K4D | Knowledge, evidence and learning for development

Family planning lessons with a focus on MENA countries

Laura Bolton
Institute of Development Studies
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Question

What are the lessons learned from family planning programmes? What worked well in previous programmes? What were the challenges?

Particularly interested in lessons from Iran from the late 80's and early 90's; and recent experience in Egypt. And other countries in the Middle East and North Africa region.

Contents

1. Overview

This report aimed to look at lessons on family planning programming focussing on Iran in the late 1980's and early 1990's and recent attempts in Egypt. Journal articles and grey literature were drawn on. A brief search on family planning lessons in Middle East and North African countries and developing countries more broadly was carried out and top level results highlighted.

Iran

Between 1989 and 1997, contraceptive prevalence in Iran went from 49 to 76 percent. Following census results indicating a population growth problem in Iran the government expanded family planning policies and programmes in 1989. This included establishment of a separate Department of Population and Family Planning. A conference was held to connect policy makers and experts. Seminars were held around Islamic perspectives on medicine and population policy. The goals were: 1) encouraging 3-4 years between births, 2) discouraging pregnancies below 18 and above 35; and 3) limiting families to 2 or 3 children. Newspaper coverage helped to spread messages to the population. A Birth Limitation Council was set up for intersectoral coordination. Social security and retirement benefits improved so that parents felt less need to have children for the purposes of looking after them in their old age. A High Judicial Council declared that sterilisation was not against Islamic laws. Delivery in remote villages was improved. Educational activities engaged different community groups.

Key to success in Iran was religious leaders being part of the government so messages were approved of and spread through Muslim networks. Policy makers acted because they had an understanding of the consequences of overpopulation. More recently there is a focus to further improve provision to reduce unwanted pregnancy rates by improving counselling and choice of contraceptive methods.

Egypt

Within the scope of this review a small amount of recent literature on family planning in Egypt was found. Contraceptive prevalence has risen alongside a marked increase in family planning clinics, from 3,862 in 1981 to 6,005 in 2005. Family planning was government-led and donor supported during this time. Quality of care is noted as important alongside the increase in numbers of facilities. Staff incentives in facilities are recommended to reduce human resource problems.

In recent years, the trend in progress represented in family planning statistics from the 1980s to the early part of this century seems to have turned around with an increase in average births per woman from 3.0 to 3.5 between 2008 and 2014. Donor funding was drastically reduced around 2007. Public-private partnerships are recommended and targeting so that those in higher wealth quintiles are paying for services. Contraceptive options could be improved by less restrictive government policies and procedures. Awarding facilities for high quality standards has shown evidence of success. There is also positive evidence from national multimedia and community-based interventions.

Improving sexual and reproductive health in schools is recommended. Non-Governmental Organisation (NGO)-supported extra-curricula education shows promising results. Activities could be further encouraged if government procedures for gaining permission were simplified.

Feedback from students and parents suggests that physicians are a preferred source of information rather than teachers.

Lessons from other regions

To supplement information on Iran and Egypt there was scope for a very rapid literature review. Top level results were included in this helpdesk report.

A survey in MENA countries suggests a need to improve health information systems to determine progress. There seems a gap between national strategy and quality implementation. Monitoring and evaluation would help to understand and improve this situation.

Vast improvements in family planning statistics in Ethiopia are attributed to political will with the government understanding the value of family planning; substantial donor and NGO support; and a health extension programme delivering services to neglected areas of the country.

Lessons from Sub-Saharan Africa emphasise high-level policy commitment and political ownership of family planning programmes. Recommendations include ensuring all parts of a country are covered; provision of a wide range of methods; and reaching out to men, adolescents and unmarried people. Broader policies such as promoting the delay of marriage, exclusive breastfeeding, and improving abortion safety are also recommended.

Evidence from reviews

A report looking at a selection of Muslim-majority countries highlights the importance of uniting government and religious authorities in meaningful partnerships. Policies should draw on Islamic teaching.

