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Holistic Approach Enhances Family Planning Programs: RESPOND's Experience with the SEED Programming Model™

CONTEXT

The Supply–Enabling Environment–Demand (SEED) Programming Model™, a holistic programming framework developed by EngenderHealth, highlights three major components of family planning (FP) and sexual and reproductive health (SRH) programs: supply, the enabling environment, and demand. While most other models and approaches focus on one or two of these components (EngenderHealth, 2011, p. 2), the SEED Programming Model emphasizes all three. SEED has been a key tool used by the RESPOND Project at the global and country levels to strengthen FP programming and to improve the outcomes of FP service delivery.

Building on decades of program experience—that of both EngenderHealth[1] and other technical organizations—the SEED Programming Model has as its grounding principle that FP/SRH programs will be more successful and sustainable if they comprehensively address the multifaceted determinants of health and include synergistic interventions that:

- *Attend to the availability and quality of services and other* ***supply-related issues.*** Improvements in FP/SRH cannot be achieved without quality services. Quality is considered good when adequate infrastructure, supplies, and equipment are in place, and when well-trained, skilled, motivated, and supported staff are available, performing to established standards, and providing services that are accessible, acceptable, and accountable to the clients and communities they serve.
- *Strengthen health systems and foster an* ***enabling environment*** *for health-seeking behavior.* An enabling environment requires equitable policies; adequate resources; effective leadership, management, and accountability; and supportive social norms, including the transformation of inequitable gender norms. Engagement of governments, communities, and other members of civil society is critical to fostering an enabling environment.
- *Improve knowledge of FP/SRH and cultivate a* ***demand for services.*** The demand for FP exists in different forms: actual use and latent demand. The latter exists among those who wish to avoid pregnancy but are not currently using FP (those with an unmet need for FP) and those who might wish to avoid pregnancy if they

[1] The SEED Programming Model™ emerged from an earlier iteration—the Supply-Demand-Advocacy Model—developed by EngenderHealth under the USAID-funded ACQUIRE Project (2003–2008) (ACQUIRE Project, 2007).

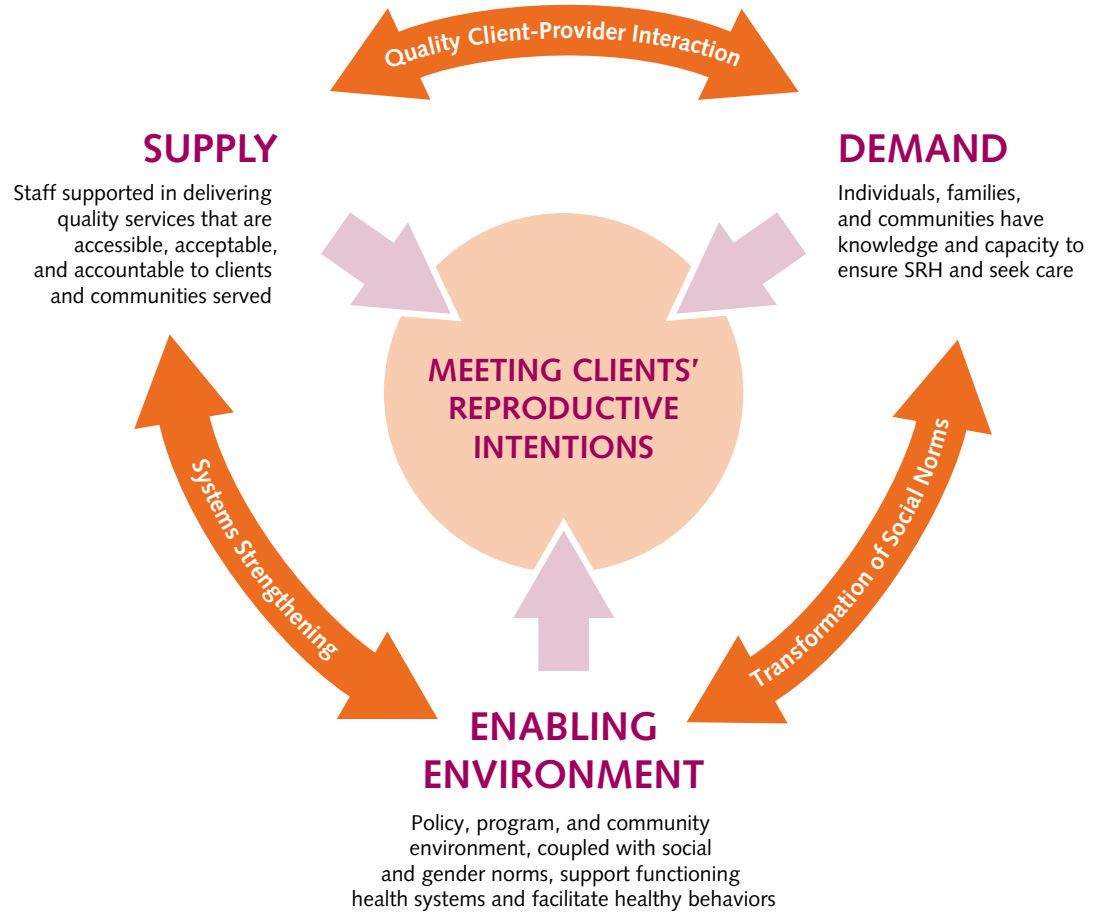
had more information about the benefits of spacing or limiting births. For many, latent demand can be translated into actual use when programs advance positive attitudes toward FP/SRH, address myths and misconceptions, provide evidence-based information, and promote available services.

