



ESD collaborates with coordinators from the Ministry of Health & Population in the Assiut and Sohag governorates.

The Extending Service Delivery (ESD) Project, funded by USAID's Bureau for Global Health, is designed to address an unmet need for family planning (FP) and to increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, to improve health and socioeconomic development. To accomplish its mission, ESD has strengthened global learning and application of best practices; increased access to community-level RH/FP services; and improved capacity for supporting and sustaining RH/FP services. ESD has worked closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associate Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

Integrating Family Planning into Clinic-Based Antenatal Counseling and Community-Based Postpartum Care Services

Scaling-Up High Impact Practices in Egypt

This paper shows how the Extending Service Delivery (ESD) Project – an international leader in scaling up best practices in reproductive health and family planning – partnered with Population Council/Egypt to deliver birth spacing messages for improving postpartum contraception use in eight districts in the governorates of Assiut and Sohag in Upper Egypt. As a result of this successful, low-cost intervention, the Egyptian Government supports continued scale-up to other districts.

PROBLEM ADDRESSED

Many Egyptian women have more children than they consider ideal. According to the 2008 Egyptian Demographic and Health Survey (EDHS), 5 percent of births were regarded as mistimed and 9 percent were unwanted. An additional 47 percent of births occur less than 36 months after a previous birth, which is associated with adverse maternal, perinatal, and infant health outcomes.²

Unmet need for family planning is greatest among women in rural Upper Egypt where conservative norms regarding childbearing and contraception prevail. Located in Egypt's Nile Valley region, the Assiut and Sohag governorates have the lowest rate of contraception use in all of Egypt at 47 and 36 percent, respectively; the national average is 60.3 percent.³

Early evidence suggests community workers can play an integral role in increasing coverage of essential interventions like postpartum family planning.⁴ Family and community care are often not regarded as part of the health system, however, and few countries have made systematic efforts to fully integrate it within the

EGYPT: FAMILY PLANNING METHOD USE¹

EGYPT (TOTAL)=	60.3%
UPPER EGYPT=	52.7%
ASSUIT GOVERNORATE=	47.4%
SOHAG GOVERNORATE=	36.3%

continuum of care.⁵ This was the goal of the Population Council/Egypt program: to successfully integrate family planning into existing health services, to increase women's access to reproductive health choices, and to institutionalize a community outreach program that enjoys the government's long-term support.

BEST PRACTICES TO IMPROVE CARE

With ESD's assistance, Population Council/Egypt developed a program to provide birth spacing messages to low parity women and husbands to help them achieve their ideal childbearing goals. Such information is critical since the lack of postpartum contraception use and incor-

¹⁻³ Egypt Demographic and Health Survey, 2008

⁴ Haines, A et al. (2007). Achieving child survival goals: potential contribution of community health workers. *The Lancet*, 369(9579), 2121-2131. Doi: 10.1016/S0140-6736(07)60325-0

⁵ Kerber, K et al. (2007). Continuum of care for maternal, newborn, and child health: from slogan to service delivery. *The Lancet*, 370(9595), 1358-1369. doi: 10.1016/S0140-6736(07)61578-5.

rect Lactational Amenorrhea Method (LAM) use are common reasons why so many women fail to achieve healthy timing and spacing of pregnancies (HTSP).

The antenatal and postpartum periods are crucial times to provide counseling on birth spacing and postpartum contraception use since most women take advantage of the health care system during these periods. However, women do not often receive this information since maternal and child health (MCH) and family planning services are separate programs in the Egyptian health care system. Earlier evidence from both the TAHSEEN and Takamol projects in Egypt, as well as integration programs in other countries, show that an integrated package of services through one provider better fulfills clients' needs and decreases missed opportunities.⁶

Population Council/Egypt introduced several evidence-based reproductive health best practices, such as integrating birth spacing messages and family planning counseling into antenatal care clinic visits; strengthening outreach services and home visits during the postpartum period; working with communities (husbands, mothers-in-laws, religious leaders, and local authorities) to change social norms around contracep-

tive use; and bolstering in-country capacity by helping the Ministry of Health and Population (MOHP) manage the program. This project created a standardized and supervised program for antenatal and postpartum care conducive to scale-up and institutionalization.

FROM RESEARCH TO ACTION

The foundation for this project began with the Population Council's FRONTIERS program, which was developed in collaboration with the Egyptian MOHP. One of its operations research studies measured the acceptability and effectiveness of models providing birth-spacing messages to low-parity women and their husbands. Birth spacing messages were shown to be effective at changing women's knowledge and attitudes towards birth spacing and increasing the use of contraception at 10-11 months postpartum.

