in hospitals and communities, campaigns for the better understanding of HIV/AIDS in the community, policy advocacy for a reduction of stigmatization and discrimination, health education for school teachers and effective community-based networks. It also aimed at strengthening the linkage between health-care facilities and communities as well as the capacity of groups of people living with HIV/AIDS to provide holistic care for HIV-infected mothers and their children. These project activities encouraged the mothers to remain with the project and to come back for regular medical check-ups.

This case study describes the successful implementation of the above-mentioned project initiated in 2005 whose activities were qualified as best practices in seven of the 41 provinces. The project was a successful service model in that it helped HIV-infected women, their children and families to receive a continuum of HIV/AIDS care and remain in the HIV care programme. Furthermore, the number of diagnosed children born to HIV-infected mothers also increased and they could be given timely and appropriate care. There was also an increase in the number of husbands participating in the HIV care programme.

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Background

The Thailand human immunodeficiency virus (HIV) sentinel sero-surveillance system, which was started in 1989, detected a median rate of HIV infection of 0.8 per cent among pregnant women in 1991. The trend increased to 2.3 per cent in 1996, began to decline in 1997 and remained constant at around 1.2 per cent until 2000. In 2000, the prevalence rate of HIV infection among pregnant women was 0.7-1 per cent.

The HIV transmission rate from mothers to children was reduced from 30-40 per cent to 25 per cent by providing formula milk to babies born to HIV-infected mothers. The national programme for prevention of mother-to-child HIV transmission using oral short-course zidovudine (AZT) started in 2000 and resulted in a diminishing number of cases of acquired immune deficiency syndrome (AIDS) in children under two years of age.

Each year, around 800,000 babies are delivered in health-care facilities. Out of these, 6,000-8,000 (0.7-1 per cent) are born to HIV-infected women. Without any intervention, it is expected that around 1,500-2,000 of these children would be infected with HIV (a 25 per cent transmission rate). Thanks to the programme on the prevention of mother-to-child transmission, which has implemented various intervention strategies to prevent HIV transmission from mother to baby, the number has been reduced to 300-400 children (a 5 per cent transmission rate).

In 2000, the Ministry of Public Health launched a policy aiming to prevent the transmission of HIV from mothers to their children. In 2001, the core component services of the policy were combined with routine prenatal care in hospitals. These services, however, did not put any emphasis on psychosocial support, holistic care or linkages between communities and hospitals.

The programme on the prevention of mother-to-child transmission was launched in all government hospitals and some private hospitals all over the country, in total 954 hospitals in 76 provinces, including regional, provincial and district (community) hospitals. The services for prevention of mother-to-child transmission were integrated into maternal and child health services: antenatal clinics, delivery rooms, postpartum wards and well-child clinics. The infected mothers, their husbands, and their children who needed antiretroviral treatment (ART) were to be referred to ART clinics.

The programme on the prevention of mother-to-child transmission was a success but new issues had to be addressed. For example, the number of orphans was becoming a serious problem and HIV-infected mothers often had the first symptoms of the illness two years after delivery. In 2002, a project entitled "Enhancing Care and Support for HIV-infected Mothers, Their Children and Families" was initiated in four provinces as a pilot model. The project focused on the follow-up of HIV-infected mothers, their children and their husbands. It was implemented by the Department of

Health, which coordinated HIV-care activities among governmental organizations, non-governmental organizations (NGOs) and community-based organizations. The programme activities included: supportive ongoing counselling; disclosure counselling for husbands; provision of HIV treatment and care for HIV-infected mothers, children and husbands; follow-up of children for HIV testing and referral of HIV-infected children to HIV treatment and care programmes; and caring for HIV-affected and HIV-infected children in an attempt to offer them a better quality of life.

Finally, in 2005, with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the project, "Enhancing Care and Support for HIV-infected Mothers, Their Children and Families", was expanded to 41 additional provinces in order to develop good practices in providing more comprehensive holistic care that included psychosocial support for HIV-affected children and HIV-infected women, their husbands/partners and families as well as strengthening the linkage between health-care facilities and community-based networks.

Implementation

This case study describes the successful implementation of the project that was identified as a best practice in seven provinces in four regions of Thailand. The project focused on coordination and participation of networks of people living with HIV/AIDS, community leaders, school teachers, affected parents and caregivers, and health-service providers. The activities included enhancing HIV-related care and treatment and the provision of antiretroviral treatment in hospitals, peer support groups in hospitals and communities, campaigns promoting better understanding of HIV/AIDS in communities, policy support for the reduction of stigmatization and discrimination, health education for school teachers, and effective community-based networks.

Project Areas

The project areas comprised 71 communities of 15 districts in 7 provinces spreading over 4 regions of the country: the Northern region (Payao and Lampoon); the Northeastern region (Sakolnakorn and Khonkaen); the Southern region (Nakorn Sri-Thammarat and Pattalung); and Cholburi in the Central region. The Northern region is an area with a high prevalence rate of HIV infection. The Northeastern region has a low HIV prevalence rate as does the Southern region. The central province of Cholburi has a high HIV prevalence rate.

Project Objectives

The project focused on:

- providing a continuum of care and services for HIV-infected mothers, their children and families through well-planned collaboration and coordination among government organizations, NGOs and community-based organizations in the health facilities and communities; and

- promoting awareness and a wider understanding of HIV/AIDS within the communities through providers of health services and leaders of people living with AIDS. The aim was to reduce stigmatization and discrimination against HIV-infected mothers, their children and their families. Increased awareness and better understanding could then lead to policy formulation.

The Continuum of Care

In this project, "continuum of care" meant all the services provided to HIV-infected mothers, their children, husbands and families. These comprehensive services included prevention, care, treatment and support and were available to patients in their homes, in the communities where they lived and in the health-care facilities. Those involved in the services included government health-care providers, NGO representatives, people living with AIDS, and other stakeholders such as community leaders and school teachers. The continuum of care enabled more people to have access to services and helped them to accept and adhere to antiretroviral treatment. It ultimately improved the quality of life of HIV-infected mothers, their children and their families.

Stigmatization and Discrimination

Stigmatization and discrimination were the barriers hindering the access to care, treatment and support of HIV-infected mothers and their families. Discrimination occurred mainly within the community. For example, children of HIV-infected mothers were not allowed to attend child care centres in the villages. For this reason, many HIV-infected mothers did not want to use the services from local hospitals since they were afraid that their illness would be disclosed to their neighbours. The reduction of stigmatization and discrimination would enhance the quality of life of HIV-infected mothers, their partners and their children.

Strategy and Interventions

Developing the Network

At the beginning of the project, a working group was set up, which consisted of health-service providers from provincial and district hospitals, groups of people living with AIDS, community members and NGO staff. The working group carried out an analysis of the situation and held discussions to identify the problems and the needs. Programme activities were then developed to address those needs. All stakeholders were engaged in the development of the work plan. Training courses were developed to train providers of health services and leaders of people living with AIDS to ensure that they were well informed and prepared for the project implementation.

Building Capacity

Training

Training sessions using the standard curriculum were conducted in regional, provincial and district hospitals and in subdistrict health stations for maternal and child-health and prevention-of-

mother-to-child-transmission clinic staff and other related staff. The aim was to enable these medical structures to offer counselling and HIV testing in antenatal clinics and in the delivery room, disclosure and risk-reduction counselling, and holistic care for HIV-infected mothers and their families. The community leaders of people living with AIDS attended separate training courses. They were trained in all aspects of the project and in their expected role and responsibilities, which included: knowledge of HIV/AIDS and prevention of mother-to-child transmission, home-based care, communities/network activities, reproductive health, child rights, opportunistic infection, antiretroviral treatment and peer counselling. These training sessions were run by the Thai National AIDS Foundation. After the course, the trainees met to map out an action plan and organized appropriate activities in clinics and within the communities to ensure that interventions relating to treatment, care and support of HIV-infected mothers, their children and families were effective. The action plan would serve as a guideline and would ensure collaboration and cooperation.

For the group of people living with AIDS, the capacity-building activities aimed to provide HIV-infected mothers and their families with the appropriate knowledge and the essential skills to improve their quality of life and enable them to live together like other normal families in the community. The activities included: family camps, child-parent and/or caretaker camps, a peer support group for people living with AIDS in hospitals, and home visits by peer leaders of people living with AIDS who were in the community.

Family Camps

Family camps were arranged for family members of HIV-infected mothers. The three-day camps aimed to encourage participants to share their knowledge of and experiences in HIV/AIDS prevention and care. Through various activities run by health-service providers and people living with AIDS, key issues were discussed, such as health-care support, dealing with loss in the family and communication among family members.

Camps for Children and Parents/Caretakers

Camps for affected and infected children under 12 years of age were organized. Caretakers or parents also participated. Child care, child growth and development, life skills, HIV prevention and treatment, and positive living with persons with HIV/AIDS were the main topics of these camps. The camps also offered psychosocial support for both the children and the caretakers. People living with AIDS and health-service providers collaborated to organize these camps twice a year.

Community Campaigns

Exhibitions and mass media campaigns on HIV/AIDS/prevention of mother-to-child transmission and care were organized on special occasions and important

national holidays to provide information and to build the capacity of NGO and community-based-organization staff in the communities. The campaigns and exhibitions conveyed messages on a broad range of topics, such as prevention of HIV/AIDS, prevention of mother-to-child HIV transmission, antiretroviral treatment, reproductive health, gender issues, peer-to-peer counselling, child care, psychosocial support, and reduction of stigmatization and discrimination. They helped community members and their leaders to have a better understanding of HIV/AIDS and prevention of mother-to-child transmission so that they could, in their capacity, support and work with HIV-infected women and HIV-affected children in their communities.

Training for Networks of Community-based Organizations

From time to time, the community networks, namely, village health volunteers, women's groups, breast-feeding support groups, youth clubs and groups of people living with AIDS, were offered one-/two-day training courses. The topics of the courses varied depending on the needs. They included: self-health care for HIV-infected mothers and family, general health care, follow-up for adherence to antiretroviral drugs, peer-to-peer counselling, and care for HIV-affected and HIV-infected children. As a result, the community networks were able to use the acquired knowledge to provide counselling, care and support to the people in need. On many occasions, the community networks participated in and contributed to various activities relating to HIV/AIDS/mother-to-child-transmission prevention and care.

Developing and Strengthening Comprehensive Services

HIV-infected pregnant women received care and treatment starting from the antenatal period. They received counselling to help and encourage them to disclose their HIV status to their partners. Once the partners had been informed, they, in turn, were encouraged to participate in the programme.

Support Group in Hospitals

A support group meeting for people living with AIDS was arranged on a monthly basis at the antiretroviral treatment clinic after the patients' scheduled appointments to receive their drug supply. This was the time when people living with AIDS would discuss their problems, share experiences and seek advice from the peer leaders. The health-service providers were also present to give moral support. Problems shared by people living with AIDS ranged from health, side effects and adherence to antiretroviral drugs to personal and family-related issues such as safe sex, condom use, reproductive health, and social and economic concerns. Usually 10 to 12 people living with AIDS would participate in such a support-group meeting.

Peer Leaders of People Living with AIDS Collaborating with and Assisting Health-service Providers

One of the important roles of the selected

and trained peer leaders of people living with AIDS was to assist health-service providers at antenatal and antiretroviral clinics. They shared their knowledge on self-health care, prevention of mother-to-child HIV transmission, physical and psychosocial care, food and nutrition, exercises, adherence to the antiretroviral drug treatment and prevention of opportunistic infections. They also provided peer counselling, moral support and advice on various matters. The assistance of these trained peer leaders was helpful to both the health-service providers and the people living with AIDS who were patients. It lessened the workload of the health-service providers and the patients felt more at ease talking to someone who had had a similar experience and was familiar with clinical settings and procedures.

Home Visits

The main persons making home visits were peer leaders of people living with AIDS. Health-service providers used their routine postpartum home visits (one visit per case) to visit HIV-infected mothers to avoid any potential discrimination of the mother in the community. The peer leaders of people living with AIDS were trained and had a basic knowledge of most aspects of antiretroviral drugs, adherence and side effects; self-health care; reproductive health care; and well-child care. Regular home visits by these peer leaders were made only to those who disclosed their HIV status and who had given their prior consent. Home visits provided regular care and psychosocial support to HIV-infected mothers and their affected children. The peer leaders usually made home visits in pairs on a monthly basis. All home visits were recorded by peer leaders of people living with AIDS in their monthly report to their central office (Thai National AIDS Foundation) and funding agency.

Collaboration of Peer Leaders of People Living with AIDS with Community-based Organizations and Administrative Organizations of Local Authorities

Throughout the project, peer leaders of people living with AIDS acted as coordinators between the administrative organizations of the local authorities, community-based organizations and people living with AIDS on matters concerning child care, child education, child support and career training. In addition, they coordinated with teachers and school authorities to discuss the children's education and fellowship opportunities and to prevent potential discriminatory treatment towards the children. On some occasions, the peer leaders would approach these local authorities to ask for their cooperation in the interest and support of the infected mothers and affected children and families.

Policy Advocacy

HIV/AIDS campaigns were conducted at least twice a year on the occasion of special festivals and on World AIDS Day. In the communities, campaign activities were arranged by NGOs and groups of people living with AIDS, with support from the government health personnel.

