



IMPLEMENTING BEST PRACTICES IN REPRODUCTIVE HEALTH

Community Based Reproductive Health Services

11-15 June 2007
Bamako, Mali

WORKSHOP REPORT



Partners of the **Implementation Best Practices (IBP)** consortium:

- Academy of Education and Development, Washington, USA
- CARE International
- Centre for Development and Population Activities (CEDPA)
- CORE Consortium
- EngenderHealth
- ExpandNet
- Family Health International (FHI)
- IntraHealth International
- Institute for Reproductive Health - Georgetown University, MD, USA
- International Council on Management of Population Programmes (ICOMP)
- International Planned Parenthood Federation (IPPF)
- Johns Hopkins Program of International Education in Gynaecology and Obstetrics (JHPIEGO), Baltimore, MD, USA
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ACRONYMS

AFRO	Africa Regional Office
ASACO	<i>Association de Santé Communautaire</i> (Community Health Association)
ASDAP	<i>Association de Soutien au Développement des Activités de Population</i> (Association to Support the Development of Population Activities)
ATN	<i>Assistance Technique Nationale</i> (National Technical Assistance Project)
BCC	Behavior Change Communication
CBD(A)	Community Based Distribution (Agent)
CBRH(P)	Community Based Reproductive Health (Programme)
CHW	Community Health Worker
CSCOM	<i>Centre de Soins Communautaire</i> (Community Health Center)
DMPA	Depot Medroxyprogesterone Acetate (Depo Provera)
EC	Emergency Contraception
ESD	Extending Service Delivery
FENASCOM	<i>Fédération Nationale des Associations de Santé Communautaire</i> (Federation of Community Health Associations)
FP	Family Planning
HEP	Health Extension Programme
HEW	Health Extension Worker
HIV	Human immunodeficiency virus
HPI	Health Policy Initiative
IBP	Implementing Best Practices
IEC	Information Education Communication
IUD	Intra-uterine device
LAM	Lactational Amenorrhea Method
MAQ	Maximizing Access and Quality
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MNCH	Maternal Neonatal and Child Health
MOH	Ministry of Health
NGO	Non-governmental Organization
ORS	Oral Rehydration Solution
PRH	Population and Reproductive Health
PRSP	Poverty Reduction Strategy Papers
RHR	Reproductive Health and Research
SDM	Standard Days Method
SSA	Sub-Saharan Africa
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

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Introduction

Community-based programmes were developed as a way to reach beyond the borders of clinic based services to better serve, mobilize and engage communities in achieving a wide range of health and development objectives. While there are many variations, in the health sector these programmes seek to reduce the social and financial costs of accessing health care by bringing services and information to where people are, rather than requiring them to visit a fixed service delivery point for services. These programmes are intended to utilize existing social networks and, in some cases, workers act not only as health providers and distributors of products, but as educators and agents of change. Recently, these workers have been called upon to respond to the need for community aspects of HIV prevention, care, treatment and support. For family planning, these programmes are especially important where cultural and social barriers, lack of information, and weak health systems limit access and utilization of clinic-based services.

Currently, governments and donors in several sub-Saharan African (SSA) countries are making significant investments in community-based programmes. These programmes have the potential to significantly contribute to achieving the Millennium Development Goals (MDGs) such as reducing maternal and child mortality through the Road Map for Maternal and Newborn Health. Their experience and impact will help define the future of community-based interventions, including delivery of family planning services. Measuring and evaluating the significance of programme inputs and the need for flexible operating procedures to respond to changing needs of communities and individuals are a major challenge for these programmes. This workshop provided a unique opportunity to learn from current experiences, foster innovation, and strengthen in-country capacity to use monitoring, evaluation and research methods to improve programme performance.

The MOH/Mali in collaboration with WHO/Mali, the Department of Reproductive Health and Research (RHR), the partners of the Implementing Best Practices (IBP) Initiative led by the secretariat at WHO/HQ, WHO/AFRO, USAID's Office of Population and Reproductive Health (PRH) Maximizing Access and Quality (MAQ) Initiative, USAID's Frontiers in Reproductive Health Programme (The Population Council) and the Extending Service Delivery Project (ESD), UNFPA, and partners in the region organized a workshop to support countries involved in implementing large-scale community-based family planning programmes within the context of reducing maternal and newborn mortality and HIV prevention, care, treatment and support.¹ .