At the request of local government officials in the study governorates, Population Council/Egypt and MOHP scaled up a modified version of the intervention into 48 health facilities in eight districts of the Assiut and Sohag governorates, beginning in June 2009. ESD awarded Population Council/Egypt with a small grant to implement this intervention as part of its tailored approach to scaling up best practices.⁷ Modifications to the original project included:

- Expanding antenatal care counseling and home visits to all women, not only low parity women;
- Emphasizing women's knowledge gain on LAM and addressing incorrect practices related to its use. (The operations study noted that a substantial proportion of women were relying on LAM without knowing the three criteria for its use, and hence did not use it correctly).
- Modified the schedule of Raedat Rifeyats (RRs) postpartum visits. Several supervisors and RRs (family planning outreach workers) found the old protocol of three RR home visits redundant and burdensome given their other health responsibilities. The modified home visits protocol included a total of four postpartum home visits (day 1 and day 4 by the MCH nurse alone, day 7 by nurse and RR together, day 21 by RR alone).



ESD and Egyptian MOHP staffers gather outside a local health clinic. ESD provides technical assistance and leads training sessions during the life of the grant.

⁶ Integration of Family Planning/Reproductive Health and Maternal and Child Health Services: Missed Opportunities and Challenges, CATALYST Consortium/TAHSEEN Project, November 2003 <http://www.pathfind.org/site/DocServer?docID=2422>

⁷ Please see the ESD document "Scaling-up best practices to meet millennium development goals 4 & 5: A tailored approach to spreading best practices" for ESD's model for scaling up best practices.

- Increasing male participation at contraception awareness-raising activities. Although husbands desired clarification on the religious implications of family planning and birth spacing, turnout at these events was generally low during the study. To increase participation, the Population Council held seminars every three months in each of the intervention villages.

FROM ACTION TO ACCELERATION

Population Council/Egypt and the MOHP cooperated to implement the intervention at MOHP facilities in the target districts. Scaling up was implemented by MOHP staff in the two health directorates of Assiut and Sohag and monitored by staff from the MOHP central office, with technical assistance from the Population Council and ESD.

The intervention package placed special emphasis on improving women’s knowledge about LAM, addressing incorrect practices related to its use and teaching modern methods of contraception to help women achieve HTSP. MOHP family planning and MCH supervisors received a three-day training of trainers on integrating birth spacing and family planning messages into antenatal and postpartum care. District managers and supervisors took primary responsibility for training providers at the facility level and for monitoring the intervention. As a result of this concerted dissemination of information, pregnant women received birth spacing messages at the facility level during antenatal care and during home visits during the postpartum period.

Prior to the intervention, the home visits conducted by MCH nurses and RRs occurred irregularly; they were not monitored or shown to contribute to better service delivery and health outcomes. During this intervention, the staff was motivated to provide home visits without any additional incentives.

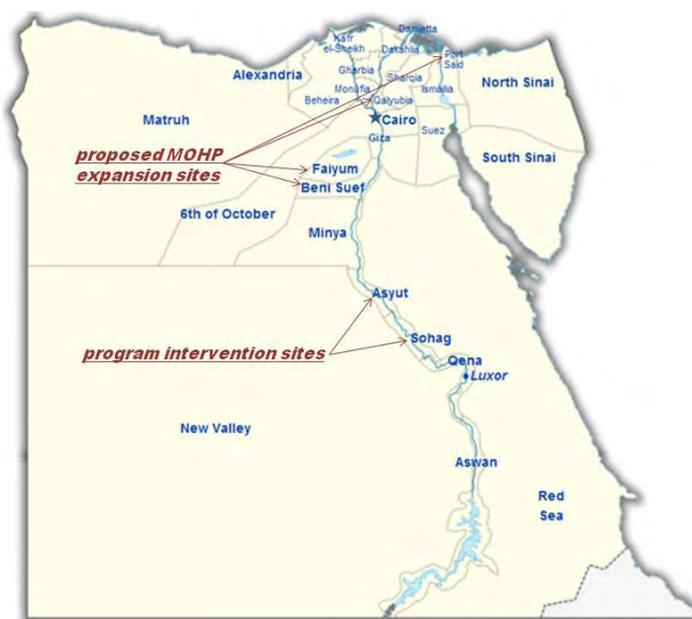
Seminars for husbands and mothers-in-law were also held in villages to explain the benefits of HTSP. A clinic doctor, a local religious leader, or a district information, education, and communication (IEC) officer usually facilitated each session.

As part of the oversight structure, district supervisors conducted field visits to intervention clinics to monitor

implementation of the activities. Project monitors conducted monthly home interviews with a random sample of three pregnant and three postpartum women per clinic (a total of 288 clients per month) to monitor the rollout.

The map below shows the 2 program intervention governorates and the 4 additional governorates where the MOHP hopes to expand. The MOHP has applied for funding and technical assistance from WHO/Eastern Mediterranean Regional Office for the intervention expansion.

Map of Egypt and project intervention sites.



ESD ROLE

In addition to providing the grant, ESD contributed technical assistance and monitored activities both remotely and on the ground. Staff visited the implementation sites to share expertise on best practices and to document results. Working with the Population Council, ESD reviewed program and quarterly reports, marked the intervention’s progress, and addressed additional challenges that arose.

