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## Extending Service Delivery Project: Best Practice Brief # 2



# TAHSEEN/CATALYST Integrated Multisectoral Family Planning Model: A Movement to Enable Adoption of Healthier Reproductive Health and Family Planning Behaviors

## Rationale

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Consistent with its mandate to identify, document, and disseminate promising and best practices (P/BPs) in reproductive health and family planning (RH/FP) for application at the community level, ESD has compiled information on a best practice model for improving quality and access of RH/FP services in rural communities in Upper Egypt. This brief presents a summary of the model components, program results, and lessons learned. Accompanying the brief is a CD-Rom titled *TAHSEEN/CATALYST Project: Integrated Multisectoral Family Planning Model* that describes the integrated model in a pictorial format. It is recommended that the brief and the CD-Rom be used together for greater understanding of the model. The brief is intended for RH/FP program planners and implementers working in NGOs, collaborating agencies, and with donor agencies.

## Background

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Since 1978, the United States Agency for International Development (USAID) has worked with the Egyptian Ministry of Health and Population (MOHP) and other partners to improve the quality of RH/FP and Maternal and Child Health Services (MCH) in Egypt. While these efforts have produced tangible results, important disparities still persist across geographic, social, and economic sectors. TAHSEEN (derived from the Arabic phrase: *tahseen sihitna bi tanzeem usritna*, which means “improving our health by planning our families”) was designed to address the lingering RH/FP gaps, improve quality of care, and increase the use of RH/FP services among underserved populations. TAHSEEN (2003-2005) was managed by the CATALYST Consortium, a global RH/FP activity funded by USAID.

TAHSEEN/CATALYST developed an integrated multisectoral RH/FP model that addressed quality improvements, behavior change, linkages to health and non-health activities, and community mobilization, among other issues. The project also integrated the previously separate sectors of family planning and maternal and child health at the community, district, governorate and national levels.

Initially, the project introduced and tested its model in five prototype communities in Minia governorate in Upper Egypt. Lessons learned from these experiences were used to refine and scale up the model.

By June 2005, the model was scaled up to a total of 69 communities in five governorates (Minia, Beni Suef, Fayoum, Giza, and Cairo) including three urban poor areas in Cairo. The project catchments area covered approximately 1.5 million people. In each governorate, the sequence, pace, and variety of activities within the model were adapted to suit the particular needs of each governorate and target community.

Outcome data were collected approximately nine months from the initiation of services<sup>1</sup>. Data indicated that utilization of services by married women of reproductive age (MWRA) improved by 21% and for young, low-parity women<sup>2</sup> by 11%. The contraceptive prevalence rate (CPR) among MWRA increased by 30% while CPR among young, low-parity women increased by 35%.

In addition, TAHSEEN was successful in leveraging about 1.3 million dollars in private funds, both in-kind and cash.

## Description of the Model

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TAHSEEN worked on two parallel tracks. The first track focused at the community, district and governorate levels. It involved a carefully designed and uniquely sequenced set of mutually reinforcing activities that included:

- Clinic renovations;
- Technical and management training for clinic staff, community leaders, outreach workers, district supervisors and managers, and governorate officials; and
- Widespread community mobilization.

The second track involved work at the central level. Collaborating, primarily with MOHP, to institutionalize policies and systems that assured central level support, capacity, contributions, and sustainable uptake of the model.

The implementation of the model involved three overlapping approaches: (1) quality improvements in service delivery, (2) community mobilization, and (3) sustainability.

## Improving the quality of clinical services

The TAHSEEN implementation strategy began by ensuring that the communities had a clean, functional, up-to-date, and inviting place in which to obtain RH/FP and MCH services. Steps included:

- **Clinic renovation.** TAHSEEN began by fully renovating the clinic in every community in which it worked. The visibly improved clinics became a resource that the communities were proud of and eager to maintain. Because TAHSEEN mobilized community members and resources in the clinic renovations, it immediately inspired trust and laid the groundwork for future community participation.

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<sup>1</sup> Pre-intervention data were collected in October and November 2004 and post-intervention data were collected in June and July 2005.

<sup>2</sup> Young, low-parity women refer to young married women less than 25 years of age and with 1 or 2 children.