Community leaders and members of the public participated in the campaigns, which aimed to provide knowledge about HIV/AIDS and its prevention and promote better understanding among the community members on HIV/AIDS and the prevention of mother-to-child transmission in order to reduce stigmatization and discrimination.

Evaluations done after the campaigns revealed that the community members and their leaders gained a better understanding of issues such as HIV/AIDS transmission and prevention, mother-to-child transmission, living life with others in the community, having a positive attitude towards people living with AIDS, safe sex and condom use. The community leaders expressed their wish to set up additional activities to prevent HIV/AIDS in their own areas. Suggested activities were: organizing campaigns to promote condom use for sexually active people and to encourage people living with AIDS to make use of the easier access to the antiretroviral treatment as well as setting up supportive measures for persons affected by AIDS.

Results and Achievements

Collaborative Effort between the Public Sectors and NGOs

Cross-institutional collaboration was necessary; it helped to build the capacity of a range of service providers in the public sector, NGO agencies and networks of people living with AIDS, which in turn ensured a comprehensive array of services. NGOs in particular played a crucial role in facilitating access to the target population at the community level and to those who might otherwise be difficult to reach.

Capability of Health-service Providers

The project evaluation collected data in the sample area and found that every large hospital had at least five to six persons trained and working as counsellors or mediators. Small hospitals had two to three counsellors. Each of the hospitals had two to three persons from the network of people living with AIDS trained as counsellors and resource persons. In some areas, service providers of the network of people living with AIDS were recognized as effective counsellors and resource persons, meeting regional and national standards of performance.

In addition, members of the network of people living with AIDS built their capacity to the extent that they could transition from service recipients to services providers and become effective focal points for AIDS activities at the community level. They contributed to an increased awareness and understanding of AIDS and helped to reduce stigmatization among various groups in the community such as young people, women and local leaders.

Results from the project progress report showed that peer leaders of people living with AIDS had well-developed capacity and achieved good results. They helped approximately 957 HIV-infected

mothers and 852 affected children to access the support services through coordinated and hence more effective contacts with 71 subdistrict administrations and municipalities in 7 provinces.

COMPREHENSIVE SERVICES: HOSPITAL-BASED POST-PARTUM CARE

Over 90 per cent of the HIV-infected women received post-partum care, which included information on hospital services and advice on infant formula feeding; 81 per cent received self-care counselling; and 77 per cent received family-planning counselling. Over half (57.9 per cent) of the husbands/partners of HIV-infected women came for HIV counselling and screening; 61 per cent joined support groups, groups of people living with AIDS, friends-help-friends groups or other related associations.

Peer leaders of people living with AIDS made 1,709 home visits to HIV-infected mothers and their children. Post-partum home visits to HIV-infected mothers were still problematic in cases where the women had not yet revealed their serostatus to their husbands or immediate families. During the project, HIV-care home visits were paired with visits for other diseases or health services. Usually, a local health volunteer and a peer leader assisted with the home visitation.

In addition, 1,377 group meetings for HIV-infected pregnant women and mothers took place in hospitals and 724 family and child camps were organized as well as 5,071 community campaigns.

SITUATION OF THE HIV-INFECTED MOTHERS AFTER THE IMPLEMENTATION OF THE PROGRAMME

A total of 972 HIV-infected mothers went to the hospital for follow-up appointments on a continuous basis. Most of them received information on antiretroviral drugs and drugs for opportunistic-infection prophylaxis. They were able to take care of their health and remain in good health. They could continue to work, for example as factory workers. They had easier access to available social services such as a monthly allowance and funds from the social development and human security office. The HIV-infected mothers gained knowledge and a better understanding of safe sex, sexually transmitted diseases and other important issues such as reproductive choice. They acquired better negotiation skills to urge their husbands/partners to use condoms. The HIV-infected women in the programme were able to lead their lives as normal persons in the community. Most of them did not experience discrimination by other community members. A majority (80 per cent) of HIV-infected mothers disclosed their HIV status to their spouses/partners and/or family members.

SITUATION OF THE HIV-INFECTED AND HIV-AFFECTED CHILDREN

Among the 182 HIV-infected children in the programme areas, 153 received antiretroviral drugs for treatment. The infected children were referred to 15 community hospitals for their antiretroviral treatment.

The children who did not receive antiretroviral treatment were followed up by a paediatrician on a regular basis. Children's camps were conducted for these children. At these camps, the affected children learned how to interact with their friends, how to participate in a group and what their responsibilities were. After participating in the camp's activities, the children felt more confident.

Strengths and Weaknesses of the Programme

Strengths

As explained earlier, the collaboration between the public sector and NGOs was one of the programme's main strengths. The project provided a chance for all stakeholders to learn and participate in the community's activities. All the community organizations and persons involved joined hands and participated in the programme with their full potential and expertise. The assigned staff from the local authority administrations, the schools, the public health sector, government organizations and NGOs devoted a great deal of their time to carrying out activities for the vulnerable people in the communities, especially HIV-infected pregnant women and children.

The programme on prevention of mother-to-child transmission of HIV/AIDS resulted in a good maternal and child health service system, which was integrated into the programme.

Routine supervision and monitoring activities at all levels of service facilities helped to strengthen the project.

Weaknesses

It remained difficult for HIV-infected mothers to agree to disclose their HIV status and this reluctance proved problematic when trying to work with them. The programme staff were not able to access a number of people in the target group because they feared stigmatization and discrimination. As a result, they refused to come forward to receive services provided by the government organizations or the NGOs.

Monitoring and Evaluation

Programme Monitoring

Programme monitoring was carried out by the programme staff at the community level on a monthly basis throughout the duration of the programme. A well-designed and tested programme record form was used to record the information needed. Data were compiled to prepare quarterly reports of programme activities, outcomes and achievements. The reports were then analysed and discussed among the project team members. Suggestions and recommendations were duly considered for problem-solving and appropriate programme adjustments.

EVALUATION

External Evaluation

External evaluation was carried out with the objective of evaluating the overall programme. The conceptual framework of the programme, the input, the process and the output variables that contributed to the outcomes and the impact of the programme all were evaluated.

Evaluation Results

The summary of the evaluation report states that the project was able to build the capacity of health-service providers at all levels of implementation by encouraging them to make the project services part of their routine occupational function. The project strengthened the health-service system and advocated for policy and activities to combat stigmatization and discrimination. The implementation plan of the project was consistent and was integrated into the national AIDS plan. It included the participation of AIDS subcommittees at the provincial level that received policy directives from the national AIDS committee. The project also worked closely with agencies in the private sector including the Thai National AIDS Foundation. The project was fully endorsed by the local administrative organization.

The study population for the evaluation report consisted of 95 HIV-positive women who had recently had a baby. The women were between 19 and 47 years old, most of them (56 per cent) were 25 to 34 years old, and only 16 per cent were 19 to 24 years old. Slightly over half of the women had completed primary education; one fourth had completed high school. Also, 83 per cent were living with their husbands at the time of the interview. By occupation, 54 per cent were employed in low-wage labour jobs; one third were housewives; and one woman was a full-time student. More than half the women stated that they did not have enough income; only 15 per cent had enough to meet their needs and for saving.

Among this group of women, 39 per cent knew of their serostatus before their last pregnancy; 58 per cent learned that they were HIV-positive during the last pregnancy; and three only learned their serostatus at the time of delivery. The (estimated) duration of infection among those who knew their serostatus before the current pregnancy was between 10 months and 15 years. Approximately one half of this group had taken antiretroviral drugs previously. Among those who learned their serostatus during their last pregnancy, the time of diagnosis ranged from 2 to 32 weeks of pregnancy.

The availability of antenatal-care services at the health-centre level enabled the referral of HIV-infected women to local, district or provincial hospitals. At the district hospital, the women were encouraged to join the peer support group for people living with AIDS. Approximately half of the women had initiated antiretroviral therapy because their CD4 cell level had declined to below 200, which qualified them for the antiretroviral therapy. Antiretroviral therapy was given continuously during pregnancy, delivery and post-partum

periods. As long as the infected patient was registered and remained in the project system, she, her partner and her children benefited from continuous medical follow-up even after they returned to their home community.

In most cases, infants were scheduled for treatment and care at paediatric clinics. To avoid the hassle of several trips and ensure group attendance, the appointments were made for the HIV-infected women and their babies on the same day. The Day Care Department continued to provide care and monitoring for them for one year post-partum.

Lessons learned

From the evaluation results and the progress report, it was learned that:

- A great deal of experience was gained by working in a model of collaboration and partnership between the government, NGOs, peer networks of people living with AIDS, local administrators and the community. The project goals required a modality of implementation that went beyond public health and extended to cultural, social and community dimensions of the local context. Thus, it was necessary to involve private-sector organizations in order to achieve full coverage and continuity of services.
- The government and NGO sectors learned more about better ways of providing care, treatment, monitoring, follow-up and accessing hard-to-reach groups such as non-Thais, displaced persons, disadvantaged groups, and persons in challenging socio-cultural circumstances that make it difficult for them to access services.
- A coordinating agency established in the community played an important role in the success of the programme as a result of its role in encouraging capacity-strengthening of the field staff to enable them to gain knowledge from the learning process.
- Groups of the HIV/AIDS network in the community that help in giving support to the HIV-infected pregnant women, children and their families are essential and needed for their better quality of life. Health care and psychosocial support extended to the mothers, their children and families need to be provided on a continuing basis.
- The role of people living with AIDS is to provide assistance and work for HIV-infected mothers, their children and families. It is important that the people living with AIDS gain not only knowledge and skills but also more experience and self-confidence and achieve better teamwork. Drawing from their personal experience, people living with AIDS can assist health personnel in how to inform patients of the result of the HIV test. Having gone through the same situation, they are fully aware of the psychological

effect that the news can have on the patients.

- Encouragement by and participation of the local authority are vital for the sustainability of the programme. Accurate knowledge and a full understanding of HIV/AIDS among community leaders contribute to the success of the programme activities. Working effectively and efficiently at the local level requires the support of all relevant organizations from the horizontal and vertical lines of management.
- Working with HIV-infected children requires a sound understanding of children's psychosocial development. A good relationship based on trust is essential for working with children. Children need encouragement and support to develop their self-confidence.
- NGOs involved in the project need to have a high level of technical skills in order to provide effective support to affected families.
- Some of the service providers in the project restricted their participation to routine activities, ignoring the added benefit to the target population that could be achieved through greater effort. Improvement and adjustment of the overall project management and coordination must be maintained throughout the duration of the project.

Replicability and Scalability

Suggestion for Replication and Scalability

Three major activities are needed for the programme to be successful: community situation analysis and preparation, collaboration of the community in programme planning and implementation, and supervision and monitoring by the technical assistant.

Community Situation Analysis and Preparation

A situation analysis should be done before starting the programme.The information gathered would include target populations and their characteristics, health problems, local diseases, the epidemiology of HIV/AIDS and other diseases, social norms, cultural practices and values, local wisdom, community beliefs and way of life, and available community resources that can support and facilitate the programme. Community preparation can be done through meetings that need the participation of all parties and sectors involved that represent people's interest groups, organizations and various networks in the community. The data analysis provides useful information about the community that will be made known to those involved and form a basis for which interventions/activities can be planned accordingly. A needs assessment of the community should also be conducted in order to find out its real needs so that the programme plan can be appropriately

drawn up to serve and address the problems and needs of the community.

Collaboration of the Community in Programme Planning and Implementation

A meeting to plan the programme activities should be organized for all stakeholders in the community, which include target populations (HIV-infected mothers, husbands, affected children and their families), community leaders (people living with AIDS/youths, housewives, etc.), community administrators (head of the village, tambon leaders), religious leaders, community government officers (school teachers, staff of day-care centres, health-centre staff, tambon administrators, municipal staff) in order to devise a plan for activities that suit the community situation and context. The meetings can be arranged for each group or for all groups together, as appropriate. This meeting also helps to encourage community members to participate, take full responsibility for dealing with their community problems and help to find a solution to such problems. Some communities may need funds for implementing the programme. Fund-raising events can also be organized to raise funds and resources available in the community with the collaboration of government organizations and NGOs. Such events, when organized to coincide or tie in with the local social, cultural or religious events, can also increase responsibility and the sense of ownership of the programme among members of the community.

Having all parties work together in a coordinated and collaborative manner to implement the programme activities according to the plan is a powerful strategy for achieving the desired results. Meetings can be arranged for involved community members to provide them with information for a better understanding of the programme implementation. Such meetings can also be venues for clarifying and clearing up misunderstandings while ensuring that everyone involved is well informed.

Supervision and Monitoring

Supervision and monitoring regularly by a technical assistant can be done through field site visits so that the programme follow-up and coordination with community networks are closely monitored. Besides fieldworkers and the participating community, people were made aware that their work in the field was an important part of the programme.

Regular follow-up meetings can be arranged for the working team at three-month intervals in order to monitor the progress of the programme, provide support to activities in the community by the technical assistant and the Thai National AIDS Foundation, make appropriate adjustments to the planned activities and troubleshoot problems that might occur. Through such meetings, the programme activities can be closely monitored on a regular basis, allowing timely and appropriate programme adjustment and problem-solving.