A review of post-partum family planning interventions in low- and middle-income countries shows promising evidence. Counselling before discharge is recommended and repeated interventions are better than standalone interventions. Research gaps are identified on demand and promotion strategies.

Family planning voucher schemes have helped to prioritise access for the poorest and evidence shows they have a significant increase on contraceptive use. They may also improve supply-side challenges and are an opportunity to gain benefits from public-private partnerships.

2. Family planning in Iran

Iran was one of the earlier developing countries to initiate a **national population and family planning programme in 1967** (Moore, 2007). The programme resulted in wide coverage and useful challenges before being stalled by the Islamic revolution in 1979. Successes up to this time include: introducing services and information through paramedical and volunteer assistants; experimenting with post-partum intrauterine device (IUD) fitting; employing older married women to motivate peers; taking advantage of existing infrastructure and staff for rapid start-up; being open to receiving technical support from the international community; participating in, and sponsoring a programme of research for policy planning and learning; and a mass media campaign to increase knowledge around family planning.

Challenges experienced are useful for consideration today (Moore, 2007):

- the rural population were difficult to reach,
- there was a lack of endorsement from religious leaders,
- the use of existing infrastructure to deliver services further marginalised rural inhabitants,
- increased oil revenues reduced perceived need for limiting family,
- vague priority setting, poor record keeping, and programme evaluation were problematic,
- communications efforts were poorly targeted with a need for more market research, and
- inefficient allocation of human resources was not cost effective.

The **Islamic Revolution leaders** stopped the family planning programme in **1979** although services continued through the Ministry of Health, retail outlets and private services. In 1984 healthcare in Iran started to become more needs-based with organised partnership between the population, volunteers and healthcare professionals (Asadi-Lari et al., 2004). Public health activities, including family planning, were integrated. Female volunteer assistant health workers played a large role in family planning in urban areas.

The 1986 census suggested that population growth may be a problem. Family planning policies and programmes were expanded again. A separate Department of Population and Family Planning was established (Simbar, 2012). In **1989 the Islamic Revolution pro-natalist religious leaders** reversed their hampering of family planning efforts (Moore, 2007). A conference was held for policy makers and experts to gather together leading up to the policy shift. This time the government made a greater effort to consult with the religious establishment to gain their support (Moore, 2007). A seminar on Islamic perspectives in medicine was held followed by a seminar on Islam and population policy (Simbar, 2012). There was wide coverage of the topic in newspapers.

Three goals were established with the renewed programme: 1) encouraging at least 3-4 years between births; 2) discouraging pregnancies outside of 18-35 age bracket; and 3) limiting families to 2 or 3 children (Moore, 2007).

In **1990** a **Birth Limitation Council** was set up for continued intersectoral coordination, monitoring, and supervision. The Council was headed by the Minister for Health and included Ministers for Education, Labour and Social Affairs, Culture and Islamic Guidance, and Planning and Budget. They planned four main activities: 1) education through schools and mass media; 2) funds for free contraceptives for married couples; 3) provision of a wide selection of high-quality contraceptive methods; and 4) conducting research on family planning delivery and population policy (Aghajanian, 1998).

Within the programme, great attention was paid to: improving social and economic indices, increasing income levels for the marginalised, enhancing women's participation in society, and decreasing child mortality (Simbar, 2012). Social security and retirement benefits were improved so that parents did not feel they needed more children to support them in their elderly years. Male participation was promoted. Monitoring and evaluation were emphasised. In 1990 the High Judicial Council declared that sterilisation was not against Islamic principles or laws.

The programme vastly improved delivery in **remote villages** via rural health houses.[1] These health houses improved accessibility and helped to keep costs low (Mehryar, 2001). Community contact in the health houses was effective in educating villagers about contraceptive methods. Urban health centres provided health promotion and are mainly run by trained women volunteers. Private services were used by some wealthier couples.

Educational activities are important. Premarital education was given to high-school students, college students, soldiers, couples considering marriage and couples already married. Education and services were made available to single people (Simbar, 2012). The programme in the 1990's benefited from the early efforts from the original programme in the 1960's which increased knowledge and raised awareness which was still embedded (Moore, 1997). A study on the effects of an education campaign in Tehran showed positive results (Montazeri , 1995). The importance of targeting is highlighted and tailoring messages differently for those with or without children.