SEED is distinguished from other models and approaches by the equal representation of supply, enabling environment, and demand components. A combination of interventions in these three interdependent, mutually supportive areas better enables programs to improve FP/SRH in the communities they serve. Interventions in any of the three components do not operate in isolation, as represented in Figure 1 by the arrows connecting the three elements. Investments in one component have an impact on the others, and activities that are well-coordinated and mutually reinforcing are more likely to have an impact.

The SEED Programming Model helps those involved in designing and implementing FP/SRH programs—technical organizations, ministries of health, donors, or others involved in FP/SRH programming activities—to take a comprehensive approach to their work, increasing the likelihood of programmatic success and sustainability, and as a result, the improved health of individuals, families, and communities. SEED contributes to a wide range of program planning functions.

This brief presents examples of applications of the SEED Programming Model by the RESPOND Project at the: 1) country level, to expand and improve access to and use of high-quality FP services, particularly long-acting and permanent methods of contraception (LA/PMs); and 2) global level, to frame initiatives to advocate, promote, and support FP as an essential primary health care intervention.

FIGURE 1. THE SUPPLY-ENABLING ENVIRONMENT-DEMAND MODEL FOR HOLISTIC PROGRAMMING



RESPOND'S COUNTRY-LEVEL APPLICATIONS OF THE SEED MODEL

RESPOND, EngenderHealth itself, and other FP organizations have gained significant experience applying SEED at the country level. This section presents the use of the model by RESPOND in Bangladesh, Burkina Faso, India, Malawi, Nigeria, Rwanda, Togo, and the West Africa region, including its application across the lifecycle of a program (i.e., in assessment, design, implementation, and monitoring and evaluation) and the results achieved.

Bangladesh

The USAID Mission in Bangladesh granted two associate awards to RESPOND that aim to improve women's health by increasing awareness of and access to LA/PMs and building the capacity of the public, private, and nongovernmental sectors. Mayer Hashi (2009–2013) and Mayer Hashi II (2013–2018) have used SEED to identify priority activities in the three component areas. Moreover, project staff were organized into three teams responsible for developing and implementing supply, enabling environment, and demand activities. The staff reported that the model helped the teams work together, ensuring that program activities were mutually reinforcing and synergistic. This team approach was viewed as a critical innovation of the project, as compared with previous project approaches. Thinking holistically, staff appreciated the policy changes needed to increase service delivery and uptake of LA/PMs, as well as the inputs required to expand supply and enhance demand for services (RESPOND Project, 2012a; RESPOND Project, 2013a).

