HIFA Discussion on Family Planning #2
Empowering Health Workers for Better Family Planning

26 March - 22 April 2018

SHORT EDIT (18pp)

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http://www.hifa.org/projects/family-planning

Background to the discussion: http://www.hifa.org/news/join-global-hifa-discussion-empowering-health-workers-better-family-planning

There were 51 messages from 19 contributors in 11 countries (Cameroon, Denmark, DR Congo, Ecuador, Netherlands, Nigeria, South Africa, Switzerland, Uganda, UK, USA). Special thanks to super-contributors Shabina Hussain, USA (8 messages) and Amy Oggel, USA (5 messages).

Background

We are grateful to the Knowledge for Health (K4Health) project, Johns Hopkins Center for Communication Programs, for their sponsorship. This is the second of three planned discussion forums on family planning. Building on themes from the first HIFA discussion held Sept-Oct 2017 (which focused largely on the FP information needs of wome, men, youth and children), this new discussion will focus on the needs, challenges, new strategies and opportunities to help health workers improve family planning service provision. We will also highlight many useful resources, including the 2018 updated Global Family Planning Handbook.

The exchange is supported by experts in family planning at the World Health Organization (WHO), University of Oxford, the Guttmacher Institute, IntraHealth International, The Johns Hopkins Center for Communication Programs, and USAID.

1. What do we know about those who provide FP advice and services (CHWs, midwifes, nurses, doctors, etc.), including their knowledge, attitudes, and beliefs about FP?
2. What challenges are the providers facing?
3. What knowledge/training/support is needed by providers?
4. What can we do to better to support health workers who provide FP?

1. What do we know about those who provide FP advice and services (CHWs, midwifes, nurses, doctors, etc.), including their knowledge, attitudes, and beliefs about FP?

Sarah Harlan, USA: When we think about those who provide family planning and contraceptive services, it is important to cast a wide net. Here in the United States, my friends and family members

often think of 'family planning providers' very narrowly - doctors, nurse practitioners, etc. However, in most of the countries where we work, contraceptive services are provided by a range of providers at all levels. In Indonesia, for example, most family planning is provided by midwives, whether public or private. In other countries, it is most often provided by community health workers. Some methods can only be provided by medical doctors, others by a range of individuals. In other words, those who provide FP advice and services are a complex, diverse group.

Who provides FP advice and services? We have listed CHWs, midwifes, nurses, doctors, and other health workers. Who else?

Moderator: Although our discussion is focused mainly on health workers, it is important to acknowledge that 'FP advice' is also provided by people who are not health workers (family, friends, religious leaders, school teachers...) and we welcome comments on these aspects also.

Gwewasang Martin, Cameroon: I have been working of Family Planning (FP) programs since September 1995, when there were no training schools for FP in Cameroon. The ground experience I have for the past 22 years working in these programmes in both rural and urban areas is that everybody (trained or not trained) provide FP services, but not advice. The reason is simple. Government has been battling it out with the population on illegal sales of generics including FP piles and even injectables by vendors to no avail.

Midwives and doctors

Gwewasang Martin, Cameroon: In the 90s, midwives and a few Medical Doctors (Gynecologist) were responsible for providing FP advice and services, but only few clients where getting these services. But unfortunately, the training of midwives was suspended several years back and was re-launched in 2011. This caused a lot of frustration within the field. The few midwives, who did the training many years back (out of the country) were retired, some died, some left the field, and majority of them left for greener pastures. The work was then left in the hands of the Doctors. Because only the public hospitals (central, regional and district hospitals) were permitted to provide FP, and most of the Doctors were civil services, they also monopolized the provision of FP. Another problem was that there is poor collaboration between government doctors and private doctors. They treat private doctors with a lot of disrespect. The programs also come with incentives (per-diem) and so they wouldn't allow the private providers (no matter how experience there are) to get involved.

Gwewasang Martin, Cameroon: I think with the introduction of the training of midwives again by the ministry in 2011, will allow many more qualified midwives and nurses including CHWs to be trained to provide effective FP advice and services. Reproductive health/FP programmes have been recognized by the government in 2011 and are now also authorizing new schools, projects and non-profits organisations to train FP providers to work in communities where the government can't reach.

People who work in drug shops and pharmacies

Peggy D'Adamo, USA: In response to the question about what we know about those who provide FP advice and services (CHWs, midwifes, nurses, doctors, etc.), I would like to alert members to a group of providers who are often at the front line of providing services in many countries --- people who work in drug shops and pharmacies. This is especially true in rural areas where there are not as many public or private clinics and for certain groups of people.

Peggy D'Adamo, USA:We should pay special attention to making sure that these providers are well trained and ready to provide clients who are seeking information or methods with correct information and good counseling. This is even more true when we consider critical health-worker shortages,

poorly stocked clinics, and high unmet need for family planning in many countries. With the right training and support, pharmacy and drug-shop staff can facilitate the use of modern contraception, especially in urban slums and rural areas where the unmet need is high, access is poor, and health-worker shortages and other barriers prevent people from accessing family planning services.

Peggy D'Adamo, USA: I would like to recommend that HIFA members take a look at this Family Planning High Impact Practice brief. [http://www.fphighimpactpractices.org/briefs/drug-shops-and-pharmacies/] It argues that drug shop and pharmacy staff can provide a wide range of methods including:
- male and female condoms
- combined oral contraceptives
- injectable contraceptives (for example, pharmacies and drug shops can sell injectables and refer women elsewhere for the injection)
- emergency contraception

Peggy D'Adamo, USA: Drug shops are also convenient places for men, boys and young people in general to get information about contraception.

Peggy D'Adamo, USA: Youth-Friendly Pharmacy Program Implementation Kit [http://www.path.org/publications/files/RH_PPIK.pdf]: Guidelines and tools for implementing a youth-friendly reproductive health pharmacy program. The kit provides guidelines, ideas, and prototype materials for designing and implementing a pharmacy capacity-strengthening project. This kit is intended to guide program managers in the development of a pharmacy training initiative and can be adapted as needed to ensure suitability in a variety of environments. It includes a pharmacy personnel training curriculum and prototype materials. Developed by PATH.