Documentation of activities implemented by reporting on the progress of the programme every three months will enable the programme to become more accountable and measurable against the plan in addition to keeping those involved informed. Lessons learned at the local and central levels can be identified to ensure that they are well documented for wider dissemination and replication. Programme evaluations should be conducted to learn about the specific results of interventions/activities as well as the overall outcome of the programme for the adjustment of the future health service system, legislation and policy advocacy.

Future Plans

Programme planning for the future includes the following:

- enhancement of the care and treatment for affected children in the community. A data reporting system regarding affected children will be developed at the community and provincial levels. The coverage of affected children who have received care should be increased;
- policy advocacy by local administrative offices to support HIV-infected mothers and children and for community participation in the prevention and control of HIV/AIDS;
- increased capacity of people living with AIDS to work on prevention and care for HIV-infected mothers and their families; and
- policy advocacy against stigmatization and discrimination of HIV-affected people in the community.

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Acknowledgements

The author would like to acknowledge the support of the following: Dr. Somsak Pattarakulwanich, Deputy Director General, Department of Health; Dr. Sompong Sakulisaliyaporn, Director, Bureau of Health Promotion; public health technical officers from regional health promotion centres of the Department of Health (Ms. Rattana Petchpun, responsible for Cholburi Province; Ms. Thisopin Thongthai, responsible for Khonkaen Province; Ms. Laksami Manowong, responsible for Payao and Lampoon Provinces; Ms. Thaworn Pumauim, responsible for Nakonsrithamrat Province; and Ms. Wanida Sukki, responsible for Pattalong Province); and Ms. Thananda Naiwattanakul, Technical Officer from the Thai-United States Centers for Disease Control and Prevention Collaboration.

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9 Tunisia

Women's Empowerment and Reproductive Health

Dr. Ridha Gataa

Summary

The topic of women's rights remains one of the most difficult issues to be addressed in the Arab world. Successful progress of women's empowerment in Tunisia can serve as a model for the region and elsewhere. Within a human rights framework, women in Tunisia have been empowered politically, economically and socially and this empowerment has benefited the Tunisian society.

During the 1950s, before Tunisia's independence, women in the country were largely poor and illiterate. Under the pretext of Islam, women were repressed and treated as second-class citizens. In the lead-up to Tunisian independence in 1956, however, there were calls from high political levels to ensure fundamental rights for women.

Some important changes took place following independence, including a ban on polygamy as stated in the Code of Personal Status and the entrance of women into the economic life of the community and the country, attaining nearly universal education, improved health care and better access to family planning and reproductive health services.

Tunisian women have benefited from a tremendous improvement in reproductive health, and their rights to control their fertility have been recognized. Family planning programmes and important strides in health have considerably lowered the birth rate and lengthened the average life expectancy for women. The life expectancy at birth of 51 years

Summary (continued)

in 1966 increased to 74.2 years in 2007; the overall mortality rate of 15 per cent in 1967 was reduced to 5.7 per cent in 2007; the infant mortality rate declined from 138.6 per cent in 1966 to 18.5 in 2007, maternal mortality from 140 deaths per 100,000 live births to 68.9 in 1994 and to 36.5 in 2006; and the immunization rates of children improved and exceeded 95 per cent in 2007 against 70 per cent in 1984. The contraceptive prevalence rate has reached 60.2 per cent currently against only 10 per cent in the 1960s. In addition, the gap between urban and rural environment has been minimized through services provided in rural areas by mobile teams, mobile clinics and special programmes in the remote areas since 1994.

Measures to empower women in Tunisia have benefited not only women but Tunisian society as well, with significant shifts in men's attitudes towards women's rights and roles in the society. The discussion of women's rights should take place within the broader context of human rights. Women's rights should not be seen as a zero-sum-game between male and female rights but rather from the perspective that everyone gains when all citizens have equal rights and can use them to expand their opportunities and achievements to benefit their societies.

Tunisia has changed for the better in the last several decades. With a history of strong and influential women, the country is a beacon for other Muslim societies in terms of its openness and progressive stance on women's rights, viewed as an affair of state for Tunisia. However, Tunisia will have to face other challenges in the years to come that are as important, particularly as regards employment, social security and better integration of women into social and economic sectors, in order to fully achieve the United Nations Millennium Development Goals.

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Introduction

The strategy adopted by Tunisia since its independence in 1956 has, over the years, reinforced the principle of equality between men and women as citizens and in the eyes of the law. This has enabled the country to thrive, to achieve social and economic development, to strengthen the bonds within families and to fully participate in the construction of a modern society.

The Code of Personal Status, promulgated in 1956, codified the relations between the different family members. It aimed at promoting the status of women and at preserving social equilibrium. The Code comprised a series of measures that consolidated women's rights and considered these rights as an integral part of human rights. It advocated women's active participation in the development process of the country and encouraged the use of their capacities. It also strived to achieve a balance between the assertion of women's status, the strengthening of family ties and the family as a basic unit of society.

Inspired by the achievements of the Code of Personal Status and taking into consideration the need to regulate its population growth and fertility indicators, Tunisia has adopted a strategic vision for population management, based primarily on this ground-breaking legislation on women's rights. Aware of the challenges linked to the promotion of human resources in the development process, the country has firmly committed itself, since independence, to an ambitious policy. It has succeeded, through sustained efforts in the fields of education, health and family planning, to progressively control the demographic pressure and reach a significant level of family and social welfare.

The successful example of Tunisia documented here is neither a pilot study nor an experimental effort like many other innovative practices. This is a national development strategy that has largely contributed to the development of the whole country and that continues to act on all socio-economic and health components in order to achieve the Millennium Development Goals by 2015.

Background

Family Structure and Women's Status in Tunisian Society before Independence in 1956

Before independence in 1956, the family model in Tunisia was the extended family model in which grandparents, uncles, aunts and cousins were integral parts of an individual's daily life. In general, the family and society were patriarchal. This social system extended beyond the home into the organizational framework of the country's political system and workforce.

In addition to living together, the family retained its influence on its younger generation by practising arranged marriages. Traditional marriages were often endogamous, with a preference for marrying one's parallel cousin,

which also increased parental control over daughters and sons. Both men and women were under the influence of their families in relatively similar ways. In a study that was undertaken in five villages in the southern region of Tunisia, 98 per cent of men and women who were married between 1940 and 1945 did not choose their spouse (Betgeorge, 2010).

Women's behaviour was closely monitored. The primary domain of women was the domestic one, and women's social interactions with the outside world were few. Since females were the family's indicators of honour, to protect them was to preserve the family's reputation in society. These customs were influenced by a mix of culture and Islamic law.

Before independence, polygamy was legal and a man could take additional wives. Polygamy diminished the status of each wife, filling the one position parallel to the husband with up to four women.

Women's Rights as an Affair of State for Tunisia: An Early Reformer

Since the nineteenth century, many Tunisian thinkers and writers have had the merit to begin a very positive reflection on the modernization of Islam and the rights of women. In 1868, a reformer, Kheireddine Pasha, explained in his book written in Arabic, *The Surest Way to an Understanding of the State of Nations*, that the future of the Islamic civilization was linked to modernization. In 1897, Sheikh Mohammed Snoussi published *The Flower's Blooming or a Study of Woman in Islam*, in which he advocated girls' education. Fifteen years later, Abdelaziz Thâalbi, César Benattar and Hédi Sebaï published *The Koran's Liberal Spirit*, which also emphasized the need for girls' education.

The roots of Tunisia's pioneering role in women's issues reach back to the beginning of the twentieth century, when an Islamic reformer, Tahar Haddad, a scholar of Tunisia's Great Mosque of the Zitouna (in Tunis), demanded that women be freed from all their traditional bonds. He demonstrated, in a book entitled *Our Women in the Shari 'a and Society* published in 1930, that Islam was compatible with modernity. He advocated formal education for women and maintained that over many years, Islam had been distorted and misinterpreted to such an extent that women no longer were "aware of their duties in life and the legitimate advantages they could expect". In the name of Islam, Tahar Haddad denounced abuses against women such as repudiation, whereby a husband could divorce his wife without grounds or explanation, send her back to her family or leave her for another wife. Refuting assertions that such conduct is permissible for Muslims, the reformer declared in his book that "Islam is innocent of the oft-made accusations that it is an obstacle in the way of progress".

Even though Haddad's proposals were condemned in his time by the Conservatives, almost all his appeals were taken into account by the first President of Tunisia, Habib Bourguiba, in the drawing up of the Code of Personal Status such as the obligatory consent for marriage,

the establishment of a procedure for divorce and the abolition of polygamy.

Needs That Have Pressed the Country to Take Concrete Actions towards Fertility Regulation

In the aftermath of its independence, Tunisia inherited a pronatalist colonial policy as well as an archaic legal and administrative system. It was faced with two major events: independence on the one hand and the peak of the population boom on the other (the birth rate was close to 50 per 1,000) in a context of very limited economic resources.

Before independence, in the late 1950s, according to the classical pattern of demographic transition, the decline of mortality as a result of advances in health care preceded that of fertility, paving the way for a rapid population growth. At that time, Tunisia was characterized by a very young population (49 per cent under 15 years of age), a natural fertility status (crude birth rate of 50 per 1,000) and a total fertility rate that exceeded 7 children per family. The mortality rate was high (a crude death rate of 25 per 1,000 and an infant mortality rate of 200 per 1,000), and the life expectancy at birth was not more than 47 years. The rural population was large, exceeding two thirds of the total population. In addition, illiteracy was widespread: it was estimated that 85 per cent of the population 10 years old and over and 99 per cent of the female population were illiterate. This situation was made worse by unemployment, with a gross rate of around 34 per cent, and high underemployment of the population, given that 70 per cent of the active workforce was employed in agriculture.

Implementation of the Practice

The practice could be defined as the national strategy of promoting women's status as a basis for implementing a comprehensive fertility and population programme in order to ensure the country's economic and social development.

Promulgation of the Code of Personal Status

The Code of Personal Status (First Version)

The Code of Personal Status, promulgated on 13 August 1956 (five months after independence), has laid the foundation for codifying the relations between family members. This foundation is based on mutual respect between spouses, on sharing burdens and responsibilities, and on guaranteeing individual rights while ensuring respect for children's interests. The Code gives women a unique place in Tunisian society and in the Arab World in general. Since then, the date of 13 August has been set aside to celebrate the anniversary of the Code in the context of National Woman's Day, which is a public holiday in Tunisia.

This Code of Personal Status includes many measures that promote the status of women and strengthen their rights. Among them are abolition of polygamy, legal regulation of divorce, permission of

marriage only with the mutual consent of both spouses and the prohibition of early marriage. At the beginning, the minimum age for marriage was set at 18 years for men and 15 years for women. However, it was increased by two years for both spouses in 1964.

Evolution of the Code of Personal Status (New Measures)

The Code of Personal Status is not considered as a static reform nor is it only a set of legislative texts aiming to improve women's status in Tunisia. The women's liberation movement has continued to receive significant political support and assistance from decision makers at the highest level.

In 1992, new measures were announced. These measures provide women and the family with new privileges and gradually give the mother greater responsibilities within the family:

- the right of a woman to guardianship not only in case of the father's death but also during his lifetime if it is proven that he is unable to meet family responsibilities;
- the right of a divorced woman with custody of children to obtain the prerogatives of guardianship;
- replacement of the notion of the wife's obedience to her husband by the obligation for both spouses to have a relationship based on mutual respect;
- creation of an alimony pension fund guaranteeing divorced women and their children the receipt of a pension and income after trial. In case of non-compliance with this ruling, debtors are liable to State prosecution;
- the right of a mother to give her nationality to her children who are born of a foreign father; and
- full legal capacity of a woman at the age of majority (18 years). A woman has the same access to legal services as any man. For the preservation and cohesion of the family, domestic violence is punishable by law.

Operationalization of the Code of Personal Status

The main goal of the Code of Personal Status is to "remove all injustice" and promote "laws rehabilitating women and conferring upon them their full rights". Since the promulgation of the Code, polygamy has become a crime sanctioned by a fine and imprisonment, a unique development in the Arab World but one patterned on a similar interdiction previously adopted by Turkey. Many reforms incorporated into the Code were based on the Islamic practice of *ijtihad*, the process of legalizing judgments reached by consensus and by applying the underlying principles of Islamic jurisprudence to changing and modern situations.

Other reforms incorporated into the 1956 Code of Personal Status abolished the right of fathers to force their daughters to marry against their will. Nowadays, marriage in Tunisia can only take place with the consent of both parties. The Code set the legal age for mar-

riage at 20 years for men and at 17 years for women, with marriage below those ages permitted only with the consent of both parents and the decision of a judge. Unilateral repudiation was abolished and the husband no longer has the right to simply terminate the marriage without explanation.