- **Clinical training for service providers.** As the clinics were renovated, clinic physicians, nurses, and lab technicians were trained in the revised standards of practice<sup>3</sup>, which included guidelines for providing integrated RH/FP and MCH services, birth spacing, postabortion care, and postpartum care.
- **Training for private providers.** To ensure that all providers in the community offered quality services, TAHSEEN upgraded the RH/FP knowledge and skills of private physicians and pharmacists, NGOs, and community health workers.
- **Quality improvement.** After clinical skills were upgraded, TAHSEEN established quality-improvement systems that involved and connected staff, supervisors, and community members. Specifically, this system integrated and rationalized district-level supervision of clinics; redefined roles to ensure that supervisors acted as facilitators and supporters rather than inspectors; and gave stakeholders at the community, clinic, and supervisory levels the tools, skills, and motivation they needed to constantly monitor and improve performance.
- **Reactivation of clinic boards and service improvement funds.** Quality-improvement training and system building were followed by the activation of long-dormant clinic boards, which were composed of both clinic staff and community representatives. Boards linked clinics to communities by monitoring clinic quality, educating community members about clinic activities, mobilizing community resources in support of clinics, and giving communities a voice on how their clinics were managed. Once Boards were reestablished, members were trained using the same quality-improvement method that had been used to train clinic staff. Among other topics, members learned to manage their Service Improvement Fund, which collects clinic revenue and disburses it for clinic-improvement projects. Because clinic training preceded the reactivation of Clinic Boards, clinic staffs understood the value of the Boards and were prepared to fully welcome them.

### **Mobilizing the community to improve its own RH/FP knowledge, services, behaviors, and outcomes**

As quality of care improved, TAHSEEN began to mobilize community leaders, religious leaders, youth, men, media, literacy facilitators, agriculture and irrigation extension workers, NGOs, outreach workers, theater groups, artists, and others to: (1) widely and consistently disseminate TAHSEEN messages about healthier behaviors such as health benefits of birth spacing and delaying age of marriage and early pregnancy; (2) begin the process of changing community norms to support behavior change; and (3) mobilize community interest in both using and supporting clinics.

Once TAHSEEN achieved community support and confidence as a result of early mobilization and clinic-improvement activities, it introduced a second round of behavior change activities addressing more sensitive topics, such as postabortion care, RH/FP education for youth, and gender-based violence.

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<sup>3</sup> To reflect the integration of services, TAHSEEN revised MOPH Standards of Practice and developed *The Integrated Maternal and Child Health and Reproductive Health Services Standards of Practice*.

## Contributing to long-term sustainability

Essential components of the project's effort to contribute to sustainability included:

- Institutionalizing pre-service training for newly appointed doctors on the new integrated standards of practice;
- Redesigning the governorate-level supervisory system;
- Establishing governorate-level sustainability committees;
- Increasing the role of NGOs and the private sector in RH/FP outreach and service provision;
- Reactivating Clinic Boards with significant community participation;
- Reactivating clinics' Service Improvement Funds;
- Mobilizing corporate and private sectors for financial support;
- Mobilizing community members to provide in-kind and small financial contributions; and
- Securing significant political support.

## Results

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To measure the impact of its activities at the community level, TAHSEEN conducted household surveys in five sentinel communities of Malattia, Shousha and Deir Abou Hennes in Minia Governorate, Metartares in Fayoum Governorate and Kom Abo Khalad in Beni Suf Governorate. The pre-intervention survey was conducted in October 2004 in Minia and November 2004 in Fayoum and Beni Suf. The post-intervention survey was conducted in June 2005 in Malattia, Minia and in July 2005 in all other sites.

All data were collected by the Central Agency for Public Mobilization and Statistics – the Egyptian government agency responsible for the national census. Data were also collected from service statistics, quality of care surveys, and client exit interviews.

In each of the five communities a systematic random representative sample of 200 MWRA, 15-49 years, was interviewed. Separate analysis was done for young married women under 25 years of age with low parity i.e., with 1 or 2 children (pre-intervention n=214, post-intervention n=266).

Survey data showed: 1) an increase in the use of clinic services; 2) an improvement in quality care; 3) an increase in the RH/FP knowledge of beneficiaries; and 4) an increase in the practice of healthy behaviors.