Further efforts in the 1990's include establishment of university family planning research centres; and vasectomy education and provision centres. Promotion was widened further to village cooperatives, refugee camps, prisons, parent-teacher associations and among the police force. Monitoring and evaluation improvements continued to be made.

Approval of religious leaders is important in Islamic countries and as the Iranian government at the time comprised of religious leaders, messages were easy to spread from the government to Muslim scholars (Marshall, 2015). Decrees were passed down through the hierarchy of religious leaders at all levels. Clerical endorsement helped reduce stigma and spread the word.

Total fertility went from around 7.2 percent in 1986 to 3 percent in 1996 (Simbar, 2012). The urban-rural gap was also markedly reduced over this period by focusing on the redeployment of rural health workers (Moore, 2007). There are broader development factors which may have contributed to improvements such as decline in infant mortality, delayed marriages, and modernisation (Simbar, 2012; Aghajanian, 1988; Hosseini-Chavoshi et al., 2016; Karamouzian et al., 2014). However, contraceptive improvement rates for this period are particularly pronounced in Iran relative to comparable countries.

Making these changes in health public policy required understanding from policy-makers of the **consequences of overpopulation** (Simbar, 2012). Contraceptive prevalence rates rose from 49 percent in 1989 to 76 percent in 1997 but further attention is required to decrease unwanted pregnancy rates. Hosseini-Chavoshi et al. (2016) highlight the importance of improving employment opportunities for young people to keep fertility rates down. A study gathering data in 2006 questions the quality of provision as contraceptive coverage rates appear to be high but there are still a high number of unplanned pregnancies (Shahidzadeh-Mahani et al., 2008). The authors highlighted a need to improve counselling and choice of methods. Effective supervision and on-the-job training would help staff deliver higher quality services.

A paper in the International Journal of Health Policy Management discusses more recent concerns that leaders in Iran have expressed over reduced fertility rate as a 'western perspective' and made budget cuts in family planning (Karamouzian et al., 2014). The more recent family planning situation was not the focus of this report and further exploration was not

[1] For a background on health houses see: https://www.who.int/bulletin/volumes/86/8/08-030808/en/

within its scope, but it is worth noting that **political changes** can drastically affect budgeting for service provision.

3. Family planning in Egypt

In 2012 Egypt had one of the **highest contraceptive rates** in the MENA region at over 60 percent.[2] The success is largely attributed to an increase in the number of service delivery outlets (Rabie et al., 2013). The number of family planning clinics rose from 3,862 in 1981 to 6,005 in 2005.[3] However, increased numbers is not enough, and quality of care is important. The country established successful government-led family planning in the latter part of the last century but from early in this century contraceptive use has levelled off or declined. Demographic Health Surveys between 2008 and 2014 show an increase of average births per woman from 3.0 to 3.5.[4] Despite high coverage, unwanted pregnancy rates remain high.

Research published in 2013 (Rabie et al.) used primary and secondary data sources to identify challenges, client demand, and rights related to family planning services. **Coverage** was found to be wide with 95 percent of the population living within 5 kilometres of a public health centre providing affordable family planning services. Public uprisings around 2010 suggest the need for a **rights-based** and person-centred approach rather than a top-down programme. Rights-related issues include lack of privacy for counselling and examinations. **Human resource problems** include a lack of female physicians and high physician turnover. Better staff incentives are recommended. Field study findings highlight areas where service quality and client awareness can be improved. Some clinics needed to offer a wider choice of contraceptives. The rights-based approach recommends strengthening mechanisms for clients to influence service performance, and incentives for staff motivation. A client grievance process should be linked to professional disciplinary procedures.