OUTCOME AND RESULTS

Population Council/Egypt succeeded in reaching a large number of women with family planning and HTSP information thanks to the intervention. Home



Babies rest in a local hospital. Health clinics in both Assiut and Sohag saw strong increases in the number of clients.

interviews in Assiut and Sohag showed that during June 2010, 100 percent (72/72) of pregnant women in Assiut and 100 percent (72/72) of pregnant women in Sohag received counseling on birth spacing and postpartum family planning during antenatal care.⁸ Among postpartum women, 99 percent (71/72) in Assiut and 100 percent (72/72) in Sohag could name two health benefits of healthy timing and spacing of pregnancy for infants and newborns. Out of the 48 clinics in Assiut and Sohag, 34 have witnessed an increase in new family planning users since the start of the intervention. In Assiut, 21 of 24 clinics saw increases from 6 percent to a 101 percent in new family planning acceptors. Similarly, 13 of 24 Sohag clinics witnessed an increase of new clients ranging between 2 to 134 percent.

As a result of these positive effects, officials in Assiut and Sohag are scaling up the intervention into more clinics within the eight target districts using local (i.e. non-donor) resources. While conducting supervisory visits, district supervisors have provided on-the-job training to staff in other clinics on integrating birth spacing and LAM messages into antenatal and postpartum care.

The overall success of the intervention prompted the

⁸ Monthly home interviews by project monitors were conducted with a random sample of three pregnant and three postpartum women per clinic (a total of 288 clients per month [144 pregnant and postpartum women per clinic: 72 pregnant women and 72 postpartum women]) to monitor implementation of the intervention.

MOH to revise the guidelines defining roles of MCH nurses and RRs on each postpartum visit (days 2, 4, 7 and 21) and integrate them into a manual. The manual explains to nurses and RRs the importance of each postpartum home visit, possible complications arising during the postpartum period, associated warning signs, and messages to communicate on each visit. As of February 2011, the manual was set for printing and distribution to all participating clinics. The Population Council held meetings with senior MOHP officials for reviewing the updated training curriculum and manual with MCH staff and RRs. The MCH and family planning sectors assigned five officers to train MOHP staff in the two governorates and scale up activities to a national level.

CHALLENGES

On the job training started more slowly than anticipated because MCH staff was already occupied with a time-consuming swine flu campaign. This public health emergency also affected their home visits, but the MCH nurses and RRs resume their normal schedule as the epidemic passed.

Turnover of high level staff at the MOHP governorate level also made maintaining program support a challenge. To address this issue and achieve institutional buy-in, Population Council/Egypt learned to adapt the intervention and scale up plans by strengthening its partnership with the main stakeholder, the MOHP.

Another challenge that the program faced was hesitation among senior level officials regarding the integration of family planning and MCH services. Some family planning officials were concerned about the clarity of roles in the MCH and FP sectors and programs. Conversely, MCH officials expressed concern that integration would overburden their staff and divert attention away from core MCH services. Population Council/Egypt addressed their concerns, working with both parties in such a way that consensus was gained that providing birth spacing and family planning messages within antenatal and postpartum services would actually strengthen both sectors. Project implementers shared evidence explained that adding only five

minutes of family planning and HTSP messages during ANC could help significantly improve maternal and infant outcomes.

To address the challenge of program sustainability, Population Council/Egypt attempted to build a sense of ownership among the partners (e.g. health directorates) by involving them in every step of the implementation process. In the two intervention governorates, the directors of health are ready to scale up the intervention to other districts. The central level MOHP family planning Secretary General has supported their efforts, holding monthly meetings in their governorates to keep abreast of their progress and the intervention results. Senior officials at the central level (family planning and MCH undersecretaries) continue to champion the intervention and show interest in scaling up this intervention into more governorates, especially those with high fertility rates.

LESSONS LEARNED/RECOMMENDATIONS FOR REPLICATION

The family planning/MCH integration package is a simple, low cost intervention suitable for scale up in resource poor settings. It reduces missed family planning opportunities and does not add a significant burden on health care providers. A key component of this model that bears emphasis is that neither MCH nurses nor RRs received any monetary incentive for conducting the home visits, making the intervention both easily adaptable and replicable at a low cost.

This intervention aimed to have project activities fully integrated into the existing public health system to increase the odds for successful scale up. With proper documentation of the process, building capacity within the government system, and incorporating tools, protocols, and standard operating procedures, scaling up to other governorates is possible without assistance from Population Council/Egypt. Population Council/Egypt intentionally limited its role to technical assistance to allow MOHP (central, governorate and district supervisors) to assume full responsibility for the program. The government is motivated to reduce unplanned pregnancies and the MOHP stayed involved through every step of project implementation.

Continued championship by governorate and central



ESD provided training to MOHP and MCH supervisors on integrating family planning and birth spacing messages into antenatal and postpartum care.

level government officials is an essential part of scaling up any intervention. Central level leadership from the MOHP family planning secretary general was crucial to the success of the program and its continued expansion at both the governorate and central levels. In addition to the 48 intervention clinics, officials in Assiut and Sohag are expanding the intervention into more clinics within the 8 target districts using local resources. While conducting supervisory visits, district supervisors have provided training to staff in other clinics on birth spacing, LAM, and integration of birth spacing messages into antenatal and postpartum care.



ESD IS MANAGED AND DIRECTED BY:



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