Today, either a husband or a wife can initiate divorce proceedings. However, a divorce can be granted only by a judge who has exhausted all efforts to reconcile the two parties. Women may also be granted a financial settlement under the law, and the Government has set up a fund to pay the divorced husband's obligations to his former wife if he fails to do so himself. Also abolished was the custom of awarding custody of children – from the age of seven in the case of boys and nine in the case of girls – automatically to the father. Custody arrangements are now worked out on a case-by-case basis by the court as part of the civil divorce procedure. Similarly, where previously widows did not automatically retain custody of their children, the Code of Personal Status now states that a surviving parent, regardless of sex, remains the principal guardian of minor children. Inheritance laws, too, were overhauled to improve the protection of women's interests.

Tunisian law also gives women the right to contraception and to abortion. As Betgeorge (2010) states, "The right to decide whether to give life and decide the number of children she would like to have is the essential element in woman's emancipation".

The change from tradition to the Code of Personal Status has shattered some other stereotypes. Formerly, a woman was treated by the law as a minor until two years after her marriage. Now, under Tunisian law, men and women alike gain full adult rights when they reach 18 years of age. They acquire exactly the same rights to vote, to enter into contracts and to buy and sell property and goods.

Penal law also applies equally to men and women. The penal code, as amended on 8 March 1968, stipulates that adultery is a crime and lays down equal sanctions for a wife or for a husband judged guilty of adultery.

Penalties for rape also have become increasingly severe. A March 1985 law allows the death penalty in cases of rape where violence and armed threat are used and where the victim is under 10 years of age. The penalty for all other kinds of rape is imprisonment and hard labour.

The Support Structures for the Promotion of Women in Tunisia

Tunisia has established operational structures to allow the proper integration of women into the process of sustainable development. The main structures that facilitate the involvement of women in decision-making and at the highest political and societal levels are: the Ministry of Women's Affairs and the Family (Ministère des affaires de la femme et de la famille, MAFF), the National Council for Women and the Family (Conseil national de la femme et de la famille,

CNFF), the National Commission on Women and Development (Commission nationale "Femme et développement", CNFD), and the Centre for Research, Studies, Documentation and Information on Women (Centre de recherches, d'études, de documentation et d'information sur la femme, CREDIF).

Ministry of Women's Affairs and the Family

Created in 1992, the Ministry of Women's Affairs and the Family (MAFF), now renamed the Ministry of Women's Affairs, Family, Children and the Elderly (MAFFEPA), has the primary duty to develop and coordinate the policy of the Government regarding the status of women and the family. It also must ensure that women's rights are respected and it strives to preserve the balance and stability of the family.

National Council for Women and the Family

The National Council for Women and the Family (CNFF) is the advisory body of MAFF. It assists the Ministry in the implementation of major policy guidelines for the advancement of women and coordinates actions between the various governmental and non-governmental stakeholders.

National Commission on Women and Development

The National Commission on Women and Development (CNFD) was founded in 1991 in the context of the preparation of the Eighth Development Plan (1992-1996). It aimed at strengthening women's participation in strategic development planning and at mainstreaming gender equality in development policies and programmes. This Commission is responsible for the annual monitoring of the objectives of the Plan as regards women's advancement.

Centre for Research, Studies, Documentation and Information on Women

Defined as the scientific body of MAFF, the Centre for Research, Studies, Documentation and Information on Women (CREDIF) has the responsibility of undertaking studies and research on women. In order to facilitate decision-making, it collects data on women's social and economic situations, disseminates all the information collected within this framework and establishes periodic reports on the evolution of women's conditions. It also analyses, observes and assesses women's status and is the interface between civil society and the Government. The Centre has several achievements to its credit, including the creation of the Observatory on Women's Status, which provides policymakers with statistical data and relevant information for the consideration of gender equality in policy formulation and programme implementation.

RESULTS AND ACHIEVEMENTS

The recent growth and development of Tunisia compared to the growth and development of other countries in the

region and countries of similar development levels in other parts of the world, particularly in sub-Saharan Africa, have been remarkable. An analysis of the country's path to development reveals that its development strategy relied primarily on diversifying its production and trade and on enhancing its human capital, with emphasis on women's empowerment.

The enhancement of women's autonomy, the free access to education and women's access to the labour market as well as the implementation of family planning programmes that have caused fertility to decline significantly are the main human development factors of the development strategy of Tunisia.

Women's Education

Tunisia has always viewed public education as a national priority and a right for both sexes without discrimination. Since 1958, the education reform has stipulated that access to education is free and compulsory from the age of six. The comprehensive 1991 reform of the educational system made attendance for both girls and boys compulsory from 6 to 16 years of age, resulting in a dramatic increase in the enrolment rates in secondary schools. Thanks to these measures, dropout rates, especially among girls, have decreased steadily. Achievements in education have not only helped to reduce poverty but have also created an increasingly educated and productive workforce.

Adult literacy rates increased from 27.4 per cent in 1970 to over 73 per cent in 2002, and the literacy rates of youths increased from 52 per cent to over 94 per cent over the same period. More impressive is the increase in female literacy. In 1970, the female literacy rate was about 15 per cent while the male literacy rate was 41 per cent. In 2004, these rates were about 77 per cent and 85 per cent, respectively. The proportion of girls in primary schools rose from 38.6 per cent in 1974-1975 to 47.7 per cent during the year 2002/2003. In secondary schools, this proportion rose from 32.4 per cent in 1975/1976 to 53 per cent in 2003/2004 while in the universities, the rate of young female students reached 57 per cent by 2004/2005.

It seems that this strategy is currently paying off and contributing significantly to the development of Tunisia. During the last 20 years, the country more than doubled the rate of its spending on public education, increasing it from 6 per cent of its gross domestic product (GDP) in 1991 to 14.2 per cent in 2005.

Economic Involvement of Women

The right to employment is defined in the Labour Code as a fundamental right for a woman and the true guarantor of her citizenship. Law No. 66/27 of 1966 contains many articles in relation to women's work: gender equality, maternity leave, unpaid leave, part-time work and specific provisions as regards the retirement plan for women.

Under the current legislation, women have the same rights as men concerning economic matters. They have the right to own property, and once they reach adult-

hood at the age of 18, they can open a bank account, take out a loan, and enter freely into business and financial contracts and transactions.

Tunisian women have gained access to various working sectors, including those traditionally closed to women, such as the judiciary, the army, engineering and medicine. The female labour force accounted for 25 per cent of the total workforce of Tunisia in 2007. Following the efforts made in the educational sector, women now represent 51 per cent of the primary school teachers, 48 per cent of the secondary school teachers and 44 per cent of the university teachers. Furthermore, 29 per cent of the judges, 42 per cent of the lawyers, 42 per cent of the medical staff, 72 per cent of the pharmacists and 44 per cent of those working in the media sector are also women.

In practice, however, women remain underrepresented in the workforce and face gender-based salary inequity and obstacles in career advancement, notably in the private sector.

Political Involvement of Women

The Tunisian Constitution of 1959 gave both men and women equal rights and duties without discrimination. Women, like men, are eligible to vote in all public elections.

In 2010, five women were part of the Government of Tunisia: one Minister and four Secretaries of State. Women comprise 22.7 per cent of the Chamber of Deputies and 24 per cent of the diplomatic corps. In addition, 27 per cent of municipal councils are women compared to 1.3 per cent in 1957, and 11 per cent of board members from the socio-economic sector are women. Tunisian women are thus represented at the highest decision-making levels and therefore may push the improvement of women's status and rights even further.

Tunisian women are represented at several international forums and organizations, such as the United Nations Committee on the Elimination of Discrimination against Women, and other international bodies.

Women's Rights and Fertility Control

All the steps that preceded the development of an explicit population policy and fertility control strategy in Tunisia were aimed at preparing the ground for this policy by focusing primarily on improving women's conditions to encourage their active and effective participation in the process of fertility control and their adherence to this policy in a responsible and rational manner.

Tunisian women have benefited from a tremendous improvement in the field of reproductive health. Their own interest in better reproductive health has increased and their rights to control their fertility and to have access to modern contraception have been recognized. The integration of reproductive health into the Tunisian health policy reflects the desire to go further in this direction.

In 1961, the French law of 1920 prohibiting the importation, sale and adver-

tising of contraceptives was repealed and replaced by the Act of 9 January 1961, which legalized contraception. However, the passage of this law was not easily achieved and parliamentary debates were very intense. Since 1961, Tunisian women have had free access to contraception and they have been able to make their own contraceptive choices.

Tunisia was the only Arab and Muslim country to legalize abortion. Enactment of the Law of July 1965 stated that induced abortion is permitted when it occurs within the first three months of pregnancy in a hospital or a recognized health facility and is performed by a physician lawfully exercising his profession and when both spouses have at least five living children. Abortion can also be performed if the health of the mother or the child's mental health could be jeopardized by the continuation of pregnancy or when the unborn child might suffer from illness or a serious infirmity. In 1973, abortion became permitted under these same conditions but regardless of the number of children. However, it is worth noting that abortion, despite its inclusion in the reproductive health services, has never been considered as a method of family planning. Unwanted pregnancies are considered as contraceptive failures. The use of modern and effective contraception methods must still be promoted through educational messages in order to further reduce the number of abortions.

Fertility Control Strategy and Reproductive Health Services

Tunisia is known for its successful population policy initiated in the aftermath of independence. The remarkable achievements in controlling the population growth rate are to be placed in the broader context of development strategies and of global and intersectoral dynamics adopted after independence. The main achievement of this strategy was the creation in 1973 of the National Bureau of the Family and Population (ONFP), which was responsible for implementing the national policy of family planning and population with two fundamental objectives, aiming at reducing the growth of population and protecting the health of women and their families. As a second step, the Superior Council of Population was created in 1974. The Council brought together different ministries and national organizations under the chairmanship of the Prime Minister and had the responsibility of defining the general guidelines for the population policy.

Many demographic analyses have shown that one third of the decline in birth rates in Tunisia in 1968 could be attributed to the national family planning programme. Raising the minimum legal age of marriage and empowering women seem to have contributed to what Fargues (1989) calls "marriage transition". The author argues that this transition is associated with two important changes: an educational transition (more women gained access to education) and increased female participation in the labour force. Both of these changes have taken place in Tunisia. Indeed, Fargues (1989) notes that "Tunisia is a striking example of what can be termed a real 'educational transition'".

The National Bureau of the Family and Population (ONFP) currently offers its services in 44 family planning/reproductive health centres; 410 primary health centres are visited by its mobile teams. It has 13 mobile clinics that cover 211 remote areas and 24 youth centres located in all the governorates of the country. In terms of allocation of human resources, the Tunisian programme records one midwife per 1,000 inhabitants (the density was 1/10,000 in 1966) and one doctor per fewer than 1,000 inhabitants.

The contraceptive prevalence rate is currently 60.2 per cent compared to only 10 per cent in the 1960s. In addition, the gap between the urban and the rural environment has been minimized through services provided in rural areas by mobile teams, mobile clinics and special programmes in the "gray" (remote rural) areas since 1994.

Impact on the Health and Socio-economic Indicators

Through the implementation of its human and social development programmes, Tunisia has managed to continuously improve its health indicators: the life expectancy at birth of 51 years in 1966 increased to 74.2 years in 2007 (life expectancy after the last child has increased from 15 years in 1966 to about 40 years at present, enabling a woman to be healthy, to participate as long as possible in the labour market and to ensure the well-being of the whole family); the overall mortality rate of 15 per cent in 1967 was reduced to 5.7 per cent in 2007; the infant mortality rate declined from 138.6 per cent in 1966 to 18.5 per cent in 2007, maternal mortality from 140 deaths per 100,000 live births in 1966 to 68.9 in 1994 and to 36.5 in 2006; and the immunization rates of children improved and exceeded 95 per cent in 2007 compared to 70 per cent in 1984.

Qualitative changes that occurred in the lifestyle of Tunisian citizens are reflected in the improvement of the following indicators (table 1-4), taking into account that the poverty rate is the number of people living below the poverty threshold.

Table 1 Poverty rate (as a percentage).

1967	1975	1985	2005
33	22	7.7	3.8

Table 2 Gross national product, per capita (in dinars).

1966	1986	2001	2007
117	960	3,000	4,400

The various components of the population policy, such as those promoting schooling for girls, the better integration of women into the labour market, and the emphasis on health programmes for mothers and children have reduced the population growth rate to only 1.09 per cent in 2007 compared to 3 per cent in 1966. The total fertility rate fell from 7.2 children per woman in 1966 to 2.03 children in 2007.

Table 3 | Population growth rate (as a percentage).

1966	1987	2007
3	2.3	1.09

Table 4 | Population size.

1966	2002	2007
4,583,200	9,781,900	10,225,400

Successes and Lessons Learned

Successes

Modernization of cultural and religious attitudes and behaviour related to fertility control

Since the adoption of the population policy, based primarily on fertility control through family planning as a basic strategy, Tunisia has met with resistance from various groups including religious groups. The aggressive media campaign carried out in the beginning provoked some opposition and rejection, but all this remained marginal. Indeed, these resistance efforts were not of a collective nature but rather cases of individual resistance, emanating mainly from males and from rural areas. The political decisions have been gradually integrated into the society, and family planning has come to be accepted and internalized by the people. This was achieved thanks to a communication strategy that was well adapted to the culture of Tunisia and that emanated from the highest political authorities at a time when Tunisia was trying to escape poverty and underdevelopment so characteristic during French colonialism.