Burkina Faso

The lowest rates of contraceptive use in the world are found in West African countries such as Burkina Faso. Only 15% of married women there use a modern FP method, and 24% have an unmet need for FP—17% for spacing births and 7% for limiting births (INSD & ICF International, 2012). Geographic, financial, informational, and health system barriers impede men and women from accessing FP methods to meet their RH needs. Between 2010 and 2013, RESPOND built public-sector capacity to address barriers to contraceptive choice in three health districts: Koudougou, Kongoussi, and Diapaga. The SEED Programming Model was applied in the assessment phase, and later in the design, implementation, and monitoring of interventions.

The project expanded the supply and quality of services by conducting clinical FP training for providers and by introducing facilitative supervision (RESPOND Project, 2013b). The Ministry of Health (MOH) adopted state-of-the-art technical materials introduced by RESPOND, including the REDI[2] counseling approach and facilitative supervision. To improve data for decision making, RESPOND helped the MOH to update its FP registers and oriented providers on their use. Demand-side activities included: community-based FP talks and theater; radio shows, spots, and advertisements (linked to special FP service days); and national dissemination of a documentary on couples communication for each of the four LA/PMs (the intrauterine device [IUD], implants, and male and female sterilization).

Access to a wide range of FP methods increased significantly in the three districts. At baseline (June 2011), eight public-sector health care facilities (out of a total of 49) offered the implant and two the IUD. By December 2012, 25 facilities offered the implant and 26 the IUD, contributing an additional 1,130 couple-years of contraceptive protection per quarter beyond what the facilities had provided before the project. IUD insertions at public-sector facilities increased nearly 14-fold, from five in the first quarter of 2011 to 69 in the same quarter of the following year. Over the same period, implant insertions rose 27% across the three districts. Results were disappointing in Diapaga District, due to intermittent stock-outs of implants. The other two project districts did not experience stock-outs; implant provision more than doubled, from 327 to 857 implants inserted per quarter in Koudougou and Kongoussi districts combined. Evidence from the endline survey suggests that IUD and implant use in the intervention districts was bolstered by mobile outreach services and special FP service days at facilities, where all methods were offered for free (RESPOND Project, 2013b).

India

In Uttar Pradesh and Jharkhand states of India, male sterilization constitutes approximately 1% of all

[2] The REDI counseling framework (rapport building, exploration, decision making, and implementing) encourages open communication and less rigid counseling.

modern FP use, while female sterilization represents 44% of modern FP use in the former and 70% in the latter (IIPS & Macro International, 2007). Awareness of vasectomy is high, but misinformation about it is pervasive. With funding from USAID/India, RESPOND implemented the No-Scalpel Vasectomy (NSV) Initiative in these two states from October 2009 to September 2013. The project's technical assistance followed the SEED Programming Model to support the governments of Uttar Pradesh and Jharkhand to expand awareness and acceptance of and access to NSV services (RESPOND Project, 2014a).

To increase supply, RESPOND trained new NSV surgeons, strengthened the skills of current NSV providers, worked to ensure the quality of NSV services, and through this training and supervision supported facilities to institutionalize NSV services. The project worked to create an enabling environment for NSV services by encouraging improved policies and by supporting the states to increase the allocation of resources to generate demand while ensuring the quality of NSV service delivery. Finally, to stimulate demand, RESPOND oriented accredited social health activists (ASHAs) in Uttar Pradesh and fieldworkers in Jharkhand on FP, including NSV. The program strived to ensure that these community health workers provided accurate information and guidance, so that their clients could choose from a full range of contraceptive methods.

Following their training and receipt of behavior change communication materials, the ASHAs reported that they felt more comfortable talking to potential clients and that the subject of vasectomy was becoming less taboo. Satisfied clients also played a major role, sharing their positive experiences and dispelling myths and fears in their communities about the procedure. Although RESPOND-supported districts comprised just 15% of the population of all districts in Uttar Pradesh and 37% in Jharkhand (Census Organization of India, 2011), by the last year of the project, they provided 48% of all NSV procedures in Uttar Pradesh and 68% in Jharkhand. The initiative's results demonstrate the impact of holistic programming: improved availability of services; essential funding leveraged and supportive policies influenced; and demand created by raising awareness and dispelling myths (RESPOND Project, 2014a).