Donor-funded projects supported family planning in the later part of the last century. Direct funding from USAID ceased in 2007. A policy brief looks at the opportunities and challenges for private sector provision of family planning services in Egypt using a desk review, survey data analysis and key informant interviews (Abdel-Tawab et al., 2016). A high number of those accessing free services were in higher wealth quintiles. Targeting these women with private services could reduce the burden on the government and improve services for less wealthy couples. A total market approach[5] would assist with priority access. **Public-private partnerships** are recommended as is increased private-private linking. Bureaucratic procedures and restrictive policies set by the government are thought to limit contraceptive options. Private sector family planning providers need more education to be able to offer high quality services.

Between 1995 and 2000 a **quality improvement programme** was introduced by the government. The Gold Star programme assessed facilities against a comprehensive checklist. A study investigated whether accredited facilities had retained high standards (Hong et al., 2011). Results showed continued high standards and greater adherence to standard practices

[2] UNFPA–Egypt: Indicators. http://egypt.unfpa.org/english/Staticpage/54790f72-6e8b4f77-99e2-4c5b78c20d5c/indicators.aspx2012 [Accessed 9/11/19]
[3] ibid
[4] https://www.familyplanning2020.org/egypt [Accessed 9/11/19]
[5] https://www.globalhealthlearning.org/course/total-market-approach [Accessed 10/11/19]

compared to non-Gold Star facilities. It should be noted there was no baseline comparison at the end of the Gold Star programme which limits conclusions. A number of other limitations to the study result were also noted.

The **Communication for Healthy Living project** developed by the Egypt Ministry of Health and USAID had a family planning component called "Your Health, Your Wealth". Empirical research finds positive effects of the multimedia campaign (Hutchinson & Meekers, 2012). It involved national multimedia and community-based interventions. The messages encouraged families to engage in healthy behaviours at different life stages. A key component focussed on newlyweds and highlighted the benefits of birth spacing.

Recent data from the United Nations Population Fund (UNFPA) Consultation on Ending Unmet Need for Family Planning in Egypt finds 14 percent of those with family planning requirements have unmet need.[6]

A policy brief making recommendations for Egypt highlights **sexual and reproductive health (SRH) education** in schools as an effective way to reach adolescents (Wahba & Roudi-Fahimi, 2012). NGOs such as the Centre for Development and Population Activities (CEDPA) and The National Council for Childhood and Motherhood (NCCM) have supported extra-curricula SRH education. The Egyptian Family Planning Association (EFPA) run health education sessions in schools near youth friendly clinics. Trained peer educators discuss early marriage, personal hygiene, female genital cutting, and sexually transmitted infections. The process for NGOs to gain permission from government to teach in schools should be simplified. The Egyptian Family Health Society (EFHS) provide a large life-skills education programme in collaboration with the Ministry of Education. Young, trained physicians aim to provide the information in an engaging manner. Discussions involve a number of SRH topics. Evaluations are promising. Students and parents found physicians a more reliable source of information than teachers.

4. Family planning lessons from other countries

MENA

A WHO family planning survey was sent to countries in the Eastern Mediterranean region and completed by WHO country offices in consultation with Ministries of Health (Das Shrestha et al., 2019). Questions were asked about policy, integration of services, commodity security, staff competencies, promotion activities, and monitoring and evaluations. Surveys were completed by Afghanistan, Egypt, Iraq, Jordan, Lebanon, Morocco, Oman, Qatar, Pakistan, Palestine, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia and Yemen. Many countries were found to struggle with **weak or non-existent health information systems** which are needed for determining progress. Family planning usage indicators seemed lower than they should be given the policy, infrastructure and resources in place. National strategies may not be implemented properly and suffer from lack of monitoring and evaluation. There are also policy gaps for vulnerable groups such as the poor, disabled, and adolescents.

[6] https://drive.google.com/file/d/1McbRn04sniJ_ERtAOwe14e8F5H8Fntpl/view [Accessed 10/11/19]

Jordan

Family planning centre clients interviewed in Jordan reported positive experiences of **client-centred counselling** (Kamhawi et al., 2013). A programme called 'Consult and Choose' encourages women to go to health centres and encourages husbands to support their wife's decisions. Activities for women include plays, debates, awareness sessions, and home visits. The programme included a training course for religious leaders. Statistics show an increase in new users.