Five country programmes were identified; Cameroun, Ethiopia, Ghana, Madagascar, and Mali as participants in the workshop. In order to optimize the country exchange experience and documentation, participating countries were identified based on the following criteria:

¹ The Scope of Work is intended to involve community-based family planning programmes designed to deliver contraceptive products and information through traditional or social networks. These programmes employ a variety of approaches and models. This variety provided richness and depth to the country exchange and documentation activities.

- Community-based programmes currently in place with plans and resources for large scale implementation Programmes included objectives to increase use and/or distribution of contraceptives
- Programmes have linkages with public sector programmes including substantial support and involvement of the Ministry of Health
- Countries allow for balanced linguistic participation, e.g., Francophone and Anglophone
- Countries include a range of programme designs and linkages with other sectors (i.e., environment, HIV, Maternal and Child Health (MCH), education, etc.)
- Countries requesting assistance in Community-based partnerships

Workshop Goal:

To contribute to improved Maternal, Newborn, and Child Health (MNCH) through Community-based Reproductive Health Service Delivery, with focus on family planning.

Specific objectives

1. Foster innovation through sharing of country experiences, lessons learnt, and challenges in implementing community-based reproductive health services, in particular family planning.
2. Identify opportunities to strengthen implementation of cost effective community actions for improvement of reproductive health.
3. Identify mechanisms for continued country exchange and follow-up

Expected Outcomes

1. Experiences shared on implementing community-based programmes, with specific focus on reproductive health.
2. Key elements of country experiences documented.
3. Recommendations for programmatic guidance and support material.
4. Opportunities for strengthening implementation of cost effective community-based programmes identified.
5. Action plan for applying follow-up activities.
6. Identification of mechanisms to facilitate country exchange and follow-up.

Workshop methodology

The workshop was organized to allow for the maximum amount of discussion and interaction between participants. Experts were primarily participants from country teams sharing experiences from their programmes. The main types of activities were:

- Plenary presentations, discussions and brainstorming
- Group work
- Small working groups
- Site visit
- Market place
- Inter-country and resource person consultations

Content and Discussions

Day 1: June 11, 2007

Opening Ceremony

The opening ceremony was presided by Mme MAIGA Zéïnab Mint YOUBA, Minister of Health/Mali in the presence of representatives from USAID, UNFPA, WHO, World Food Programme (WFP), and President of the *Federation Nationale des Associations Communautaires* (FENASCOM), as representative of civil society. The Minister expressed her continuing support for the critical role community based programmes play in meeting the populations need for family planning in Mali.

Key Note Address

The keynote address delivered by Dr. Ayorinde Ajayi, Population Council, Regional Director, SSA, provided a historical overview of community-based reproductive health programmes (CBRHP) in Sub-Saharan Africa. He discussed the evolution of the community-based family planning movement from the introduction of Primary Health Care with the 1976 Alma Ata Declaration, the WHO goal of "Health for all by the year 2000", the introduction of community-based family planning in South East Asia in the 1960's & 70's to its adaptations in Africa in the late 1970's and 80's, finally leading to the Millennium Declaration in 2000 and MDG 4, 5 & 6. Through this process, Dr Ajayi noted that the family planning movement in SSA has lost focus and failed to achieve fertility reducing goals in SSA. Attention has been diverted by the urgent need to respond to HIV in the region. Ajayi provided evidence of high unmet need for contraception and its potential as the most cost-effective way to reduce maternal mortality and achieve national development goals and Millennium Development Goals (MDG) 4, 5, and 6. Dr. Ajayi encouraged participants to investigate the assumptions underlying the operational design of community based distribution (CBD) in Africa. He urged participants to remember that human behavior is complex and cannot be completely explained by the simplistic supply and demand dichotomy; that social, economic and psychological factors play crucial roles at the individual level in defining reproductive norms and family planning behavior; and finally that family planning programs must interact with all these factors to introduce and sustain behavior change.