Malawi

In 2013, RESPOND collaborated with the Directorate of Reproductive Health (DRH) of the MOH in Malawi to convene a national conference and three stakeholders' meetings to agree on short- and long-range planning options to increase access to and use of a wide range of FP options, both to meet clients' reproductive intentions and to achieve the country's Millennium Development Goals and FP2020 commitments. The SEED Model (along with data generated using EngenderHealth's advocacy and planning tool, Reality Check) served as a platform for assessing FP programming at the local level. Once the participating districts understood the importance of holistic programming and saw the gaps in their current plans, they were able to develop plans and establish district-level contraceptive prevalence rate (CPR) goals. By June 2013, all 28 districts in Malawi had an agreed-upon FP plan and CPR goal, as outlined in their district implementation plans.

Prior to RESPOND support, while FP activities were included in the vast majority of the district implementation plans (92% in 2012–2013), funding was not sufficient to meet districts' goals. A comparative analysis of the 2012–2013 and 2013–2014 plans for the 13 USAID-supported districts revealed that the total amount of funding requested and secured by districts increased dramatically following the technical assistance from RESPOND. The focus districts secured more than twice as much funding for FP activities in 2013–2014 as in 2012–2013. In addition, holistic planning increased: In 2012, two districts requested funds for activities from all three SEED elements, whereas in 2013 this number jumped to 11 (RESPOND Project, 2014b).

Nigeria

In 2010, USAID/Nigeria asked RESPOND to conduct a strategic analysis of the use of, unmet need for, trends in, and current programs for LA/PMs and to develop strategic approaches for strengthening access to and availability, quality, and use of these services. The assessment advocated a comprehensive, holistic approach using SEED to meet the country's high unmet need for contraception. RESPOND emphasized the necessity of demand generation strategies to raise awareness, dispel myths and misconceptions, and create community acceptance for LA/PMs. The team recommended that demand creation activities be car-

ried out in conjunction with supply and enabling environment interventions to ensure an adequate supply of contraceptives and related supplies, quality services, supportive policies, and evidence-based advocacy to build support at national and state levels. The SEED Model now underpins USAID's bilateral assistance program (Bakamjian et al., 2010).

Rwanda

In 2011, RESPOND provided technical assistance to the MOH and the USAID Mission in Rwanda to draft a new five-year national FP policy and related strategies. The government of Rwanda was revitalizing its FP program, with the goal of increasing modern CPR among married women to 70% by 2012 and 90% by 2017. Although Rwanda achieved an impressive increase in CPR in one decade, from 4% in 2000 to 45% in 2010 (NISR, MOH, & ICF International, 2012), at the time of RESPOND's work, the country still was far from reaching its CPR goals. Using the SEED model, RESPOND worked with the MOH to develop a results framework, to create an assessment scope of work, and to synthesize the assessment findings. This assistance yielded a comprehensive results framework and tools to guide the development of the new FP policy and strategies, as well as a blueprint for future workplans. The government's realistic, results-based framework for FP was subsequently approved by its parliament (Bigabiro et al., 2011).

Togo

Togo has one of the highest levels of unmet need for contraception in the world. According to the 2010 Multiple Indicator Cluster Survey (DGSCN, 2011), 37% of married women were estimated to have an unmet need for FP—23% for spacing and 14% for limiting. The CPR is low, with 13% of married women of reproductive age using a modern method. LA/PMs comprise approximately 15% of the overall method mix. From January 2011 to February 2013, RESPOND built public-sector capacity to identify and address barriers to contraceptive choice, access, and use through collaboration with the MOH and implementation of program activities based on the SEED model in two districts, Blitta and Haho. Interventions undertaken to address needs in the three elements were similar to those conducted in Burkina Faso. Between 2011 and 2012, the number of facilities offering the implant increased from five to 32, and the number offering IUDs increased from three to 31. Intervention districts provided more than twice the number of implants per month in 2012 compared with 2011. IUD insertions increased more than seven-fold between 2011 and 2012 (RESPOND Project, 2013b).