### Increase in the use of clinic services

The percentage of women who reported anyone in the household visiting the primary health center (PHC) in the last 6 months before the survey increased for all MWRA (73% to 94% [ $P < 0.01$ ]) and for young, low-parity women (87% to 98% [ $P < 0.05$ ]). In TAHSEEN intervention areas the use of the PHC as a source of FP commodities increased from 47% to 81% for all MWRA ( $P < 0.01$ ) and from 47% to 74% for young, low-parity women ( $P < 0.05$ ).

## **Improved clinic quality of care**

In general, clients (women) were satisfied with quality of services at the clinics. The greatest perceived quality service improvement was client-provider interaction. Interaction between client and physician increased from 40% to 85% and client nurse increased from 30% to 67%. Clients also reported increased satisfaction with cleanliness (from 14% to 74%) and the layout and transparency of clinic operations (from 16% to 63%). All results were significant ( $P<0.001$ ). It is important to note that after the intervention most people expressed dissatisfaction with the lack of drugs in the clinic, according to the household surveys (from 31.8% to 46.5% [ $P<0.001$ ]). Indeed, many clinics experienced stock-outs due to the increased client load. An alternative explanation could be higher client expectations. This might have resulted in lower perceived satisfaction even with drug availability.

The project made use of every opportunity to sensitize clinic staff to the need to integrate RH/FP and MCH services. Household survey results indicated that the proportion of clients who reported receiving two or more services in the same visit increased from 20% to 49% ( $P<0.001$ ).

## **Increase in RH/FP knowledge**

### ***Contraceptive Prevalence Rate (CPR)***

The CPR in Minia Governorate was 47% according to the *Egypt Demographic Health Survey 2000*. In the household survey, TAHSEEN measured a baseline of a comparable 50% for all MWRA. As a direct result of increased clinic services, CPR increased in all five sentinel sites. There was a dramatic rise in CPR for all MWRA from 50% to 80% and from 38% to 73% ( $P<0.001$ ) for young married women of low parity. Considering the emphasis of the project on reaching young people, this latter figure is of particular importance.

### ***Optimal birth spacing interval***

There was a substantial, significant increase in respondent's citing the optimal birth spacing interval as three to five years (from 20% to 95%; [ $P<.000$ ]). There was also a significant increase in respondent's citing the ideal age for marriage for a woman to be 18 years or older (from 85% to 94% [ $P<.000$ ]).

## **Increase in the Practice of Healthy Behavior**

### ***Ante- and Postpartum Care***

The household survey showed that more pregnant women go to the PHC center for ANC (from 30% to 83% [ $P<.000$ ]). Postpartum care improved significantly in the PHC facilities with more women examined within forty days postpartum (from 26% to 60% [ $P<0.001$ ]), and receiving FP counseling (from 31% to 84% [ $P<0.001$ ]). The female community outreach workers, as befitting their new role in PPC, were significantly more often the source of the FP counseling (from 66% to 78% [ $P<0.05$ ]).

### **Postabortion Care**

The improvement in quality of care at the clinic increased the willingness of women to seek postabortion care there. Following TAHSEEN's intervention, more women who had miscarriages decided to get PAC from general hospitals (from 14.7% to 29.17%). Also, fewer women reported that they had not sought care at all at endline (from 15% to 4%). Both results were significant ( $P < .001$ ). When married women of reproductive age were asked about what a woman should do after a miscarriage, 99% at endline versus 94% at baseline indicated that she should seek care from a doctor. The increase was significant ( $P < .000$ ).

The combination of PAC clinical training and the training of private providers (through the Ask/Consult network<sup>4</sup>) has resulted in increased FP counseling for PAC patients in both sectors. Counseling for FP increased in both public sector and private sector facilities (from 20% to 63% and from 29% to 40% respectively [all  $P > 0.05$ ]).