Participant Expectations

Participants were then invited to express their own expectations for the workshop. Most participants expected the workshop to assist in:

- Exchanging experiences and new perspectives to improve reproductive health,
- Capitalizing on best practices,
- Creating a common vision between partners and government within countries,
- Exposure to new approaches,
- Learning about innovative approaches to integrate family planning into the larger context of community health
- Identifying specific follow-up needed to apply lessons learnt, and
- Identifying innovative approaches to increase motivation of community based agents and sustainability of activities.

Country Presentations

Countries were requested to make brief presentations on their approach to community-based family planning. Common themes included:

Rationale to support CBRH programmes:

- Poor coverage by health services and in particular, difficult access to family planning,
- Unmet need for contraceptive services and products,
- Weak contraceptive prevalence in all countries,
- High fertility rates,
- High maternal, neonatal and infant mortality,
- Existence of social and cultural barriers to family planning.

Common design of programmes:

All countries relied on some form of community-level worker who lived in the community where they worked. In all countries the volunteer workers were selected from their own communities. In two countries (Ghana and Ethiopia) paid workers were also dispatched to communities and work closely with volunteers. Community level activities included Information, Education, Communication (IEC), advocacy, mobilization of community leaders, decision-making and the offering of a package of services. Each presenter described some degree of community sensitization and the importance of community participation. Some countries described very specific activities and longer periods of preparation to allow for substantial involvement of community members. All programmes involved distribution of a range of products, including contraceptives. Some programmes involved a wider range of contraceptives and/or other health products such as Oral Rehydration Solution (ORS), chloroquine, treated mosquito nets, etc.

Value-added:

Presenters discussed the value of CBRHP that responds to the socio-cultural context of each country, contributes to an increase in contraceptive prevalence, contributes to an increase in the utilization of clinic-based RH services, and can offer a range of services expanded to other prevention and promotion programmes.

Common challenges:

CBRHP are challenged by the limited availability of qualified human resources, difficulty in motivating and retaining volunteers, in the long-term sustainability of the system. A number of participants were interested in the cost of programmes or programme inputs. Lack of information in this area creates a barrier to scale-up and introduction of innovation.

Participants identified a number of immediate needs common to all country programmes. The needs to:

- Strengthen supervision:
- Foster better linkages between nurses and other health system personnel and volunteer workers.
- Scale-up in order to reach the population needing coverage
- Identify additional resources to support national scaling-up;
- Strengthen the impact of CBRHP on contraceptive use through development and implementation of innovative approaches
- Strengthen information and management systems.
- Gather information on cost-effectiveness of programmes through targeted research efforts.
- Strengthen commitment of decision-makers to support and sustain CBRHP.
- Mobilize communities to support CBRH worker.

Life After the Workshop- Panel

Workshop organizers provided information about opportunities and resources available to support country plan activities.

- ESD and USAID described the process for how the programme descriptions for each country would be completed. Presenters offered ideas for how the descriptions might be used as an advocacy tool for countries to explain their programmes to other donors and partners. “Practices that work” and challenges identified during the workshop will also assist in determining further follow-up technical assistance during the next twelve months. Focus will be on important elements of CBRH programmes that require further strengthening in scale up that are feasible and doable within this timeframe and also lead to measurable results.
- UNFPA will assist in follow-up after the workshop. They have certain software available and could offer targeted technical assistance to implement action plans
- WHO/AFRO will support and promote collaboration, cooperation and coordination among and between partner organizations present at the workshop and also that exist within the region and countries. The regional office has developed tools to assist MOH efforts to integrate RH services and in repositioning as well as technical assistance in developing effective SRH programmes for adolescents.
- Implementing Best Practices Initiative (IBP) offers a connection to a large group of partners that promote collaboration globally and at regional and country level. The Knowledge Gateway offers an electronic forum for sharing information.
- The Special Programme on Social Science and Operations Research in Sexual and Reproductive Health (WHO/RHR) supports developing country scientists in conducting research to improve the quality of SRH service

delivery. Technical and financial assistance are available through this initiative.