West Africa Region

Between 2012 and 2014, RESPOND and six International Planned Parenthood Federation (IPPF) member associations (MAs) in West Africa worked to improve access to and use of LARCs, using a holistic approach. RESPOND and the MAs in Benin, Burkina Faso, Côte d'Ivoire, Niger, Senegal, and Togo applied an Organizational Capacity Assessment Tool (OCAT) to evaluate the current situation in the MAs' delivery of LARCs; using the OCAT results, the MAs developed action plans guided by the SEED Programming Model to identify needs in the three elements. The first three MAs to participate in this effort reported substantial increases in contraceptive use, and several of the MAs indicated that they were able in the year following implementation to successfully obtain additional funding with activities built around the SEED model (RESPOND Project, 2014c). With the evidence of success of the OCAT tool and SEED programming, RESPOND and IPPF's Africa Regional Office (IPPF/ARO) agreed to institutionalize the use of OCAT and SEED in the IPPF Africa network. IPPF/ARO officially endorsed SEED and OCAT as innovations for programming and is distributing the materials throughout its Africa network (RESPOND Project, 2012b; RESPOND Project, 2013c; RESPOND Project, 2014d).

RESPOND'S GLOBAL INFLUENCE: USE OF THE SEED MODEL

The SEED Programming Model was a guiding principle used to inform development of a practical framework for rights-based FP programming, for USAID's High Impact Practices (HIP) work, and for international conferences.

In September 2012, RESPOND sponsored an expert consultation in Bellagio, Italy, to deliberate on how to move contraceptive choice from rhetoric to reality (RESPOND Project, 2013d). This was part of a longer term effort to realize informed choice in practice by increasing equitable access to the widest possible range of FP methods and preventing coercion and barriers to access. Subsequently, this consultation led to a Bill & Melinda Gates Foundation–supported partner-

ship with the Futures Group to develop a conceptual framework *(Voluntary Family Planning Programs That Respect, Protect, and Fulfill Human Rights)* to guide the practical implementation of a voluntary and right-based FP program. The Voluntary Rights-Based FP Framework has filled a critical theoretical and programming gap (Hardee et al., 2013; Hardee et al., 2014). This collaboration has also produced a user's guide to the framework (Kumar et al., 2014) and a systematic review of tools that support voluntary family planning programs that respect, protect and fulfill human rights (Kumar et al., 2013). These resources, grounded in the holistic SEED programming model, offer a practical approach for operationalizing human rights in the design, implementation, monitoring, and evaluation of FP programs. The World Health Organization (WHO) included the framework in a consultation entitled "Ensuring and Monitoring Rights, Equity, Choice and Quality in Family Planning Programmes" in April 2013 (WHO, 2014). The user's guide enables stakeholders to modify or add activities and indicators to strengthen choice and rights in their FP programs.

USAID's documentation of High Impact Practices (HIPs) in FP aims to provide decision makers and programmers with up-to-date evidence and experiential knowledge to inform strategic decision making and programming for FP. In an age of evidence-based decision making, there is increased interest in identifying and adopting best, promising, and high-impact practices. HIPs in FP are identified and developed by international experts from a variety of organizations, including donors (USAID, UNFPA, and World Health Organization) and many USAID cooperating agencies, including EngenderHealth. Until recently, USAID's HIP work focused on practices and did not address guidance on how a comprehensive FP program should be designed (USAID, 2013). The HIP working group saw the need for a framework in which to place the HIPs so that it would be easy to see where a particular HIP might be situated in comprehensive programming and implementation. Advocacy by RESPOND staff led USAID to adopt the SEED model as an overarching construct for its HIPs. Because the model provides a clear and comprehensive view of FP programming, the HIP Technical Advisory Group viewed SEED as a useful way to conceptualize and structure an FP program. The model has been included in the *USAID Resource Guide for Family Planning* (USAID, [no date]). In addition, SEED was listed as a "useful tool for developing a costed implementation plan" in FHI 360's *Costed Implementation Plans: Guidance and Lessons Learned* (FHI 360, 2013).