A strong will to adopt a population policy as part of the overall development of the country

The Tunisian population policy is distinguished by its comprehensiveness and its integration into the overall development process. It is a dynamic, multidimensional and progressive policy that aims at achieving a balance between population growth and economic growth in order to ensure the well-being of the population. Its originality stems from the way in which it was applied.

Lessons Learned

Improving the status and rights of women is fundamental to successful fertility regulation.

It is very difficult to build up a fertility control programme in a population where women have no status. Indeed, if women have no natural and socially attributed roles and if they do not occupy a privileged position in their family, no population and development programme can succeed.

The Tunisian example is an interesting illustration of how fertility control and the socio-economic development of a country are intrinsically linked to the improvement of women's status. The Code of Personal Status, the liberalization of the sale of modern contraceptives and their use, and the right to abortion are all key elements of women's emancipation.

Possibilities of Replicating the Practice

While the experience of Tunisia with the practice has demonstrated some successes and has generated lessons learned, the potential for its replication elsewhere would require an enabling environment. Factors to consider include the following:

- **It is first necessary to have a progressive policy vision and courage in decision-making.** To achieve an effective population policy, a family planning programme on its own is not enough. The Tunisian experience has shown that politicians and civil society organizations must first raise the status of women. The abolition of polygamy and repudiation has had an impact on the birth rate and, contrary to common belief, it has increased family stability.

  The results achieved by Tunisia in matters of fertility control, health and socio-economic development stem from a visionary policy decision and courageous leadership based on simple communication strategies and convincing speeches targeting all social strata.

- **Islam is not against family planning and fertility control: the population policy may be part of a dynamic interpretation of Islam.** In practice, in most Muslim countries, the women's situation has not undergone many changes. Women are by far less educated than men and participate to a lesser extent in the labour market or in schools. This situation perpetuates the domination of men while women retain their traditional role as mothers and housewives serving their husbands and their families.

  These factors are not the only ones influencing the birth rate in the Muslim world. Other relevant factors include: the survival of social traditions and customs (such as values attached to masculinity and reproductive virility or the importance of giving birth to a boy); political factors (opposing Western influence); and more specifically, socio-economic under-development (illiteracy, mode of agricultural production, low living standards and unequal income distribution).

  There is a need to change the religious and cultural factors encouraging reproduction and that exist throughout the Muslim world by adopting advocacy and mobilization strategies within the religious community and at political levels. It has been demonstrated in several countries, including Tunisia, that a significant change, even a radical one, would occur in the demographic trend if Muslim women had the same opportunities as men in the fields of education and employment, had access to modern facilities and social services, and could fully benefit from economic opportunities in an environment of responsible freedom and family empowerment.

ACKNOWLEDGEMENTS

I am pleased to extend my sincere thanks to all those who gave me the opportunity to accomplish this assignment, in particular to the National Bureau of the Family and Population of Tunisia, which nominated me, in my capacity as Consultant, to carry out this research. The confidence that it placed in me will remain a personal source of pride.

The execution of this assignment represented a wonderful opportunity to meet and talk with many persons from countries participating in the drafting of reports on "National Innovative Practices and Successful Approaches in the Field of Population and Reproductive Health". Each person has, to varying degrees but with equal kindness, made a positive contribution to the finalization of this study and I would like to express my thanks to them all.

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10

Uganda

Involving Parliamentarians as Advocates for Reproductive Health

Mr. Hannington Burunde

Summary

Uganda has involved its Members of Parliament in promoting reproductive health and family planning issues among the decision makers using evidence-based advocacy as a strategy to influence policy decisions. This approach has transformed a large proportion of the Parliamentarians into active advocates of reproductive health and family planning issues, committed to influencing other decision makers both in Parliament and elsewhere to take actions that bring about desired change in terms of policies, programmes, strategies and allocation of resources.

Evidence-based advocacy as an approach seeks to equip selected advocates with data and information to be used in drawing the attention of decision makers to socio-economic realities on the ground. The aim is to inform them, motivate them, persuade them and prompt them to take actions that address the issues so identified.

A comparative analysis of the situation before and after the introduction of this evidence-based advocacy initiative indicates that Uganda has, through this innovation, managed to put population and development issues in general and reproductive health and family planning issues in particular high on the policy, public and media agendas. Key indicators used as evidence included low life expectancy, a high population growth rate, a high total fertility rate, a high maternal mortality ratio, low contraceptive use, a high unmet need for family planning, and high incidences of unintended pregnancy and induced abortion as well as high levels of poverty.

Summary (continued)

The link between these indicators and the overall socio-economic development was also highlighted. The implications of these indicators for the provision of social services such as health, education, water and sanitation, employment and housing and for the government efforts to eradicate poverty and to achieve the national vision of social transformation were also highlighted to emphasize the need for policy action.

Apparently these implications had, in the past, not been brought to the attention of Parliamentarians and other decision makers so that they would be sufficiently informed, motivated, persuaded and prompted to take appropriate policy actions. As such, reproductive health and family planning issues had remained largely unattended to and were placed low on the policy and funding agendas.

Evidence-based advocacy as a practice was therefore conceived as an appropriate strategy primarily to create a substantial number of Members of Parliament who would be convinced and committed to bringing these issues onto the floor of Parliament in order for other Parliamentarians to appreciate the realities on the ground and to take policy actions that would bring about desired change. The Parliamentarians were also prepared and equipped to take the message to other decision makers at national and subnational levels who might not be members of Parliament but who were in positions of leadership.

An elaborate implementation modality was put in place and tools and materials were developed to guide the entire initiative. These included the development of the Advocacy Subprogramme as part of the Country Population Programme and the formulation of the National Advocacy Strategy and the Media Advocacy Strategy within the framework of the National Population Policy. The *Advocacy Training of Trainers Curriculum and Manual in Support of Population Programmes* was also developed to guide the capacity-building process.

The Members of Parliament were then identified and recruited, sensitized and equipped with advocacy skills and instruments to prepare them to become actively involved in advocacy-based events and to assist them to use various forums to advocate for reproductive health and family planning issues whenever opportunities arose.

After a period of about ten years, there are new developments to show that evidence-based advocacy through Parliamentarians is a good practice that can influence a policy agenda in great measure. Statements by decision makers show that the messages of the Parliamentarians have been taken on board and are the basis for a number of decisions in various sectors and at various levels including district and lower levels. The integration of population factors into the development plans at national and district levels are a clear manifestation of this initiative.

The practice has to a great extent become self-sustaining, with decision makers expressing concern over the people-centred issues and calling for quick action to address them.

Despite the challenges encountered, it is apparent that the replicability and spreadability of this practice can benefit many other countries and institutions as a lesson from which to draw in their effort to promote reproductive health and family planning as well as prompt policy action and resource allocation.

Information on the Author

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Introduction

Uganda has been implementing evidence-based advocacy through Parliamentarians since 2001 to influence decision makers at various levels to advocate for putting in place policies, programmes and strategies that address reproductive health concerns of the country and to mobilize the necessary resources and prioritize their allocation for implementation of the interventions.

The main target has been the members of the country's legislative body: the Parliament. Parliamentarians make policies and endorse decisions that guide government implementing agencies and other stakeholders in addressing the socio-economic needs and the management of society. In addition to legislation, Parliamentarians represent the views of their constituencies, which cut across sectors of the population, including the grass-roots level. They are elected leaders, they are trusted and they are seen to represent the desires, aspirations and interests of the majority of their constituents. They also play a central role in budget appropriation and oversight.

Over time, evidence-based advocacy as a practice has enabled Uganda to transform a large proportion of the Members of Parliament from mere politicians into active advocates of reproductive health and family planning issues and to have a strong lobbying group in Parliament to champion population and development concerns of the country.

Evidence-based advocacy was conceived as the best practice for promoting population and development issues in general and reproductive health issues in particular after it was realized that these were not priorities on the policy, public, media and development partners' agendas. It was introduced to influence government policies and programmes to address population trends and patterns and to mobilize and allocate resources to implement them. Uganda has one of the highest population growth rates in the world and the root cause of this is linked to the lack of prioritization of reproductive health issues in government policies and programmes. Population and development factors cover a broad spectrum of issues that include reproductive health, gender and demographic challenges. Evidence-based advocacy is a cross-cutting intervention that aims at attracting the attention of decision makers at various levels not only to be informed about such issues but to also develop an interest in them and become convinced enough to take the necessary investment and policy actions.

A comparative analysis of the situation before and after the introduction of this type of advocacy intervention shows that, indeed, after a period of sustained campaigning using this approach, Uganda has managed to put population and development issues on the policy agenda and in the public domain. Media coverage of these issues has increased tremendously, implying that such issues have become topics for public debate.

Over 200 Parliamentarians out of the 333 who constitute the whole of the Ugandan Parliament have been enrolled in voluntary parliamentary associations involved in advocating for improved population programmes that they are convinced will bring about a positive change in the country. This has helped in increasing the visibility of reproductive health and family planning in particular and of population and development issues in general in Parliamentary debates.

Background, Including the Design of the Practice

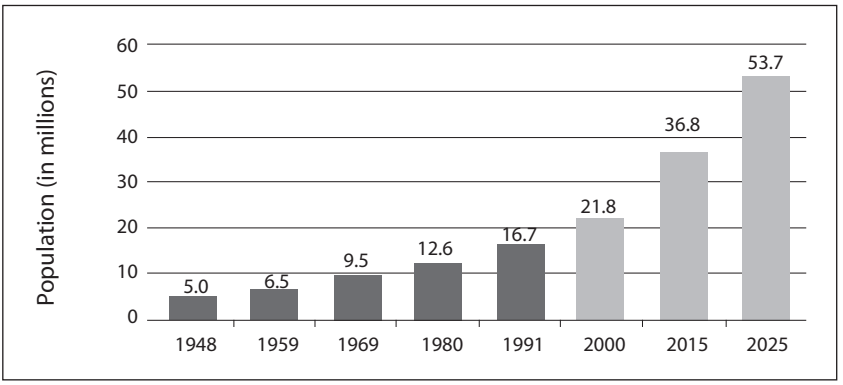
Need for the Innovative Practice

Following the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994, it was identified that Parliamentarians play a crucial role in changing communities, given their unique roles and the fact that they have the support of the majority in their communities. It became imperative to emphasize the role of Parliamentarians in advocacy and in the mobilization of resources and the masses, with a special emphasis on achieving the Millennium Development Goals (MDGs). Every country was required to domesticate the resolutions of the ICPD and this situation called for favourable legislation that could put in place appropriate policies, effective and focused programmes, good strategies, and suitable mechanisms for resource mobilization and allocation to address them.

A general overview of the health situation in Uganda over the years shows that for a long time, the health status of the population has been poor, with life expectancy at birth standing below 50 years in 2002. The infant mortality rate was at 88 per 1,000 live births in 2000 (*Uganda Demographic and Health Survey 2001/2002*) and the maternal mortality ratio had stagnated at the unacceptably high figure of 505 per 100,000 live births (ibid.).

In addition, reproductive health services remained inadequate yet the population, according to the 2002 National Population and Housing Census, was increasing at the very high rate of 3.2 per cent per year. The total fertility rate stood at 6.9 children per woman in 2000, making Uganda the country with the highest fertility rate in sub-Saharan Africa. Contraceptive use stood at a mere 18.6 per cent in 2000/2001. The unmet need for family planning had been increasing from 7.8 per cent in 1995 to 38 per cent in 2001 and to 41 per cent in 2006, implying that many more women wanted to use family planning but were not doing so for various reasons, includ-

Growth of the population of Uganda.



ing low level of knowledge, limited availability and access, and issues of affordability as well as side effects, myths and misconceptions.

Most of the above-mentioned issues and their socio-economic implications had not been brought to the attention of decision makers, especially the legislators and those in leadership positions, so that they would become sufficiently informed, motivated and persuaded to address the situation in terms of appropriate legislation. As such, reproductive health issues had largely remained unattended to and were placed low on the policy and funding agendas. The advocacy intervention was therefore designed with the above-mentioned issues and requirements in mind, with the mission of bringing about policy change.

Description of the Practice, Including Its Design

During the development of the Government of Uganda/UNFPA Country Programme 1997-2000, it was agreed that Advocacy should be a subprogramme to support Reproductive Health and Population and Development Subprogrammes. A total of 10 per cent of the funds for the Country Programme were therefore allocated to Advocacy as a stand-alone subprogramme. This provided an opportunity for the implementing institutions and organizations to build capacity in advocacy as an intervention and to come up with strategies for influencing various agendas, with special emphasis on decision makers at various levels.

In the Government of Uganda/UNFPA Fifth Country Programme (2001-2005), Advocacy was again made a subprogramme, which provided a chance for Uganda to consolidate the achievements made under the previous Country Programme. The intervention has since become a permanent cross-cutting intervention supporting Reproductive Health, Population and Development, and Gender Subprogrammes and targeting decision makers including Members of Parliament.

Evidence-based advocacy is a type of advocacy that aims at bringing about a better understanding of issues among decision makers using evidence (scientific data) to prove the real situation on the ground and justifying the need for urgent practical solutions. As such, its primary target is those holding positions of authority where they influence policy decisions that affect society. An evidence-based advocacy intervention is premised on the realization that unless the attention of decision makers is drawn to the realities on the ground, the decision makers may not appreciate them enough to be able to take policy actions aimed at meeting the socio-economic challenges of the population. The design of the intervention followed the steps in the advocacy process presented in the following table.