- The Family Planning Unit of WHO/RHR develops tools and support materials for delivery of family planning services. Participants were encouraged to discuss the need and ideas for adaptation of these tools for use by community-based workers.

Discussions that followed the panel presentations highlighted the necessity to harmonize approaches and work together to integrate community-based programmes into national RH strategies and national health plans. It was felt that assistance from all of these different organizations could assist in that endeavor.

Day 2: June 12, 2007

The Role of Evidence

Morning sessions were devoted to discussing the role of monitoring, evaluation and research in strengthening community-based programmes. Presentations were made to review basic concepts and describe regional experience. Main points included:

- The differences between concepts :
 - **Monitoring** allows us to monitor indicators, correct gaps and modify the direction in view of unforeseen obstacles that may come along and occurs either by a schedule (i.e. quarterly, annually) or through regular monitoring of activity indicators so that you can correct problems along the way
 - **Evaluation** is a tool used to measure project effectiveness or if the project was able to achieve its objectives. Evidence is used in policy and resource allocation decisions and can be a powerful tool in advocacy.
 - **Research** provides an answer to a question in adapting the intervention strategy of the programme in order to maximize expected results. Evaluation of a programme or an action takes into consideration the determinants and factors that are often outside of the problem.
- Linking the concepts: Monitoring and evaluation are supported by research. Each has a specific role to play in project management and should be carefully coordinated to maximize benefit.
- Points to consider when using data to improve programmes:
 - Which decisions require which type(s) of evidence – and is that evidence readily available?
 - Beware of collecting too much and the wrong type of data. Know why it is being collected and how it will be used.
 - Is existing evidence being wasted?
- Specific examples of data collection and utilization were presented.

Participants discussed generally the role of monitoring, evaluation, and research. Questions involved the timing of evaluation design and its effect on validity of results, presenters were asked to describe their experience with participatory evaluation, monitoring, and the use of evidence for sanctioning and how that effects data collection, and questions were raised as to how to use data collected from volunteers in national health plans. Presenters commented that participatory approaches are difficult to implement and development of objectives has proven problematic. Involvement of community and staff in identifying evaluation plan will help in promoting ownership.

Participants were then split into two groups to present and discuss country programme monitoring and evaluation plans. Participants were asked to identify strengths and weaknesses of their M&E plans and to suggest ways to strengthen their existing approach.

The groups concluded that indicators were well-defined, that collection tools exist, and the roles and profiles of CBD agents are described. Challenges identified by participants included maintaining regular supervision of all types of community level activities, ensuring the quality of reports, including their completeness and promptness, being able to evaluate impact of the community-based interventions, harmonizing data collection tools, and building the capacity to utilize and analyse data. The groups recommended the following approaches to strengthen M&E efforts: integrated supervision, monthly meetings with community partners and involvement of local government in the financing of community activities.

Support and sustainability of large scale programmes

The importance of financing and costing large-scale programmes was emphasized in a series of presentations including measuring the cost of community-based programmes, an example from Ethiopia on how to gain political and financial support for large-scale implementation of scale up, USAID best practices in community-based family planning, and fostering change. Main points of the presentations follow.

Financing and Costing of Large-scale Programmes

Providing evidence of cost-benefit can play an important role in gaining financial and political support for programmes. A central issue in designing a CBRHP is cost benefit of paid versus volunteer workers. Evidence shows no direct relationship between cost-benefit and salaried personnel. Other programme factors, such as supervision and training, play a key role in determining the productivity of salaried and volunteer workers. In some cases, volunteer worker programmes can be more productive than salaried workers if provided with the right support and motivation.

The cost of community-based RH programmes is often compared to clinic-based programmes. The comparison, however, is not straight forward. There is limited cost data on any RH programme, and they often do not take into account the full range of funding sources. Traditionally, CBRHP are heavily funded through community resources, personnel and product fees, while clinic-based services are supported by donors, governments, and user fees. In addition, studies historically have neglected to take into account the unique role that CBRHP play in reaching disadvantaged populations , such as the poor. Therefore, the need for more

comprehensive cost-benefit analyses (or just relative benefits of each approach) should be undertaken.