### **Community Outreach Workers (Ra'aidat Rifiat)**

- Significant increase in women of reproductive age reporting having been visited by a *ra'aidat rifiat* at endline than at baseline (from 34% to 94% [ $P < .000$ ]).
- Among women of reproductive age visited by a *ra'aidat rifiat*, 59% at baseline and 78% at endline indicated that the *ra'aidat rifiat* had referred them to the primary health care facility for other health services. The increase was significant ( $P < .000$ ).
- Among women of reproductive age visited by a *ra'aidat rifiat*, 95% at baseline and 99% at endline reported that during her home visit the *ra'aidat rifiat* had spoken with them about family planning. The increase was significant ( $P < .000$ ).
- One hundred percent of women of reproductive age at endline versus 95% at baseline reported that the family planning counseling provided by the *ra'aidat rifiat* was useful. The increase was significant ( $P < .000$ ).

### **Couple communication**

The household survey showed more women were discussing FP with their husbands (from 34% to 64% for all women and from 46% to 78% for young, low-parity women, both  $P < 0.01$ .) By improving couples' communication, the project has likely increased the possibility that women and girls can seek health care when they need it. In that respect, the increase among young couples is particularly heartening and an important marker for joint future fertility decision making.

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<sup>4</sup> Ask/Consult network is a nation-wide database that includes training and contact information for 12,309 private physicians and 27,956 pharmacists in 22 governorate. The database was updated and finalized by the TAHSEEN Project.

## **Lessons Learned**

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There were several lessons that could be drawn from the TAHSEEN project's experience in implementing and scaling up its integrated model for reproductive health and family planning.

### **Choose the right starting point**

Carefully selecting the first governorate and first communities for project implementation are essential to long-term success. Working in the underserved areas of the governorates legitimized the project's good intentions. Although working in more of these areas can make it more complicated to achieve immediate successes, it also presented good testing ground for an emerging model.

### **Political support**

Political support from the governor was essential at all stages of project implementation, including scale-up. Working in a governorate that was familiar with foreign assistance facilitated the ease and speed with which the project operated at the governorate level.

### **Pursue an integrated multisectoral model**

The integrated model, although sometimes challenging to implement with so many active partners, is most likely to succeed in the long run. By involving the entire community, the project is not dependent on one group or individual to determine the success of the intervention and uses many outlets to improve people's knowledge, attitude, and behaviors. It also plays an essential role in providing services to meet their needs. All these changes need to be matched with the means to sustain them over time. For this reason the project focused on long-term sustainability and facilitating participation of other partners such as NGOs and, the commercial sector.

### **Adopt a participatory approach to development**

It is essential to involve community members in decision-making and implementation. Putting change in the hands of the community contributed to developing a sense of ownership and commitment. It was also important to involve key community leaders in order to gain acceptability and momentum for the project within the community. Local NGO partners proved to be crucial for supporting the will of community members and the implementation of the model. Gathering all partners together and formalizing their support by signing a Memorandum of Understanding is also an effective way of advocating support for the model and encouraging teamwork among partners.

### **Community trust in the clinic needs to be rebuilt**

The project implementers learned that even after renovations, community ambivalence about the clinic remained. In some cases, community members believed that the renovations meant that the clinic was now private, and thus out of their price range. The project realized that it had to

expand its project intervention to include activities that would bring community members to the new clinics and prove to them that the services had improved and were accessible. Activities like *Shabab TAHSEEN Village*—where youths increased awareness of the new clinic—were essential to establish trust. Once individuals visited the clinics for the first time, the quality of services ended all previous misconceptions.

## Conclusion

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The TAHSEEN/CATALYST Project made use of several best practices and developed a number of promising practices in its integrated RH/FP model in addition to innovative activities that proved successful in the field. The viability of the integrated approach is evident in the results presented in this document.

The model provides innovative strategies to improve RH/FP at the community level. Building on the project integrated model, ESD is scaling-up several of the community-based approaches such as involvement of religious leaders, community postpartum care, postabortion care, community participation, and integration of birth spacing messages into health and non-health programs.

To obtain a copy of the CD-Rom titled *TAHSEEN/CATALYST Project Integrated Multisectoral Family Planning Model*, please send an email to **[esdmail@esdproj.org](mailto:esdmail@esdproj.org)**.

The Extending Service Delivery (ESD) Project, funded by the United States Agency for International Development (USAID) Bureau for Global Health, is designed to address unmet need for family planning (FP) and increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associates 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.

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