Steps in the advocacy process.

Advocacy Strategy	1.	Collecting Data	Gathering, analysing and using appropriate quantitative and qualitative information to provide supportive evidence for identified issues.
	2.	Identifying Issues	Identifying problems that require policy action through changes in policies, programmes, strategies and resource allocation.
	3.	Developing a Mission Statement	Setting out the overall aim, ultimate goal or purpose of the advocacy initiative.
	4.	Setting Goals	Stating goals as the general results to be achieved over a specified length of time.
	5.	Setting Objectives	Setting the objectives, that is, the incremental steps towards achieving each of the goals. Objectives should be specific, realistic, measurable and time-bound.
	6.	Identifying Target Audiences	Identifying the policy makers, public institutions, community and religious leaders, politicians, development partners and organizations that need to be influenced to support the priority issues and to take positive action.
Action Plan	7.	Identifying Activities	Determining the specific actions to be taken in order to achieve the agreed advocacy objectives.
	8.	Message Development	Developing statements tailored to different audiences that define the issues, suggest solutions and describe the actions that need to be taken and the benefits.
	9.	Identifying Channels of Communication	Identifying the means by which a message is delivered to the various target audiences, e.g., radio, television, flyers, press conferences and meetings.
	10.	Building Support	Building alliances and networks with other groups, organizations or individuals committed to supporting the priority issues.

Steps in the advocacy process (continued).

Taking Action	11. Fundraising	Identifying and attracting resources (money, equipment, volunteers and supplies) to implement the advocacy initiatives.
	12. Implementation	Carrying out a set of planned activities to achieve advocacy objectives (action plan).
	13. Monitoring	Gathering information to measure progress towards the advocacy objectives.
	14. Evaluation	Gathering and analysing information to determine if the advocacy objectives have been achieved.

The starting point for evidence-based advocacy as an intervention was to identify the policy issues and challenges that needed to be addressed, set goals and objectives, and establish who the main actors were and who had the best comparative advantage to undertake specific tasks.

The main goal was to have a substantive number of Members of Parliament who were convinced and committed to influencing policy decisions made by the legislative organ of Uganda aimed at bringing about positive changes. The Members of Parliament debate and endorse decisions that shape the management and running of society. They represent constituencies that cut across sectors of the population. They are elected leaders, are trusted, and are expected to champion the desires, aspirations and interests of their constituents. Based on these principles, a national advocacy strategy was developed, identifying Members of Parliament as one of the main actors that could influence policy decisions and general perceptions of the population regarding reproductive health and family planning issues.

The Parliamentarians were expected to play an instrumental role in influencing decisions not only on the floor of Parliament but also in convincing the general public about the need to demand specific services from their leaders. It was agreed that once converted as advocates of population and development concerns, they would bring these concerns onto the floor of Parliament and influence funding and the policy environment to address them.

An advocacy steering committee was established to guide the implementation of advocacy interventions. It comprised representatives from line ministries, civil society organizations, international and bilateral and multilateral donors, and the media. The coordinating organ was the Uganda Population Secretariat.

Advocacy Issues

The evidence-based advocacy programme of the Uganda Population

Secretariat selected six key broad issues that needed to be addressed urgently through advocacy efforts in order to increase the access to and use of high-quality reproductive health and family planning information and services in Uganda.

- **Issue 1: Public leadership and support**

  Inadequate promotion and support for reproductive health and family planning by leaders at all levels;

- **Issue 2: Access to information**

  Inadequate support for information and communication programmes that address male involvement, rumours and misconceptions, the benefits of family planning, and information on sources of family planning methods and services;

- **Issue 3: Availability of commodities and supplies**

  Inconsistent availability of the right family-planning commodities and supplies in the right quantities, at the right times and in the right places at service delivery levels;

- **Issue 4: Access to services through integration**

  Inadequate policies, guidelines and tools to support integration of family planning services into existing health services and programmes and into multisectoral community-based services and programmes;

- **Issue 5: Capacity for service delivery**

  Inadequate numbers of appropriately skilled service providers to offer a full range of quality static and outreach family-planning services, including men-friendly and adolescent-friendly services; and

- **Issue 6: Education for young people in the formal school system and those not in school**

  Inadequate implementation of life-skills training and population education in school curriculums and for youths out of school.

Implementation Details

The Uganda Population Secretariat, as the lead agency, established links with the Uganda Parliamentarians' Forum on Food Security, Population and Development and other stakeholders to introduce evidence-based advocacy to the legislators. The implementation of the intervention required the mobilization of stakeholders and the creation of partnerships and networks. It also called for resource mobilization from development partners and government as well as capacity-building; the development of tools, guidelines, messages and materials; and the organization of advocacy-based events to raise the profile of population issues in general and reproductive health and family planning in particular. These elements made the implementation of evidence-based advocacy in Uganda possible since they helped in harmonizing the messages and speaking with one voice. Particular Parliamentarians were

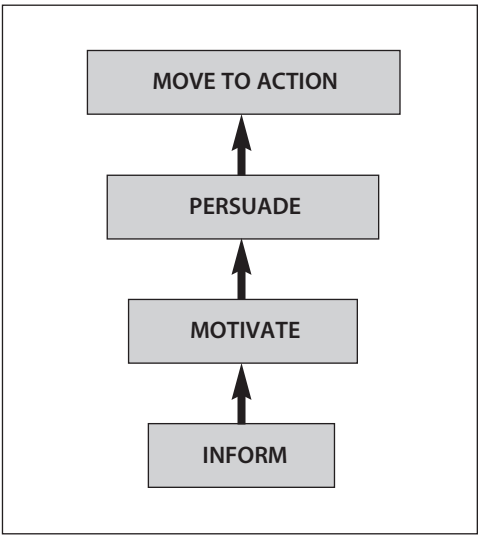
brought on board and equipped with evidence data and information to back their advocacy activities and to lobby and propose solutions that called for policy actions.

Some of the tools and materials included a national advocacy strategy in support of reproductive health, population and development programmes, which was developed in 2005 to guide stakeholders (including Parliamentarians) in implementing advocacy interventions. The strategy was designed clearly spelling out reproductive health issues and the actions that needed to be undertaken by Parliamentarians as pointed out in the National Population Policy (1995 and 2008 versions).

The National Family Planning Advocacy Strategy (2005-2010) was also developed by the Ministry of Health in collaboration with the Population Secretariat as a subset of the National Advocacy Strategy to focus specifically on family planning issues.

The implementation process employed the communication model (fig. 1) that aims at moving the target audience (Parliamentarians) to action. It does so through providing them with information, motivating them, persuading them and ultimately influencing them to take necessary actions that would put in place appropriate policies, programmes and strategies and mobilize and allocate resources to address the identified issues and converting Parliamentarians into a cadre of advocates to sensitize others to support this cause.

Figure 1 | A flow diagram of the communication model used in the innovative practice in advocacy.



The sensitization of the members of Parliament followed this model to equip them with information and data in order for them to be able to speak authoritatively on reproductive health and family planning issues with ease and confidence. The model also helped them to not only give information and motivate their colleagues but also be able to persuade them to take the required policy actions.

The model formed a basis for the formulation of messages to be used by the Parliamentarians. The principles of message formulation were as follows:

- to state an **issue** and propose a realistic **solution** (policy, programme, strategy, resource allocation);
- identify the possible **action** and who should take that action (specific **actor** or decision maker); and

- mention the possible **benefits** to society as a result of taking that action. The benefits also serve as motivational factors that would influence the targeted decision maker to act.

Challenges

A number of challenges were encountered during the implementation of the evidence-based advocacy interventions:

- The recruitment of the legislators was not simple at the beginning since many Parliamentarians were not interested in population and development issues in general and reproductive health and family planning issues in particular.
- Some of those who had been converted were not re-elected and the new entrants were not aware of the issues. Parliamentarians also have a very busy schedule, which makes it impossible to engage them for a long period.
- The implementation also faced challenges of lack of expertise in advocacy since capacity was still low at the national level and worse at lower levels.
- There are cultural leaders in the communities who have been mobilizing communities, advocating for the advantages of having a bigger population and for giving an incentive to families to have more children. These views of the community leaders have been sending negative messages that have undermined the advocacy campaign.
- The challenge of inadequate resources cannot be overemphasized, especially where the Parliamentarians had to be assisted to go out to their constituencies to sensitize the people.
- Results and achievements of evidence-based advocacy take a long time to achieve (ten years and above). There was therefore a need to exercise a great deal of patience and persistence while carrying out this work, yet many partners would become frustrated and leave the campaign before it created the required impact.
- Some development partners are also unable to sustain a long campaign whose results take years to achieve.
- Time for elections has affected the involvement of the Members of Parliament in organized campaigns since they are engaged in political campaigns. However, several population and development issues are being put on the candidates' campaign and manifesto agenda.

Advocacy Support Tools and Materials

A number of other advocacy support tools and materials were also produced to guide and equip the Parliamentarians with knowledge and skills and to provide quick reference points whenever needed.

They include the following:

- An **advocacy training-of-trainers curriculum and manual** were developed whose purpose is to ensure that advocacy as a concept is well understood and is employed as a strategic intervention by the Parliamentarians, and a series of training sessions was carried out to equip the Members of Parliament with advocacy skills and to try out role playing to sharpen their skills.
- A **media advocacy strategy** was also developed to influence the media agenda to give coverage to decision makers especially Members of Parliament who speak about reproductive health and family planning issues at various forums so that the message is widespread. Various interactive media talk shows (television and radio) were held in the country hosting members of Parliament to deliberate on various population issues in the country in local languages. At first, they were being paid for using donor resources but some radio stations later saw the need to exercise corporate social responsibility by giving free airtime for such talk shows. In any case, the talk shows were seen to add quality to media house programming since they turned out to be educational for the communities and informative, thus increasing their audiences.

The main objective of the evidence-based advocacy intervention was to drum up support for reproductive health and family planning issues, to convince Parliamentarians to bring these issues onto the agenda of Parliament, and to influence other stakeholders as well as development partners to address the issues. The implementation of the intervention was carried out in phases (fig. 2).

- **Phase one** aimed at sensitizing legislators to raise their level of awareness and appreciation of

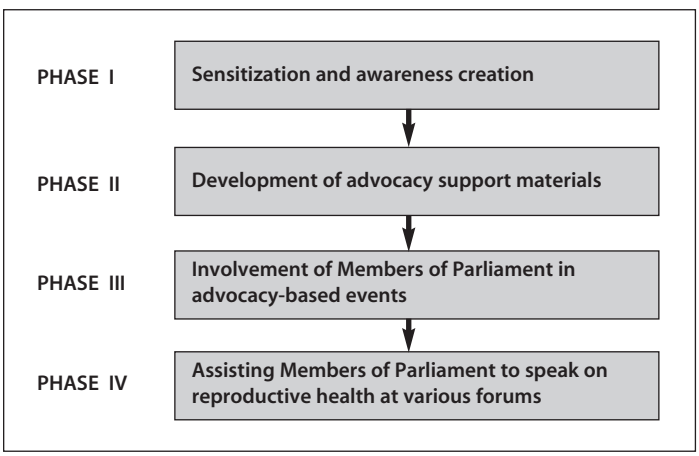


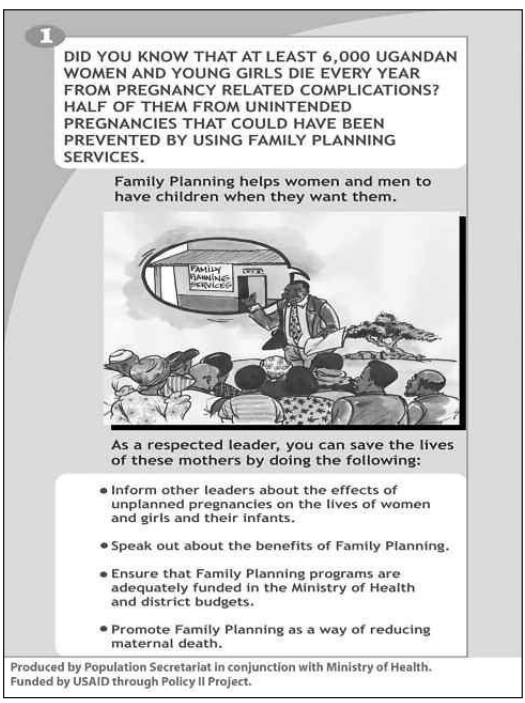
Figure 2 | Phases of the implementation of the evidence-based advocacy intervention.