Ethiopia

Impressive statistics from Ethiopia show that from 1990 to 2011 contraceptive use increased by nine times and the birth rate went from 7 to 4.8 (Olson & Piller, 2013). Evidence suggests four main success factors:

- **Political will**. The government recognised over-population problems and the value of family planning for poverty reduction. The Health Minister was a globally recognised malaria researcher and an expert global health leader. He helped secure support from donors.
- **Donor support**. Funds from the UK, USA and UN supported commodity purchase and government capacity building. US$173 million was received between 2000 and 2010.
- **NGOs**. Non-profit organisations have supported government efforts with social marketing, behaviour-change campaigns, mobile clinics, and social franchising. Their predominant focus is procurement, management, and distribution of family planning commodities.
- **Health extension programme**. The government made large investments in human resources to extend outreach. The Health Extension Plan in 2003 was significant for delivering services and information to the most neglected areas of the country.

Ethiopia are recommended to: improve integration of family planning with HIV/AIDS prevention; increase trust within the government of civil society organisations and the private sector; diversify modern contraceptives offered; and better use the private sector (Olson & Piller, 2013).

Religious engagement in Muslim countries

A report investigated **religious engagement in family planning policies** in six Muslim-majority countries: Indonesia, Bangladesh, Pakistan, Iran, Morocco, and Senegal (Marshall, 2015). Common to success was the coming together of government and religious authorities to address family planning and drawing on Islamic teaching to inspire policies and set boundaries. Partnerships between religious leaders and policy-makers should be meaningful and involve early consultations, include scholarship and practice, and engage religious networks involving both formal and informal leaders. When religious tensions occur, a fast response is required.

Sub-Saharan Africa

Analysis of **national policies, institutional frameworks, and service delivery strategies** in selected Sub-Saharan African countries identifies a number of lessons learned (Sharan et al., 2011). To begin with, high-level policy commitment and political ownership of the family planning programme is required. Recommendations from successful cases include: ensuring delivery

points covering all of the country; provision of a wide range of contraceptive methods; and ensuring good availability of methods. Strategies should make sure they reach out to adolescents, men, and unmarried people to improve fertility decline. Other successful programmes identified are those that promote spacing methods, give women the responsibility of methods choice, and allow women to use contraceptives without their partners knowledge. Policies addressing broader determinants of fertility such as delaying marriage (through law or behaviour change), promoting exclusive breastfeeding, and improving abortion safety are also recommended for fertility decline.

Developing countries

A review of family planning progress in developing countries highlights limited access and insufficient choice of contraceptive method as the key challenges (Mbizvo & Phillips, 2014). Cultural challenges such as attitudes and beliefs also pose problems with many women perceiving side-effects of contraceptive use, simply being unaware, or being superstitious. Effective knowledge dissemination is required through community-wide approaches. There are also recommendations to make laws and policies on SRH education and adolescent friendly-services. Cost barriers should be considered in relation to cost savings. Darroch & Singh (2011) estimate that $1 spent on family planning saves $1.40 in maternal and child health services.

5. Evidence on family planning approaches

Post-partum interventions

A review of post-partum interventions in low- and middle-income countries found **positive evidence** (Cleland et al., 2015). The review found gaps in information from Asia and Africa on demand and promotion strategies for immediate post-partum family planning. Counselling before discharge is recommended for improved contraceptive uptake. Repeated intensive antenatal interventions are found to be effective as opposed to short, stand-alone interventions. There was a lack of evidence with long-term observation periods. In general, post-partum services are often unavailable. There is a strong case for greater integration of family planning into maternal and child health services.

Evidence on voucher schemes

Voucher schemes which subsidise costs for lower-income families help to target those with a lower probability of service access whilst charging those who can afford to pay. A review of family planning voucher schemes finds significant increase in contraceptive use (Bellows et al., 2016). The voucher schemes have the potential to improve **supply-side challenges** with quality assurance mechanisms and financial reimbursement for service delivery. Governments are able to use private sector capacity in a flexible way.

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