Peggy D'Adamo, USA: Good Pharmacy Practice [http://apps.who.int/medicinedocs/en/d/Js18676en/]: Joint FIP/WHO guidelines on good pharmacy practice: standards for quality of pharmacy services. This guide from WHO and the International Pharmaceutical Federation was published in 2011 and is the best overall guide on good pharmacy practice.

Gwewasang Martin, Cameroon: I recommend that drug vendors should be trained to provide FP methods with correct information and good counseling, instead of allowing them to work illegally. After all, there are the first points of contact with the clients. This will help to reduce corruption and encourage good accountability within the system. Finally, there is a growing shortage of trained providers, inadequate and poor clinics and stock-out for the various methods.

Community health workers

Moderator: I recommend this blog by Sarita Panday (Communications Coordinator) and HIFA member David Musoke (Co-Chair) of the HSG Thematic Working Group on Supporting and Strengthening the Role of Community Health Workers in Health Systems Development. They celebrate the effectiveness of volunteer CHWs in Nepal and Uganda. (It's interesting to hear about the success of volunteer programmes at a time when there is overwhelming pressure to shift from volunteer to paid CHWs.)
Full text:
http://www.healthsystemsglobal.org/blog/277/Community-health-workers-a-paramount-force-on-the-path-to-universal-health-coverage-.html

Moderator: Sarita Panday mentions the role of CHWs in family planning in Nepal: 'Another main role of CHWs is to provide temporary means of family planning, such as pills and condoms. In some places, they reported that they counsel women on the availability of safe abortion services and provide

emergency contraception. Such services are important especially given that abortion is a socially tabooed issue despite being one of the major causes of deaths among women of reproductive age. In situations, when women are often hesitant to talk about such an issue in public, having a female CHW from the same village is far more helpful for the services users, as she understands the issue and provides confidential services.'

Chia Benard Ful, Cameroon: Many thanks for the question empowering health workers for better family planning. BARUDEV-Cameroon has not been empowering health workers but rather empowering village health workers to provide better family planning services to rural communities. This has been through seminars and workshops where they have learned all the various methods of family planning. The essentials of contraceptive technology from John Hopkins bloomemberg school of public health has been our technical guide. We are looking for partners to join us especially at this time that we are having internally displaced people in anglophone Cameroon. Condoms have been distributed and village health workers have been taught how to use them. Many thanks for bringing up this topic.

What do we know about their knowledge, attitudes and beliefs?

Moderator: Knowledge, attitudes and beliefs around family planning are shaped by cultural, societal and other influences. Myths and misinformation around pregnancy and family planning are common among the general population [http://www.hifa.org/sites/default/files/publications_pdf/FP_Discussion%231_ShortEdit.pdf].

Moderator: To what extent do these factors influence knowledge, attitudes and beliefs of health workers? What is the quality and accuracy of FP advice given by different types of health worker?

Sara Tornquist, Sweden/Kenya: It many times has more to do with the societies views and and health care providers believes and needs that the actual woman needs and right to make decisons about her own body. Here is a new article just published on the topics:

"Human rights versus societal norms: a mixed methods study among healthcare providers on social stigma related to adolescent abortion and contraceptive use in Kisumu, Kenya" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5841529/

Andre Shongo Diamba, USA: But, for one or another reason, whether someone among those providers undertakes a discouragement campaign by spreading the fake informationâ€™s, the barrier will be hard to remove. The traditional or religious believes are among the main factors that push some providers to be counterproductive in Family planning field.

Are you, or have you worked with, an FP service provider? Can you share a personal experience or anecdote that relates to 'knowledge, attitudes, and beliefs about FP'?

Daniel Rivkin, USA: We publish a monthly News Review of the most important Family Planning stories affecting Africa and the world. http://cirht.med.umich.edu/news-review/

Daniel Rivkin, USA: On a personal note, I have worked in many African countries on and off for the past 25 years, as a journalist for Reuters and as a strategic communications advisor and producer. I feel very fortunate to be able to do this work.

Sarah Harlan, USA: Keeping all this in mind, I find it helpful to hear directly from those on the frontlines about what their challenges are Â and how they're working to ensure qualiity care for their clients. Two years ago, K4Health and FP2020 launched Family Planning

Voices (FP Voices) to document and share personal stories from people around the world who are passionate about family planning. Many of these individuals are providers of family planning. Reading their stories, you can get a sense of how broad their experiences and challenges are. I've pasted just a few here:

1. Dr. Fred Yao Gbagbo's provides clinical care in Ghana. Read (and listen to) the powerful story behind his decision to work in family planning and reproductive health: http://fpvoices.tumblr.com/post/143001910260/dr-fred-yao-gbagbo-director-of-clinical
2. Emma Maravilla is a community health worker in the Philippines. She talks about her experience using family planning and how that helps her provide care to her clients: http://fpvoices.tumblr.com/post/168748824842/emma-p-maravilla-community-health-worker
3. Robina Anene is a nurse manager in Kenya, who realized the myths and misconceptions that her clients bring with them when they visit her clinic: http://fpvoices.tumblr.com/post/168007892672/robina-anene-nurse-manager-mukuru-health-centre
4. Patrice Douglas is a medical intern in Guyana. Read about her interactions with patients and what makes her rejoice: http://fpvoices.tumblr.com/post/157608216246/patricee-douglas-medical-intern-georgetown
5. Iga Paul JembelyambuziÃ¢€™s is a co community mobilizer in Uganda. Read about his work sharing information about vasectomy with his community: http://fpvoices.tumblr.com/post/153298674195/iga-paul-jembelyambuzi-community-mobilizer

Sarah Harlan, USA: I encourage you to keep these stories in mind through this discussion Â and to read more at www.fppvoices.org. You can even search for service provider (http://fpvoices.tumblr.com/tagged/service-provider) to read a range of stories from those providing essential FP services daily.

Have you been involved in any research on this subject? Or would you like to recommend a relevant research paper or report?