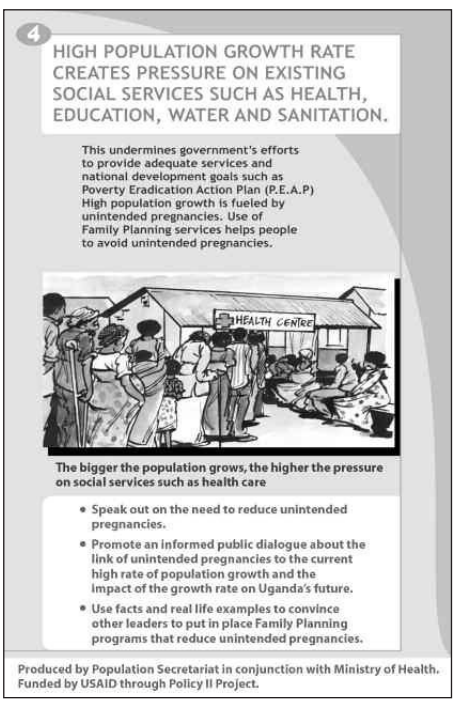
reproductive health issues, using scientific evidence from credible sources both locally and internationally. The Members of Parliament were, for example, shocked to learn that approximately 6,000 women die in Uganda every year owing to pregnancy-related complications. They were equally shocked to know that every year, 297,000 induced abortions are performed in Uganda. The sensitization phase also shared experiences of other countries for comparison purposes and to show that Uganda can achieve what countries such as Thailand and Malaysia and other Asian Tigers have achieved if it puts in place what is required.

- **Phase two** involved the provision of information kits, advocacy support messages and materials to enable Members of Parliament to use evidence to advocate for reproductive health issues. Materials were designed in such a way that they cater to the interests of an average reader.

  The legislators not only were equipped with advocacy skills but they were also given facts and figures to enable them to back up their information and to convince their audiences with evidence. The materials included fact sheets, posters, reports, data sheets and booklets (fig. 3).
- **Phase three** entailed involving Members of Parliament in advoca-

Figure 3 | Sample advocacy posters.





cy-based events as chief guests, resource persons, discussants and participants in order to equip them with advocacy skills for presenting issues in a convincing manner. Members of Parliament have always had the opportunity to also share personal experiences with the communities so as to learn from them.

- **Phase four** involved assisting Members of Parliament to use various forums to advocate for reproductive health issues. The Members organized workshops in their constituencies to talk to the district and community leaders about such issues. Some managed to mobilize resources from government, the private sector, NGOs and development partners in order to provide items such as ambulances, reproductive health and family planning commodities, and construction and renovation of health facilities as well as to offer specialized reproductive health services such as cancer screening and other outreach services. By the end of 2009, 69 out of 80 districts had had mobilization meetings and some Parliamentarians decided to mount the campaign at the county/constituency level. Many district leaders admitted that reproductive health issues were issues to which they had given less attention and called for increased advocacy for them.

The main aim was to have Members of Parliament be part of the advocacy team as respected members of society at both national and community levels and as legislators who bring and debate bills in Parliament.

Results and Achievements

The above-mentioned modalities have helped Uganda to register some modest results and achievements in terms of the roles that the Members of Parliament are playing today in advocating for reproductive health and family planning. The achievements can be categorized into policies, programmes, strategies and resources. Some of these are long term so that the results may not be very visible in a short period but it is possible to identify a few.

At the national level, evidence-based advocacy efforts have resulted in having a strong lobby group of legislators in the Parliament. The membership of the Uganda Parliamentarians' Forum on Food Security, Population and Development has increased over time and has become a strong advocate both in Parliament and outside for reproductive health and family planning issues and population and development in general. The Forum has a membership of 199 Members of Parliament out of the total of 333 Members from different political parties and representing various constituencies in the country. This has helped in projecting population issues as having no political, religious or tribal boundaries.

The lobby group has generated

greater appreciation of reproductive health issues, mainly family planning and maternal health issues, among all Members of Parliament and the Cabinet as well as among the members of the public and the media. Some of the Forum members are ministers and ministers of State, indicating an influence in the executive arm of government. This has also influenced the political agenda, with various manifestoes of aspiring candidates including presidential aspirants listing maternal health as one of the issues that need urgent attention.

Reproductive health issues and family planning are now debated on the floor of Parliament and are part of the legislators' agenda. As such, the Cabinet, including the President, can now be heard making statements in their speeches that reflect their appreciation of reproductive health and family planning issues. Statements such as "No woman should die while giving life" are common with the top leadership and the Parliamentarians at various functions.

The wife of the President, who is herself a Member of Parliament and a minister, is advocating for safe motherhood in Uganda and stresses that "you cannot speak about safe motherhood without promoting family planning". She has agreed to be a Goodwill Ambassador of Reproductive Health after appreciating the impact of such issues on the well-being of families in the country, and her work is influencing a number of policy decisions in Uganda. The Minister of Finance, who is also a Member of Parliament, stated in August 2010 that "poor health is one of the underlying causes of poverty in Uganda and as such health is an essential prerequisite and an outcome of sound economic development". Such statements indicate that through evidence-based advocacy, the Parliamentarians in Uganda have influenced not only the policies and allocation of resources to health issues but also the perception of the decision makers regarding reproductive health issues in general and maternal health in particular.

Budgets and Resource Allocations

The 2008/2009 national budget for the first time included population, reproductive health and family planning issues as budget line items. The appreciation of Members of Parliament of reproductive health issues resulted in the Minister of Finance announcing an additional US$62,500 for reproductive health in the 2008/2009 national budget. This implies a 13 per cent increase in the budget line of that financial year. The 2009/2010 national budget also included the same issues, implying that this has now become an item that will continue to feature in the future budgets, courtesy of the Parliamentarians. Similarly the allocation of funds to the health sector saw an increase from 7 per cent in the 2007/2008 national budget to 9 per cent in the 2008/2009 national budget and to 10.4 per cent in the 2009/2010 national budget.

The Parliamentarians' advocacy efforts have been successful in influencing the Ministry of Health to request a loan from

the Ministry of Finance for maternal health issues, which has resulted in a US$200 million fund specifically for maternal health. Uganda is also beginning to attract a great deal of attention from development partners with respect to investing in reproductive health and family planning. Donors such as the Bill and Melinda Gates Foundation, UNFPA, the United States Agency for International Development (USAID), the World Bank and the World Health Organization have provided funds to address reproductive health and family planning issues in Uganda. In January 2010, Parliament refused to pass a supplementary budget for the financial year 2009/2010 until the World Bank loan on maternal health that had not been passed for the previous two years had been considered. The loan has now been secured and disbursed to the Ministry of Health to improve the health system in the country, including reproductive health.

The five-year National Development Plan (2010/2015) presented by the Uganda National Planning Authority has for the first time ever included an entire section on population and development issues. This is an indication of the influential role that the Members of Parliament play in the planning process. The Plan was presented to them for their input and approval.

At the community level, the Parliamentarians, through the joint district/constituency field visits, have sensitized communities about maternal health issues, mobilized communities to use health services, advocated for the allocation of resources to have maternal mortality addressed in Council budgets, and held district leaders, local governments and health workers accountable to the population that they serve.

In addition, a number of policies, programmes and strategies have been put in place to ensure that reproductive health and family planning service delivery is integrated as an essential strategy to provide quality health services.

Policies and systems have also been put in place to ensure that adequate quantities of reproductive health and family planning commodities and supplies reach service delivery points.

The National Policy Guidelines and Service Standards for Reproductive Health Services (2004) is being implemented to ensure that all health facilities in the country offer an appropriate range of family planning services. The same policy requires that adequate numbers of appropriately qualified and skilled service providers be in place in all levels of health-service delivery units to offer the entire range of quality, facility-based and community-outreach family planning services.

These achievements may seem modest but considering where Uganda is coming from, the Parliamentarians have played quite a commendable role.

Partnerships and Networking

The Members of Parliament have formed partnerships with the Uganda Population Secretariat and various stakeholders and

development partners. The development partners include Family Health International, the Guttmacher Institute, Partners in Population and Development, Population Action International, the Population Reference Bureau, UNFPA, USAID and the World Bank. They have provided financial, technical and material support to enable the legislators to carry out their advocacy activities.

Partners in Population and Development in particular has been in the forefront in assisting Parliamentarians to play the advocacy role at local, national and international levels. It has funded regional conferences for Parliamentarians and breakfast meetings meant specifically to discuss reproductive health and family planning issues as well as constituency meetings where Parliamentarians discuss reproductive health issues with communities. These efforts have enhanced the advocacy role of Parliamentarians and have increased their resolve to take reproductive health and family health issues to higher levels. Partners in Population and Development has also provided a platform for decision makers to interface with communities to discuss these rather sensitive issues and to collect popular views to inform legislation.

The Parliamentarians also network through groups such as the Uganda Parliamentary Forum on Food Security, Population and Development (1996), the Network of African Women Ministers and Parliamentarians – Uganda Chapter (2006), the Uganda Parliamentary Forum on Youth Affairs (2009), the Parliamentary Social Services Committee and the Eastern Africa Reproductive Health Network.

In addition, the Parliamentarians have formed strategic partnerships and networks with key Government line ministries such as the Ministry of Health, the Ministry of Gender, Labour and Social Development, the Ministry of Education, and the Ministry of Finance Planning and Economic Development as well as the National Planning Authority, the Bureau of Statistics, the Makerere University School of Public Health, and the African Peer Review Mechanism to mention but a few. Partnerships and networks have also been formed with civil society organizations including faith-based NGOs and cultural institutions, professional organizations such as Rotary International, and the media fraternity. These strategic partnerships have yielded a number of positive results.

Impact and Sustainability

The knowledge, information and advocacy skills imparted to the legislators have enabled them to have a better understanding of reproductive health issues and to champion, in the legislative assembly debates, such issues as increased funding and tabling of bills as well as popularizing reproductive health issues in general at the national, district and lower levels (constituencies).

This has had a positive impact on the legislators' ability to influence bills and to see them passed by Parliament. Parliament has, for example, prioritized reproductive health issues and passed a number of pieces of legislation as a result.

The legislators have continued to lobby Parliament to increase health-sector budget lines and allocate more resources to reproductive health and family planning. They have also extended the resource mobilization and allocation campaign to development partners and the private sector, which now allocate resources directly to reproductive health activities.

Indeed, the percentage of the national budget allocation to the health sector has been on the increase from as little as below 7 per cent in the 2006/2007 financial year to 10.4 per cent in the 2009/2010 financial year. The challenging issue is to focus now on how this increase benefits reproductive health and family planning. The Parliamentarians are at present taking up the matter through the Social Services Committee of Parliament and the Ministry of Health and are pushing for the national budget to allocate 15 per cent of the total budget to the health sector as recommended by the Abuja Declaration and for the Ministry of Health to prioritize reproductive health in its allocation of the health resources.

The legislators have also mobilized resources from outside the government budget for implementation of reproductive health and family planning activities and programmes, including the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015).

The involvement of and partnering with Members of Parliament have enabled the sensitization of communities about maternal health issues, mobilized communities to use health facilities, and persuaded community leaders to allocate resources to maternal health in council and district budgets.

At the national level, advocacy efforts of Members of Parliament have generated greater appreciation of reproductive health issues among all Members of Parliament, the Cabinet, the public and the media and have added a strong voice to the reproductive health agenda in Uganda.

In May 2010, the World Bank approved a US$130 million loan to Uganda for improvement of the health infrastructure on condition that government prioritizes maternal health. In a media statement regarding this loan, the World Bank country manager in Uganda said that the money is meant to strengthen the country's health system and improve reproductive health care, including family planning services. While meeting Members of Parliament, the Permanent Secretary in the Ministry of Health assured them that at least US$30 million of the funds will go towards improving maternal and reproductive health services.

Speaking after signing the loan agreement with the World Bank in Kampala, the Minister of Finance was quoted by the media as saying that "Uganda's maternal health was among the worst in Africa", and warning that "if the trend continues, Uganda will not be able to meet the Millennium Development Goal

of reducing 435 maternal deaths (2010) to 131 deaths per 100,000 live births by the year 2015". Statements of this nature from top leadership show that reproductive health issues are beginning to get the attention that they deserve from big decision makers in the country.

The Parliamentarians are also influencing policies, programmes and strategies to address reproductive health issues in Uganda. They have proved not only to be strong advocates and lobbyists but they have also taken on that role ably, willingly and consistently. This has facilitated the sustainability of evidence-based advocacy activities. The structures that the Parliamentarians have put in place and the influence that they have had on how to handle reproductive health and family planning issues in the country have resulted in the entrenchment of such issues on various agendas. There is an indication that such issues will remain on the policy, public and media agendas in Uganda for a long time.

Integration into Development Policy, Planning and Programmes

Some of the issues being advocated for have been integrated into policies, programmes and various strategies as well as into the national development planning process, which also takes into account poverty reduction strategies in the country. The National Development Plan has now taken on population and development issues as some of the items that need to be addressed. Similarly, the African Peer Review Mechanism has taken on population issues as cross-cutting concerns for the attention of top leadership. This has resulted in the following:

- The commitment of district officials in improving reproductive health services has been generated and many of these officials have either committed funds or promised to incorporate reproductive health and family planning as priority issues into their development planning activities.
- There has been increased male involvement in reproductive health issues, which differs from the situation in the past when women languished in labour wards without the support of their husbands. Several districts have come up with an initiative that gives incentives to husbands who escort their wives in antenatal wards/clinics by having them attended to first and giving Mama Kits and mosquito nets to those husbands who are present when their wives are delivering. After a continuous sensitization exercise, there has been a continuous phasing out of the traditional birth attendants, who have been a major source of labour complications. Training, retraining and recruitment of health workers to handle maternal concerns are now on the increase.
- Some districts have been empowered and gone ahead to establish district task forces on reproductive health and HIV/AIDS, e.g., Bundibugyo, Gulu, Kanungu, Jinja and Mubende. These task forces

are lobby groups that would help to roll out programmatic activities to communities where most reproductive health cases originate.