USAID, the French Agency for Development (AFD), the Bill & Melinda Gates Foundation, and The William and Flora Hewlett Foundation convened a regional conference in West Africa on in February 2011 in Ouagadougou, Burkina Faso, titled "Francophone West Africa Conference—Population, Development, and Family Planning: Urgency to Act." USAID requested technical assistance from RESPOND to shape the technical content of the agenda, prepare technical guidance for country delegations, and support 20 presenters and facilitators. Through its technical assistance and presentations, RESPOND introduced the SEED Programming Model as a guiding principle for the conference. The event achieved extraordinary political support, including: a formal endorsement from President Compaoré of Burkina Faso; an AFD pledge of 100 million euros for FP; a call to action through the Ouagadougou Declaration; and a joint donor Statement of Commitment. Each delegation developed a preliminary country action plan based on SEED for strengthening FP programs and policies. Although the conference did not use the terminology "SEED," all of the model's elements were used and are reflected in the outputs. Since the conference, the Ouagadougou Partnership has had a high level of visibility, including at the 2012 London Summit on Family Planning. Several countries developed costed FP implementation plans, with Guinea, Mauritania, Niger, and Togo using the SEED Programming Model as an organizing framework for their plans (Le Partenariat de Ouagadougou, 2013).[3]

The SEED Programming Model was used at a USAID-sponsored regional meeting on postabortion care (PAC) in October 2013. One objective was to strengthen postabortion FP programs through the

[3] Plans that specifically referenced SEED or were arranged according to SEED included those of Togo (http://partenariatouaga.org/wp-content/uploads/2014/05/Plan-National-de-Repositionnement-de-la-PF-TOGO.pdf); Guinea (http://partenariatouaga.org/wp-content/uploads/2013/11/Plan-Repositionnement-PF-Guinee-Draft-du-12-9-2013.pdf); Mauritania (http://partenariatouaga.org/wp-content/uploads/2013/11/Plan-Repositionnement-PF-Mauritanie.pdf); and Niger (http://partenariatouaga.org/wp-content/uploads/2013/11/Niger-Plan-daction-2012-2015-PF-final-valid%C3%A9.pdf).

development of country road maps. Seventy-six participants from eight countries (Benin, Burkina Faso, Guinea, Mali, Niger, Rwanda, Senegal, and Togo) and 11 organizations participated. Meeting participants were oriented to the SEED Programming Model during a plenary session. SEED was used as one of two organizing approaches for developing the country road maps. To facilitate planning, RESPOND staff developed a checklist tool to guide participants between the PAC Global Resource Guide checklists and the SEED model (Walton & Mielke, 2013).

CONCLUSION

Holistic, client-centered approaches to FP programming create effective, successful programs that ultimately support health systems to meet the RH intentions of women and men. The applications and successes from implementing the SEED Programming Model demonstrate the value of using such a model. Given the experiential evidence of applying SEED in multiple environments, policymakers and program managers charged with developing and implementing FP programs should consider programming their scarce resources to achieve better results. To be successful in sustaining contraceptive use and meeting the growing demand for FP worldwide, two critical elements should be addressed: engaging in sustained health system change using a holistic approach, and safeguarding individual rights and choice in contraception. The SEED Programming Model will continue to be instrumental in developing, implementing, and evaluating FP programs to stimulate and sustain client-centered, health systems change.

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Writers: Alison Ellis, consultant; Maureen Clyde and Jane Wickstrom, RESPOND/EngenderHealth
Contributing reviewer: Caitlin Shannon, RESPOND/EngenderHealth
Editor: Michael Klitsch
Design/Layout: Elkin Konuk
Photo credits: Page 1 (top to bottom), Staff/EngenderHealth; C. Ngongo/EngenderHealth; S. A. Shareef/EngenderHealth

The RESPOND Project at EngenderHealth • 440 Ninth Avenue • New York, NY 10001 • 212-561-8000
info@respond-project.org • www.respond-project.org