2. What challenges are the providers facing?

Moderator: Are you (or have you worked with) an FP service provider? We would love to hear what have been the major challenges to providing high-quality services. Such challenges may be to do with inadequate support - in previous discussions we have used the acronym SEISMIC to describe some of the fundamental needs to empower any health worker: Skills, Equipment, Information, Systems support, Medicines, Incentives (including a decent salary), and Communication facilities. For FP service providers, there are doubtless other challenges, including social, cultural and religious.

Social norms and human rights

Olajumoke Onaolapo, Netherlands: In addition to Amy's contribution, I am a family planning service provider and also train both skilled and unskilled service providers in Nigeria before my masters. These are picked from my MPH thesis findings: Sometimes provider bias emanates from a "protective behaviour". SPs [service providers] limit access based on their own values, norms, and culture and decides who should or not use a method considering the client's age, parity, and marital status. Unmarried clients can access less effective male condoms and emergency contraceptive pills (ECPs) but most providers will not want to give more effective or LARC such as IUDs, implants or injectable thus forcing them to use less effective methods which might not be the client's choice (Schwandt et al, 2017)

Olajumoke Onaolapo, Netherlands: Provider's attitude is driven by various reasons as reported in different studies. It is sometimes related to the gender of those accessing the method and the method of choice. As revealed in a study, male condom doubles as the most widely used and with the least provider bias. This is said to be associated with the fact that the society is less restricting with unmarried young men without children when it comes to sexual behavior and use of contraception than the women in the same group (Schwandt et al, 2017).

Olajumoke Onaolapo, Netherlands: Another study revealed some providers are biased because the providers are not well informed about certain health conditions and a method, such as concerns about IUDs and increase risk of infections. FP guidelines might be outdated, not available or the providers might not adhere to the instructions in the guidelines. They might also lack training/mentoring to equip them with updated skills, knowledge and attitude which would have limited or prevented bias (Calhoun et al, 2013).

Shabina Hussain, USA: Answering this question as someone who has extensively worked as a FP service provider and also worked with FP service providers in LMIC. I have felt social-cultural norms play a huge role at the point of care.

Shabina Hussain, USA: I have observed my colleagues asking for parental consent in case of adolescent girls needing FP services (contraception or abortion) and also insisting on spousal consent for female patients needing abortion or D&C for incomplete abortions.

Shabina Hussain, USA: While helping develop a training manual for FP service providers (I was coordinating a consortium of academic medical educators and service providers in 2001), I stressed the need of providing services to a female patient without creating social difficulties for her by compromising on her privacy and insisting on unnecessary consent from the family members. Often it is a life and death situation for female patients who need the services due to incomplete unsafe abortions, just because they couldn't access the services without compromising their privacy.

Karah Pedersen, USA: I really appreciate Shabina Hussain's comment that socio-cultural norms are a particular and challenging barrier for FP service providers, and I agree. This includes norms related to gender, age, sexuality, ethnicity, early marriage, and so many other specific cultural factors. In my work providing technical support to training programs for health workers, I have always advocated for including sensitization, values clarification, and awareness-raising activities for these areas as important groundwork before or during a training of health workers on family planning methods. My experience as a trainer in these situations is watching participants through the course of a training with many 'light bulb' moments of revelation as they consider how their ethical responsibilities as a health care provider should reinforce human-rights approaches. However, it's time consuming —” and costly — to ensure this type of sensitization is aavailable to FP providers, especially for community health workers who may be working in remote areas.

Karah Pedersen, USA: What have others done to mitigate the role of harmful socio-cultural norms by family planning providers?

Ede Michael, Nigeria: I agreed with Karah Pedersen totally however I will like to stress some factor based on my experience in Nigeria, working with Adolescent and young people especially those living with HIV and AIDS in Nigeria, on several occasions our Adolescents complain of the attitude of Health workers when it comes to request for contraceptives Items, the health workers will be embarrassing them because of their age not minding some of them are sexually active. I have hard conversation with some of the guys who told me they are using Condom on their sexual partners, one because they don't want to infect other people and they are not ready to be a father.

Ede Michael, Nigeria: Another setback for Adolescents and Young people living with HIV/AIDS is lack of disclosure, some of this people in their 18 years yet they don't know the reason why they are on treatment because their parent never allowed them to go to clinic and get their peels all in the name of protecting family image from discrimination they will keep deceiving this young Adult to take their drugs for other reasons than HIV and hinder them from going to clinic where they can access FP information in HIV/FP integrated facilities.

Karah Pedersen, USA: While I am not surprised by the additional barriers many adolescents and young people have in accessing strong FP and sexual and reproductive health (SRH) services, your story of families not disclosing a young person's HIV status to them are very troubling. My own family did not tell me that my uncle had died of AIDS-related complications until I was 14 years old and I remember vividly being angry that I was not told sooner. They did this to protect me, but instead it did the opposite and made me question if I could trust what they said. Parents and caregivers have a very special role to play in balancing how to protect young people and to support their agency (and capability of consenting) to health services they seek voluntarily.

Karah Pedersen, USA: As I think about how this relates to our conversation on the role of the health worker, I think about how important it is for health workers to be trained and sensitized to supporting young people who are capable of consenting to family planning services to receive those high-quality FP services. One approach that is used to mitigate the stigma that may impact a young person's ability to get FP and SRH care is the integration of adolescent-friendly services into existing family planning services and existing SRH services to respond to the specific needs of adolescents, which includes how to best interpret and address country-specific medical guidelines and policies related to consent to services and confidentiality.

Karah Pedersen, USA: Incorporating adolescent-friendly service delivery elements includes, for example, creating more privacy for adolescents in the health facility and ensuring health workers are trained and sensitized to providing services to adolescents, is considered a High Impact Practice (https://fphighimpactpractices.org/briefs/adolescent-friendly-contraceptive-services/) for Family Planning.

Karah Pedersen, USA: More High Impact Practices in Family Planning can be found in this excellent web site: https://fphighimpactpractices.org/.

Karah Pedersen, USA: What are others' experiences with supporting health workers to provide stigma-free FP services?