- Laws eliminating all forms of domestic violence have been enacted, e.g., the passage of the Domestic Relations Bill, the Marriage and Divorce Bill, the Trafficking Persons Bill and the Bill outlawing Female Genital Mutilation.
- There has been increased awareness of reproductive health issues and the empowerment of communities to demand reproductive health services as their right.
- The number of cases of violence (in any form) against women has been reduced.

Evaluation and Assessment

The implementation of evidence-based advocacy for reproductive health and family planning is monitored through a coordination mechanism involving the Population Secretariat, the Ministry of Health, the Parliamentarians' Forum on Food Security, Population and Development, UNFPA and various other development partners. A monitoring and evaluation framework was developed in 2006 by the stakeholders to guide the monitoring of implementation and to put in place an agreed mechanism for evaluation. This tool has helped in documenting the achievements through quarterly and annual reports made by the implementing partners, who include Members of Parliament.

The reports refer to process, progress, performance and impact indicators. The Monitoring and Evaluation Framework is complemented by the strategies, goals and objectives stated in the National Population Policy, the Reproductive Health Subprogramme and the National Advocacy Strategy, which clearly state the situation on the ground and set the objectives that interventions are designed to achieve. It is against the objectives set out in the Monitoring and Evaluation Framework that progress is assessed and challenges identified. The National Advocacy Strategy is particularly handy in the evaluation of evidence-based advocacy since it focuses on the policies, programmes and strategies put in place to address issues being advocated for and the resources mobilized and allocated to deal with such issues.

Means of verification also included media reports, relevant statements made by decision makers at various forums, the statements made on the floor of Parliament as recorded by the Hansard (the official report of the proceedings and debates of the Parliament), and individual in-depth interviews with selected decision makers and other categories of respondents. Evaluation studies have been carried out by UNFPA and the Guttmacher Institute and the reports indicate that the advocacy role of the Parliamentarians has contributed positively to popularizing reproductive health and family planning issues in the

country. However, there is a need to carry out a more comprehensive study of this practice to assess the long-term impact that it has had in Uganda, with a view to duplicating it in other countries.

Various surveys over the years have indicated a positive trend in the areas of reproductive health and family planning in Uganda. The *Uganda Demographic and Health Survey 2006*, for example, indicated that contraceptive use had increased from 18.6 per cent in 2000/2001 to 24.4 per cent in 2006. Similarly, maternal mortality had been reduced from 505 per 100,000 live births in 2002 to 435 in 2006 and unmet need was said to be at 41 per cent, having increased from 38 per cent in 2002. Fertility was also on the downward trend although decreasing slowly, from 6.9 children per woman in the 1990s to 6.7 in 2000/2001 and showing signs of dropping even further. These surveys have confirmed that evidence-based advocacy through Parliamentarians made a substantial contribution to achieving these positive trends.

Lessons Learned

The above-mentioned results, achievements and impact of evidence-based advocacy with Members of Parliament indicate that:

- involving and engaging legislators in reproductive health programmes deliver results;
- legislators need to be sensitized and made aware of the reproductive health issues affecting society;
- legislators need to be equipped with information, tools and advocacy support materials;
- legislators need to be given an opportunity to talk to the people about reproductive health issues in order to use the feedback to prepare themselves better;
- legislators need to be facilitated to sensitize other leaders and the public and to advocate for reproductive health issues at various forums; and
- legislators need to be constantly updated on the situation using scientific findings and research information and regularly involved in reproductive health and family planning campaigns.

Uganda has also learned that having a strong, credible coordinating body with qualified, committed and consistent staff is crucial to sustaining evidence-based advocacy and to achieving positive results.

The elaborate modalities, strategies and approaches put in place to enable members of Parliament to implement evidence-based advocacy have helped Uganda to achieve the following:

- They have increased the level of awareness and appreciation among Members of Parliament regarding reproductive health issues and enabled Parliamentarians to have a better understanding of the implications of such issues for the lives of the people whom they repre-

sent and the need to promote family planning as a solution.

- The development of advocacy support materials and information kits equipped the legislators with information, knowledge and scientific evidence to back their statements and arguments and to relate them to the real situation on the ground. The materials gave them points of reference and enabled them to speak out confidently and authoritatively on such issues and to quote credible sources such as the Uganda Bureau of Statistics and the Population Reference Bureau. On several occasions, the Parliamentarians and Cabinet Ministers have taken on top leadership and challenged it, especially regarding the perception that Uganda needs a bigger population than it currently has.
- The involvement of Members of Parliament in advocacy-based events enabled the Members of Parliament to try out the skills involved in presenting reproductive health issues to various audiences and to obtain feedback in order to perfect their arguments and persuasion skills to convince their audiences.
- Assisting Members of Parliament to organize advocacy events and to participate in reproductive health activities provided them with an opportunity to own reproductive health issues and to highlight them in order to show their commitment and support to solving such issues, including those affecting the people at the constituency level.
- The biggest achievement as a result of this partnership with the legislators is that they have become advocates of reproductive health issues and are now spreading the information largely on their own. The Members of Parliament have now become a cadre of advocates to advance reproductive health issues in Parliament and outside, including at any international conferences. As such, a change is beginning to be seen in the policies, programmes, resource allocation and decisions made at the national and lower levels in the country. The awareness of the public is also increasing, and with it, pressure is mounting on decision makers to address reproductive health and family planning issues.

Replicability and Spreadability

In spite of the challenges mentioned earlier, it is possible to replicate and spread the Uganda experience in using evidence-based advocacy in other countries to influence policy decisions. The lessons learned by Uganda indicate that evidence-based advocacy with Parliamentarians can bring about desired change when dealing with reproductive health issues or any other population and development concerns that need supportive policies, adequate

programmes, effective strategies, and mobilization and allocation of required resources.

The case of Uganda can therefore be regarded as a good practice that could be adjusted and replicated in other countries to address similar situations. Some of the prerequisites for ensuring success in involving Parliamentarians include the establishment of a good working relationship with Members of Parliament and a strong coordinating body with a good knowledge of advocacy and communication skills. This forms the basis for formulating strategies and mobilizing resources needed to develop tools and materials and to facilitate the implementation process.

Acknowledgements

It is not possible to mention the names of all individuals and organizations that in one way or another had an input into this documentation of a best practice. However, we are very grateful to the Chairperson of the Uganda Parliamentarians' Forum on Food Security, Population and Development, the Hon. Dr. Chris Baryomunsi, and, through him, all the members of the Forum, for reviewing the draft outline and providing the invaluable comments and inputs that went a long way to adding value to the final document. We also would like to thank the Coordinator of the Uganda Parliamentarians' Forum, Mr. Musa Wamala Buyungo and his team, who took off time to include finer details in the draft and for providing inside information on the operations of the Parliamentarians.

Special gratitude goes to Dr. Jotham Musinguzi, Regional Director, and his team at the Partners in Population and Development Africa Regional Office in Uganda for their part in carrying out an internal review of the document; Mr. Charles Zirarema, Acting Director, Uganda Population Secretariat; and Dr. Betty Kyaddondo, Head of the Family Health Department at the Population Secretariat, for her input.

I am grateful to you all.

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United Nations Development Programme (UNDP)

The United Nations Development Programme (UNDP) is the UN's global development network, an organization advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. It is on the ground in 166 countries, working with them on their own solutions to global and national development challenges. As they develop local capacity, they draw on the people of UNDP and its wide range of partners.

World leaders have pledged to achieve the Millennium Development Goals, including the overarching goal of cutting poverty in half by 2015. UNDP's network links and coordinates global and national efforts to reach these Goals. Its focus is helping countries build and share solutions to the challenges of:

- democratic governance;
- poverty reduction;
- crisis prevention and recovery;
- environment and energy; and
- HIV/AIDS.

UNDP helps developing countries attract and use aid effectively. In all its activities, it encourages the protection of human rights and the empowerment of women.

Special Unit
for South-South
Cooperation

Special Unit for South-South Cooperation (SU/SSC)

The Special Unit for South-South Cooperation, formerly known as the Special Unit for Technical Cooperation among Developing Countries (TCDC), was established by the United Nations General Assembly within UNDP in 1978. It carries out its United Nations mandate to mobilize international support for sustained South-South cooperation for development.

The Special Unit for South-South Cooperation:

- encourages developing countries to become important providers of multilateral cooperation;
- fosters broad-based partnerships for supporting South-South initiatives;
- supports the efforts of the South to pool the vast resources of Southern countries as a way of achieving common development goals; and
- facilitates South-South policy dialogues.

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This monograph and other SSC documents are accessible on the Internet at http://ssc.undp.org.

Partners in Population and Development
A South-South Initiative

Partners in Population and Development (PPD)

Partners in Population and Development (PPD) is an intergovernmental initiative created specifically to expand and improve South-to-South collaboration in the fields of reproductive health, population and development. PPD was launched at the 1994 International Conference on Population and Development. Its mission is to assist member countries and other developing countries to address successfully the sexual and reproductive health and rights and population and development challenges through South-South collaboration. PPD carries out its mission by raising a common voice and sharing sustainable, effective, efficient, accessible and acceptable solutions considering the diverse economic, social, political, religious and cultural characteristics of member countries.

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United Nations Population Fund

The United Nations Population Fund (UNFPA) is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV, and every girl and woman is treated with dignity and respect. UNFPA works in partnership with governments, along with other United Nations agencies, communities, non-governmental organizations, foundations and the private sector, to raise awareness and mobilize the support and resources needed to achieve its mission. It works in some 150 countries, areas and territories and is a field-centred, efficient and strategic partner to the countries it serves.

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The Global South-South Development Academy

The Special Unit for South-South Cooperation has committed to transforming, consolidating and institutionalizing its current programme activities into integrated, mutually reinforcing components of an architecture that supports multilateral South-South cooperation. It is doing so by introducing an innovative approach aimed at strengthening social and economic cooperation among developing countries and the sharing of knowledge and best practices with the goal of actual transfers. The Special Unit is building this 3-in-1 architecture as a key contribution to the implementation of its fourth cooperation framework for South-South cooperation (2009-2011), guided by the vision of its director, Mr. Yiping Zhou. This architecture has the following three interlinked components:

1. The Global South-South Development Academy (GSSDA): to enable development partners to systematically identify, document and catalogue Southern development solutions for subsequent validation and mutual learning;
2. The Global South-South Development Expo (GSSD Expo): to enable development partners to showcase successful, scalable development solutions for visibility to the broader international development community in order to obtain feedback and build partnerships; and
3. The South-South Global Assets and Technology Exchange (SS-GATE): to enable development partners to list the most scalable solutions and technologies for partnership-building, resource mobilization and actual transfer.

The GSSDA is a platform for knowledge production, management and sharing for human development solutions. It offers knowledge products and tools to enable partners to research, document, publish and learn about effective practices. Among its many elements, the GSSDA includes a network of focal points; how-to training materials such as manuals, e-courses and workshops; rosters of experts; and publications. The knowledge produced, refined and catalogued through this platform will serve as the stepping stone to the other components of the architecture.

(continued from previous page)

The GSSD Expo is a marketing platform for showcasing Southern solutions to facilitate and promote their dissemination and replication. It focuses on presenting proven development solutions through poster and booth presentations at an annual exhibition. In addition, the GSSD Expo includes forums, round tables and an award competition for innovative development solutions in order to promote best practices and encourage and facilitate their transfer and replication.

SS-GATE is a transactional platform that enables the listing of Southern technologies and development solutions as proposals for social investment. It operates as an open, market-driven mechanism to attract social investment via coordinated but independent tracks to capitalize on different market segments with their distinctive dynamics and players. Current transactional tracks in the design, pilot or operational stage include:

- Track 1 – Technology Exchange: to increase trade of assets and technology among Southern countries and global markets. Phase: operational;
- Track 2 – Human Development Investment Exchange (HDSX): to focus on social investment that will scale up successful development practices in Southern countries. Phase: design;
- Track 3 – Creative Economy Exchange: to increase trade of creative products and services among Southern countries and global markets. Phase: design; and
- Track 4 – New Energy and Energy-saving Technology Exchange: to facilitate the exchange of new energy and energy-saving technology among Southern countries and global markets. Phase: pilot.

With this novel architecture, the Special Unit is offering a service platform that can strengthen social and economic ties among developing countries and capitalize on best practices with the goal of their actual transfer.

Participants in the international workshop on population and development organized by Partners in Population and Development and the UNDP Special Unit for South-South Cooperation in Bangkok, Thailand, in August 2010.

Other volumes in the series:

1. Examples of Successful Initiatives in Science and Technology in the South
2. Examples of Successful Initiatives in Small Island Developing States
3. Examples of Successful Economic, Environmental and Sustainable Livelihood Initiatives in the South
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May 2011