Marthe Zeldenrust, Netherlands: Thank you for the interesting messages and sharing of experience so far. I would briefly like to touch on the experience I had when working as a doctor in reproductive health in a hospital in rural South Africa in 2013-2015, in an area with high numbers of unplanned and teenage pregnancies and with a high unmet need for family planning. Although on paper, there are good guidelines for reproductive health and family planning in South Africa, in real life there is still a big discrepancy. When I first started working in the obstetric department, it surprised me that the 'family planning' box was ticked in the file of every postnatal woman, but I never heard any health care provider discuss family planning with a patient. An injection of depo-provera without counseling was regarded as enough to tick the box. Later on, the implant was introduced as an additional method, but counseling and informed consent remained an issue.

Marthe Zeldenrust, Netherlands: During the antenatal visits, many women who came to me indicated a fulfilled child wish and requested, often begged, for a permanent FP method. Although we had the

skills to help them with this, each and every time, it was such a struggle to make this possible for them. Multiple reasons added to this challenge:
- overcrowding at the postnatal ward, making the head nurse to refuse patients who would need another day of admission after delivery
- this was linked with the strong religious beliefs of the head nurse of the postnatal ward
- lack of prioritization in the operating room, as other (emergency) procedures were prioritized and took longer than expected
- (religious) beliefs of others including fellow doctors who were hesitant to performing these procedures.

Marthe Zeldenrust, Netherlands: Coming to work in the hospital with a clinical task description, as a foreign medical doctor in South Africa and with a high clinical workload, it was difficult to make a big impact in all these elements, but I was happy each time that I was able to support a woman in her reproductive rights and wishes. I would be interested to hear from other medical doctors or other providers who had similar experiences how they dealt with this.

Religious challenges

Moderator, quoting from FP Voices: 'Previously, most of the women in the community explained that the religious leaders opposed [family planning] that religion forbids use of family planning. They talked as if it is a sin. But after the religious leaders were engaged with us, after they got a workshop and we organized together as a village health committee, things got simpler and simpler. This is what we did...'
Luncho Bedaso, Model Woman, Volunteer and Member of Village Health Committee, SHARE-BER Project. Wesha Kebele, West Arsi Zone, Oromia Region, Ethiopia
http://fpvoices.tumblr.com/post/170263476566/luncho-bedaso-model-woman-volunteer-and-member

Olajumoke Onaolapo, Netherlands: Young people had negative experiences and were judged as being promiscuous. Providers gave religious advice instead of contraceptive services. This prevents young and unmarried to access sexual reproductive health services when needed subsequently (Hebert et al, 2013)

Marg Docking, Uganda: Our greatest challenge to increase uptake of family planning is to actively encourage religious male leaders to work on our behalf.
Wise Choices For Life has reached hundreds of leaders who have shifted the way they think about FP and family size.
Visit our website and view some short films for more information.
Www.wisechoicesforlife.org

Availability of FP methods

Amy Oggel, USA: I have worked with small, nonprofit, reproductive health and family planning clinics in Latin America. Regarding FP, the principal challenge they face is being able to obtain and stock a sufficient quantity and variety of methods.

Amy Oggel, USA: The value add of these nonprofit clinics is the quality of care that is administered in terms of customer service and methods availability and mix, as compared to the public health centers operated by the Ministry of Health, which frequently experience stock-outs of methods.

Amy Oggel, USA: Since the nonprofit clinics are small, their buying power is reduced, which means they don't get the price breaks given to larger purchasers. Because of this, it's a challenge to provide the methods at a low/competitive price and still earn money from them.

Amy Oggel, USA: In addition, it can sometimes be difficult to find all the methods the clinics would like to stock. Jadelle and female condoms, as well as a variety of male condoms and oral contraceptive pills (typically just one male condom and one - or maximum two - types of OCPs are stocked), are usually the methods most difficult to find, and then purchase at a reasonable price.

Amy Oggel, USA: Being able to stock a sufficient quantity and variety of FP methods ensures that these clinics maintain their competitive edge and are able to give clients their choice of FP method.

Moderator (Neil PW): FP service providers face the same SEISMIC challenges as other frontline health workers (Skills, Equipment, Information, Systems support, Medicines, Incentives, Communication facilities: http://www.hifa.org/about-hifa/hifa-universal-health-coverage-and-human-rights). In addition, they - perhaps more than any other group of health service providers - are constrained (willingly or otherwise) by their own norms and values and by the norms and values of the institution in which they work and the society within which they live. In family planning, religious norms and values are particularly important. The result is a denial of basic human rights, especially for women, and especially for younger, unmarried women and girls. We look forward to explore these issues further over the coming weeks.

3. What knowledge/training/support is needed by providers?

Moderator: From the discussions we have had so far, there is a need for technical knowledge, information and training to empower providers to offer competently a comprehensive range of FP services.

Moderator: We have also heard how FP service providers are a hugely diverse group, ranging from thos with minimal training (or no traiing at all) to those with advanced, specialist FP training. What are the information and training needs of those who work in drug shops and pharmacies? community health workers? generalist nurses and midwives? family physicians? specialist FP providers?

Moderator: In the past 2 weeks we have seen how social norms and values are such a huge barrier to FP services. What knowledge/training/support is needed to promote a person-centred, human rights-based approach rather than a judgemental, values-laden approach?

Moderator: We heard about the WHO guide to help Monitor Human Rights in the Provision of Contraceptive Services as well as a Checklist for Health Providers to assess Quality of Care based on Human Rights standards. Have you used these in your practice?
http://www.who.int/reproductivehealth/publications/contraceptive-services-monitoring-hr/en/
http://www.who.int/reproductivehealth/publications/qoc-contraceptive-services/en/

Moderator: My co-coordinator Karah Pedersen has introduced The Knowledge for Health toolkits [https://www.k4health.org/toolkits/all] and,in particular, the toolkit on Meeting the Sexual and Reproductive Health Needs of Young Married Women and First-time Parents [https://www.k4health.org/toolkits/meeting-ftp-needs]

Moderator: What information resources have you found especially useful?

What knowledge/training/support is available?

Daniel Rivkin, USA: I work at the Center for International Reproductive Health Training (CIRHT) at the University of Michigan. The Center is focused on academic partnerships with medical, nursing and midwifery schools in the developing world, to integrate pre-service training in contraception and safe abortion care into the curricula, and support faculty in their teaching and research capacities. With knowledge, those healthcare professionals are better positioned to help women decide for themselves what the best options are for managing their reproductive lives. With increased research capacity, evidence-based policy can evolve which will lead to better service and healthier outcomes for women and girls around the world.

Daniel Rivkin, USA: CIRHT is currently working with 10 partner universities in Ethiopia, and the University of Rwanda has just launched a partnership (http://cirht.med.umich.edu/2018/03/14/university-of-rwanda-launches-partnership-with-cirht-for-pre-service-education-training-in-family-planning/).

Nandita Thatte, Switzerland: It has been great following the discussion on Empowering Health Workers! The issue of ensuring Human Rights is important when providing all health services including Family Planning and is a hallmark of good quality services. WHO recently published a guide to help Monitor Human Rights in the Provision of Contraceptive Services as well as a Checklist for Health Providers to assess Quality of Care based on Human Rights standards.

Nandita Thatte, Switzerland: This tool is intended for use by countries to assist them in strengthening their human rights efforts in contraceptive programming. The tool uses existing commonly-used indicators to highlight areas where human rights have been promoted, neglected or violated in contraceptive programming; gaps in programming and in data collection; and opportunities for action within the health sector and beyond, including opportunities for partnership initiatives.

Nandita Thatte, Switzerland: For more information and to download the guide, visit: http://www.who.int/reproductivehealth/publications/contraceptive-services-monitoring-hr/en/

To download the Checklist for Health Providers, visit: http://www.who.int/reproductivehealth/publications/qoc-contraceptive-services/en/

Nandita Thatte, Switzerland: Please note that these documents builds on previous work by WHO and UNFPA including an Implementation Guide to ensure Human Rights in Service Delivery: http://www.who.int/reproductivehealth/publications/family_planning/hr-contraceptive-service-delivery/en/

Karah Pedersen, USA: The Knowledge for Health toolkits [https://www.k4health.org/toolkits/all] on family planning are great places to start in becoming more acquainted with training resources and FP program models. In particular, the toolkit on Meeting the Sexual and Reproductive Health Needs of Young Married Women and First-time Parents [https://www.k4health.org/toolkits/meeting-ftp-needs] has some excellent training resources.

Olajumoke Onaolapo, Netherlands: Some providers are biased because the providers are not well informed about certain health conditions and a method, such as concerns about IUDs and increase risk of infections. FP guidelines might be outdated, not available or the providers might not adhere to the instructions in the guidelines. They might also lack training/mentoring to equip them with updated skills, knowledge and attitude which would have limited or prevented bias.

Shabina Hussain, USA: Neil, as you mentioned the fact that family planning providers are diverse in their education and skill-sets, they may have wide ranging needs of training to effectively provide the services. I am wondering if we have data on the "knowledge, aptitude and attitude" of different levels of family planning providers working in different settings. This can be an interesting topic for the future research.

Amy Oggel, USA: Perhaps this does not get to your inquiry, but have you searched POPLINE to see what literature has been published on knowledge, aptitude, and attitude of different levels of FP providers working in different settings? (https://www.popline.org/) … In my search of POPLINE, I found several articles on the topic of health worker knowledge, aptitude, and attitude of FP providers, but most are specific to a country or method, or provider level.

Sarah Harlan, USA (in response to Shabina question on KAP): I agree that this would be a fascinating topic for future research! We do have some information about this - and some of our previous work at the Center for Communication Programs offers insights into knowledge (and knowledge needs) of health workers at different levels. For example, I worked on a project in Indonesia called Improving Contraceptive Method Mix, which started off by exploring knowledge needs and attitudes among midwives in Indonesia regarding provision of long-acting and permanent methods of contraception. Here is a link to one of the papers we wrote from baseline research from that project: https://www.ncbi.nlm.nih.gov/pubmed/28763720...

Sarah Harlan, USA (in response to Shabina question on KAP): It is important that needs assessments and situation analyses are done before any work in a new setting, as the needs can be drastically different from country to country (and even from district to district!). Also, sometimes we go into settings making assumptions (for example, thinking that young professionals need digital solutions) and are surprised by what we find… we should always be asking ourselves, 'What do health workers know? What they want to know? And what information would empower them to serve their clients more effectively?'

Siri Tellier, Denmark: We finally have quite a number of widely used family planning metrics involving KAP for users (e.g. unmet need is arguably a reflection of client AP), but so little on providers. Yet there are some settings where method choice is decided by health service provider, or even at higher level as operational policy.

Shabina Hussain, USA: As to training needs of the health providers for human rights approach, it is essential to sensitize providers about their role as "healthy society preservers/creators" rather than the upholders of the morality prevalent in their culture or society. Let's face it there are enough religious and other faith based institutions as well as social and cultural norms that lay out distinct rules of social and personal behaviors. Some of these rules impede dissemination of health education material and limit access to contraception and protection(condoms). Health providers must be trained to see the bigger picture. A community stays healthy when all have access to basic preventive care and emergency care without any bias of age, gender, marital status or economic status. It is this bias that prevents a HIV positive adolescent from not knowing their status. Or a young, 11 year old rape victim carry the pregnancy to term. Protecting the privacy of the client and providing them the tools to stay healthy is the only morality health providers must follow in their practice.

Amy Oggel, USA: In addition to the Knowledge for Health (K4Health) toolkits that Karah Pedersen introduced and that Neil mentions in his post, the K4Health web site also hosts the Global Health Learning Center (https://www.k4health.org/products-page and https://www.globalhealthlearning.org/courses). There are several e-learning courses on Family Planning, including the following:

* FP and HIV Service Integration
* FP Counseling
* Healthy Timing and Spacing of Pregnancy
* IUD
* Postpartum FP
* Long-Acting/Permanent Methods of FP
* Hormonal Methods of Contraception

Amy Oggel, USA: While on-the-job training should come from the Ministry of Health so that the information is in line with the methods available in-country, e-learning platforms like the one on K4Health are a great way for health care providers to incorporate new information and/or get a refresher.

Andre Shongo, DR Congo: Although late to intervene, my contribution in this stage would like to say that the training contents will be focused in basic and appropriate vocabularies and lessons;
- Female cycle (Fertile days versus no fertile days, conception versus contraception), contraceptives methods (natural versus modern, mechanism of action, indications and contraindications, managements of side effects)
- Contraception / family planning and human right
- Social norms / culture / religious believes versus contraception/ family planning / reproductive in country policy
- Communication strategies in Family Planning; counseling, interpersonal and crowded communication

Andre Shongo, DR Congo: From this initial stage, the training content will be tailored to each specific groups, Community based Distributors, pharmacists, midwives, nurses, Doctors, The aim will be to make available a network of those having a comprehensive knowledge in modern contraceptives methods managements.

Daniel Rivkin, USA: I am enjoying the on-going discussion about the aspects of promoting FP in many local contexts. We produce a monthly news review, with this month looks at articles about education and male involvement in FP, as well as the legal and economic dynamics of contraception and abortion care. I think the group may be interested but donâ€™t want to be too much of a promoter. Please let me know what you think.
http://myemail.constantcontact.com/CIRHT-News-Review-for-March-2018.html?soid=1129474327058&aid=bMv3Zb2i5uw

Paula Baraitser, UK: Contraceptive counselling is essential for contraceptive decision-making but remains challenging to deliver. Despite evidence that method satisfaction and consistent and correct use increases with effective counselling women report limited information and support for contraceptive decision making in clinical contexts (Jain, 2016).

Paula Baraitser, UK: There are many reasons for this. Contraceptive discussions require a personal and social approach to health care that may not fit well with traditional clinical consultations structured to provide a biomedical response to illness (French et al, 2014). Contraceptive discussions require the transfer of significant amounts of complex information, opportunities for consideration of the pros and cons of each method and time to make an informed decision. It remains challenging to deliver this within the short time frames of clinical consultations.

Paula Baraitser, UK: The UK Faculty of Sexual and Reproductive Health has developed a free, open access online course on contraceptive counselling. We are currently piloting it and would be really pleased if interested health professionals would take the course and provide us with feedback.
The course supports the development of:
Key concepts in contraceptive counselling
Key skills for effective contraceptive counselling
Understanding good and bad consultations
Action planning to improve your contraceptive consultations
You can find the learning via the link below and simply self-register to access the course (instructions on how to register are provided). The course will take up to 2 hours to complete.
https://fsrh.learningpool.com but can be done in your own time and in stages. You can go back to it whenever you wish.

Daniel Rivkin, USA: Please have a look at our counselling lecture materials, which were developed with our colleagues in Ethiopia as a curriculum enhancement.
https://sites.google.com/view/cirht-learning/topic-presentations/counseling?authuser=0

4. What can we do to better to support health workers who provide FP?

Shabina Hussain, USA: I feel the human rights approach is the best approach in providing health care services that must include FP/RH/SH services for adolescents & vulnerable girls.

Marthe Zeldenrust, Netherlands: I think sensitizing health care personnel on reproductive human rights is a great way of improving access and quality to family planning.

Sarah Harlan, USA: Working on the Knowledge for Health (K4Health) Project, I spend my time thinking of ways to ensure that health workers have the knowledge they need to provide high-quality family planning services. We have heard time and time again (from the health workers themselves) that they need synthesized evidence in a format that is digestible and easy to implement.

Sarah Harlan, USA: In collaboration with the WHO, we recently updated one of our key resources, Family Planning: A Global Handbook for Providers (https://www.fphandbook.org/). This handbook offers family planning providers the latest clinical guidelines and information in plain language, with graphics, charts, and job aids that assist with provision of a range of contraceptive methods. We have distributed over half a million copies of this guide in its previous formats, and weâ€™re currently distributing the new version. We are also working on translating the new handbook into additional languages (the previous 2011 version is available in more than 12 languages). Copies of the handbook can be ordered from the site I listed above (at no cost for those in low- and middle- income countries). Please spread the word about this valuable resource!

Other

Susana Guijarro , Ecuador [translated by Google] "Professional interests: I am a medical doctor and specialist in adolescent medicine.
I directed the adolescent and adolescent pregnancy prevention program in the Ministry of Public Health of Ecuador. Ecuador is the country that has one of the highest indicators of unintended pregnancy in adolescents, especially in those under 15 years of age.

Currently I work in the largest maternity in the country in which we have a service for comprehensive care of pregnant teenager"

FP resources highlighted by HIFA members

1. WHO guide to help Monitor Human Rights in the Provision of Contraceptive Services as well as a Checklist for Health Providers to assess Quality of Care based on Human Rights standards. Have you used these in your practice?
http://www.who.int/reproductivehealth/publications/contraceptive-services-monitoring-hr/en/
http://www.who.int/reproductivehealth/publications/qoc-contraceptive-services/en/

2. The Knowledge for Health toolkits [https://www.k4health.org/toolkits/all] and,in particular, the toolkit on Meeting the Sexual and Reproductive Health Needs of Young Married Women and First-time Parents [https://www.k4health.org/toolkits/meeting-ftp-needs]

3. The K4Health web site also hosts the Global Health Learning Center (https://www.k4health.org/products-page and https://www.globalhealthlearning.org/courses). There are several e-learning courses on Family Planning

4. CIRHT monthly news review: http://myemail.constantcontact.com/CIRHT-News-Review-for-March-2018.html?soid=1129474327058&aid=bMv3Zb2i5uw

5. The UK Faculty of Sexual and Reproductive Health has developed a free, open access online course on contraceptive counselling https://fsrh.learningpool.com

6. Counselling lecture materials, developed with colleagues in Ethiopia as a curriculum enhancement. https://sites.google.com/view/cirht-learning/topic-presentations/counseling?authuser=0

7. Debrah Dickson, USA: Family Planning High Impact Practices product.
Social and Behavior Change: A critical part of effective family planning programs.
https://www.fphighimpactpractices.org/wp-content/uploads/2018/04/SBC_Overview.pdf

Profiles

HIFA profile: Paula Baraitser is a Consultant in Sexual Health at the Kings College Hospital NHS Foundation Trust and Honorary Senior Lecturer in the Global Health Unit, Kings Health Partners, London, UK. She is interested in 'health links' between global north and south to share learning. paula_baraitser AT mac.com

HIFA profile: Peggy D'Adamo works as Technical Advisor to the Policy, Evaluation and Communication Division of the Office of Population and Reproductive Health in USAID's Global Health Bureau. She works on knowledge sharing and ICTs. Peggy was previously Deputy Project Director of the INFO Project, based at the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, Baltimore, USA. She is a member of the HIFA working group on Family Planning.
http://www.hifa.org/projects/family-planning
http://www.hifa.org/support/members/peggy
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HIFA Profile: Andre Shongo Diamba is a medical doctor, currently in GLOBAL HEALTH SYSTEM AND DEVELOPMENT training, a master in public health program at Tulane University, school of health and tropical medicine, New Orleans, USA. Previously, Andre worked as coordinator at PISRF-Programme Integrale de sante reproduction et familial (Integrated program of reproductive health and Family), a DRC participative NGO of family planning and reproductive health who provide awareness and care in favor of women and children of low social area , and toward this group to whole community. PISRF undertake sociological, public health and biomedical research in the matter, it encourage the humanitarian and research project and open his availability to all. Andre has a tremendous experience in providing community reproductive health projects such information, communication education; provide care and leading the research. He has participated at many international conferences in the field of reproductive health and population, health, environment. Andre is interesting to provide the Millennium Development Goal (MDG) in the DRC and very engaging, He pleads for public private partnership and the improving of use of mobile phone as a network able to raise the awareness of reproductive health and support the country commitment to do progress in this matter. He received the HIFA Country Representatives certificate of achievement in 2013, and is writing two books as help memory to facilitate the one-to-one members contact. http://www.hifa.org/people/countryrepresentatives/map Andre can be contacted at pisrfrdcATyahoo.fr

HIFA profile: Marg Docking is founder and director of Wise Choices for Life, which empowers vulnerable men and women in the child bearing age group in Uganda with reproductive health knowledge and skills to break the poverty cycle. marg AT wisechoicesforlife.org

HIFA profile: Chiabi Bernard Ful is Director of Boyo Association for Rural Development (BARUDEV--Cameroon). This is a local NGO found in Boyo district of North Western Cameroon. Our activities are to empower women, protect the sexual and reproductive health for women and girls, and protect the rights of children. We have been training community health workers to follow up patients, pregnant women, sick children and refer them to the hospital. barudev AT yahoo.co.uk

HIFA profile: Susana Guijarro is a doctor at the Ministry of Public Health in Ecuador. Professional interests: Ecuador is the country that has one of the highest indicators of unintentional pregnancy in adolescents, especially in minors under 15 years old. susanaguijarro AT gmail.com

HIFA profile: Sarah Harlan is the Director of Learning & Partnerships with the Knowledge for Health Project (K4Health) at Johns Hopkins Center for Communication Programs (CCP), US. Professional interests: Reproductive Health, Family Planning, HIV Prevention, Knowledge Management, Strategic Communication. She is a member of the HIFA working group on Family Planning.
http://www.hifa.org/projects/family-planning
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HIFA profile: Shabina Hussain is an independent global health consultant and is based in the USA. Professional interests: Maternal & Child Health, Family Planning, Reproductive & Sexual Health, women's rights, survival of girl child, poverty eradication, Prevention of Infectious diseases. hussain.shabina@gmail.com

HIFA profile: Gwewasang C Martin is a Clinician, Researcher and Sexual & Reproductive Health Consultant. He is the Founder & CEO of Adele Reproductive Health Foundation, the project of the Clinical Training Center for Family Planning and Co-founder of the Youth Policy Group for Reproductive Health (YPG). He is also HIFA Country Representative in Cameroon. Professional interest, Family health, community & School health, Maternal & Child Health and Alternative & Complementary Medicine. Gwewasang is a HIFA Country Representative for Cameroon.

http://www.hifa.org/people/country-representatives
http://www.hifa.org/support/members/gwewasang
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HIFA profile: Ede Michael is Home base Care Officer at Network of People Living with HIV/AIDS in Nigeria. Professional interests: Public Health, Sexual Reproductive Health and Right, Positive Health Dignity and Prevention for PLHIV, Monitoring and Evaluation. edmikey4real AT yahoo.com

HIFA profile: Amy Oggel is a Program Officer at IntraHealth International, USA. Email address: aoggel AT intrahealth.org

HIFA profile: Olajumoke Onaolapo recently completed MPH at the Royal Tropical Institute (KIT) in the Netherlands. Professional interests: Sexual Reproductive Health, Adolescents, Quality Improvement and Systems Strengthening. eniolami13 AT gmail.com

HIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All - www.hifa.org), a global health community with more than 17,000 members in 177 countries. He is also current chair of the Dgroups Foundation (www.dgroups.info), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

HIFA profile: Karah Pedersen is a Technical Advisor at IntraHealth in the United States. Professional interests: adolescent and youth; gender equality; contraception and reproductive health; cervical cancer; SDGs; information sharing and knowledge management. She is joint coordinator of the HIFA Project on Family Planning. www.hifa.org/projects/family-planning www.hifa.org/support/members/karah
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HIFA profile: Daniel Rivkin is Communications Manager at the Center for International Reproductive Health Training, CIRHT, in the USA. rivkind AT med.umich.edu

HIFA profile: Nandita Thatte is a Technical Officer at the World Health Organization, Geneva, Switzerland. She is a member of the HIFA working group on Family Planning:
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HIFA profile: Siri Tellier is a lecturer at the University of Copenhagen in Denmark. stellier AT sund.ku.dk

HIFA profile: Marthe Zeldenrust is an MD working in sexual health at the local public health department and sexual health clinic in Alkmaar, The Netherlands, and a volunteer in an SRH project for undocumented migrants at Medecins Du Monde the Netherlands. She has previously worked clinically in hospitals in South Africa, Somaliland, Mexico and Zambia. Personal interests: access to healthcare, reproductive health, family planning, global health, human rights, infectious disease control. marthezeldenrust AT gmail.com

Citations

1. PSI: http://psiimpact.com/2018/03/contraception-game-changers/

In Kenya, more than half of women who want contraception have access to it. But in places like Kilifi on the eastern coast, 'Mwenye Syndrome'— the belief that a husband â€œowns' his wife — keeps many women from accessing thee family planning they desire.
But across the country, it's women volunteers, community health workers, doctors and researchers who are changing the game. Many women are becoming experts at spreading the 'gospel' of family planning.
The women below are speaking up in support of contraception as part of a new pilot project implemented by PSI and its local network member, PS Kenya. With a seed investment from Maverick Collective, the project aims to improve access to contraception for women in underserved areas of Kenya like Kilifi...
'There are so many myths and misconceptions. I give women the truth about family planning so they have all the information they need to choose.'
Lydia Indetie puts on her red apron filled with various contraceptive samples, grabs her colorful book of infographics and gets ready for another presentation. More than a dozen women crowd under a makeshift tin porch along a dusty Nairobi street, many holding babies in their laps. They are here this afternoon to learn about family planning methods, either for themselves or for their daughters.
Lydia has been working as a health educator in the low-income neighborhood of Dandora for 15 years, first as a community health volunteer and now as a 'mobilizer' for the local Tunza health clinic. So she is not surprised when one woman asks if a contraceptive implant in the arm can travel through the body to the heart. Or when another woman says she's heard that all contraceptive methods cause cancer...

2. She knows best: Engaging girls in adolescent programming
by Rita Nehme and Nathaly Spilotros
International Rescue Committee (IRC), 2018
https://www.rescue.org/sites/default/files/document/2595/packardasrh20180321.pdf

'Young people, particularly girls, encounter significant barriers to accessing quality health care, including provider bias, age restrictions or stigmatization when seeking services, and concerns about confidentiality. Unprotected and early sex, early pregnancies, and STIs increase and childbearing risks are compounded. The IRC's multi-pronged approach aims to address foundational facility and community-level barriers that prevent adolescents from accessing, using and receiving quality sexual and reproductive health (SRH) care. It also introduces a participatory framework to meaningfully integrate their participation in all aspects of the program cycle.'
'A total of 40 in and out of school adolescent girls and health providers across all three pilot sites participated in the activities.'

SELECTED EXTRACTS
'A strong theme that was prevalent throughout the activities was the emphasis on attitudes and stigma surrounding adolescent sexual and reproductive health, which was consistent with the findings from the baseline facility assessment and health provider questionnaires. All of the groups mentioned aspects of poor attitudes, whether specifically by citing 'staff attitudes' as a barrier, commenting on the poor reception that adolescents receive when trying to access services at the health center, or stating that parents may not encourage their daughters to access services.'
'Another significant finding was the emphasis on lack of information that teenage girls have surrounding their sexual and reproductive health and the services available to them. While they could name much of the anatomy of the reproductive system, they were not always clear on what purpose each part served. This was also evident during the discussion on prevention of pregnancy, methods of modern contraception and the positive and negative side effects. All groups continually brought up the theme of lack of information or knowledge for adolescents and emphasized this as a priority in trying to increase adolescent access to sexual and reproductive health care.'

3. One literature review on providers in Sub-Saharan Africa found that, 'Negative behaviors and attitudes of healthcare workers, as well as other personal determinants, such as poor knowledge and skills of SRH services, ... are associated with provision of inadequate SRH services. Some healthcare workers still have negative attitudes towards young people using contraceptives and are more likely to limit access to and utilization of SRH by adolescents especially. Knowledge of and implementation of specific SRH components are below optimum levels according to the WHO recommended guidelines.'Â https://www.popline.org/node/663269

4. In the US, it can be difficult for female adolescents to obtain long-acting reversible contraception (LARC), and provider beliefs is one of the barriers. Three articles on this topic in POPLINE: https://www.popline.org/node/567078, https://www.popline.org/node/652877, https://www.popline.org/node/644053.

5. A paper in Global Health: Science and Practice introduces work on SRH in Pakistan: 'Pakistan has long been a challenging setting for the promotion of adolescent sexual and reproductive health (SRH). As in many other countries worldwide, there is little acknowledgment that adolescents have sex, whether consensual or coerced, before marriage and many believe that exposure to sexuality education will incite unwanted behavior. Furthermore, despite the fact that many adolescent girls marry early, there is also little acknowledgment that married adolescents need to be proactively prepared to meet their SRH needs and promote their well-being.'

CITATION: Building Support for Adolescent Sexuality and Reproductive Health Education and Responding to Resistance in Conservative Contexts: Cases From Pakistan
Venkatraman Chandra-Mouli, Marina Plesons, Sheena Hadi, Qadeer Baig, Iliana Lang
Global Health: Science and Practice March 2018, 6(1):128-136; https://doi.org/10.9745/GHSP-D-17-00285

'... This article reviews the work of 2 organizations—Aahung and Rutgers Pakistanâ€€”that are successfully implementing large-scale sexuality education programs in Pakistan, collectively reaching more than 500,000 students. This review aims to answer the following questions: (1) How did Aahung and Rutgers Pakistan work to understand Pakistani society and culture and shape their programs to build community support? (2) How did Aahung and Rutgers Pakistan overcome resistance to their efforts? Results: The success of Aahung and Rutgers Pakistan was grounded in their readiness to understand the nuanced context within the communities, collaborate with groups of stakeholders — including parents, school offficials, religious leaders, media personnel, and adolescents themselves — to ensure support, and stand up to forcces of resistance to pursue their goals... We call on other programs to continue sharing challenges, specifically related to resistance, with sexuality education programs in order to develop a toolbox of additional strategies for community uptake.'