Gaining Financial and Political Support

This presentation stressed the importance of collaboration between government and donors and at all operational levels. The CBRH and Health Extension Worker (HEW) programme in Ethiopia is considered a government priority. As such the programme plays a central role in the country's Poverty Reduction Strategy Papers (PRSP), MDGs, RH strategy, and other country development plans. HEW has broad-based support receiving financial, technical, and political support from local UN, bilaterals, multilaterals, NGOs, communities, faith based organizations, professional associations, and the private sector. There is commitment from all RH partners to support this programme, and the government continues to increase funding at national and district levels. Communities make in-kind contributions. The programme faces many challenges, but the government and partners are optimistic that the programme will meet its objectives.

Best Practices in FP/RH

USAID presented the evidence-based practices that it believes are important for most programs to incorporate into their family planning programs.

Since there are many practices that are considered 'best' or 'better', USAID identified specific criteria for practices it is promoting as 'priority' for systematic introduction and incorporation: evidenced-based; replicated; high potential for increasing contraceptive use; requires minimal input to implement; inexpensive to implement; considered state-of-the-art, and remain underutilized.

Two 'packages' of priority practices have been developed—one for clinic-based services and one on community-based practices. The clinical-based practices include:

- Systematic screening-- providers can use to make sure that their clients are receiving key services. Experience indicates that systematic screening can increase the use of select services by approximately 20%
- Using checklists to improve access to, and use of, contraception - pregnancy checklist and three method specific checklists: for pills, Depo-Provera and IUDs.
- Four practices designed to improve the provision of hormonal contraceptives. 1) 'Quick Start (pills)—take first pill in office and use pregnancy checklist!, 2) Advance Provision (pills)—provide multiple pill packs, 3) Missed Pill instructions (pills)—provide instruction what to do is a pill(s) is missed, and 4) DMPA grace periods—two weeks early or late is OK
- Expanding method mix to include underutilized methods,

For programs that support or manage community-based programs, the following practices are recommended:

- Use of checklists by CBDAs,
- Expand the method mix—adding Lactational Amenorrhea Method (LAM), Standard Days Method (SDM), and Depo-Provera,
- Including men as CBDAs, and

- CBD agents include in their counseling and education sessions messages relating to the Healthy Timing and Spacing of Pregnancies.

Fostering Change and Scaling Up

An overview was presented of how partners at a national level can work together to change and improve reproductive health. IBP partners have worked to harmonize existing approaches and tools into a guide which aims to assist countries in "fostering change". The presentation emphasized the importance of "change" in the work we are all doing. It is the single most important issue when we look at the reasons why programmes and personnel are not utilizing known evidence based practices that could improve health.. The issue is that change is not easy and must be managed carefully. In particular the issue of scaling up figures prominently. Scaling up must be well planned with strategic choices being made early on in the development stage. Many tools, support materials and experts are available for supporting all stages of the "change" process. The guide to Fostering Change is available to each country team as are the Guides for Scaling Up produced by ExpandNet. Additional information can be found through the IBP Gateway, <www.ibpinitiative.org> as well as the Expandnet website: <www.expandnet.net>

Essential Programme Management Components

The afternoon focused on key management components for community based programmes - logistics, community mobilization, integration within the health system, FP/HIV integration, training, motivation, personnel tasks, and supervision. Participants were organized into small groups and asked to address the following questions:

- What recommendations or issues raised in the documents are relevant or consistent with participants' experiences?
- What recommendations or issues in the documents should be updated to better reflect the current situation?
- Are there other issues, challenges or guidance that are useful for the programmes?

As a basis for discussion, several widely recognized documents were used. The following documents were the basis of discussions:

1. Network (English and French)
2. Parts of the book *The Community Health Worker: Effective Programmes for Developing Countries*.
3. *Community Health Workers : The Way Forward*

In general, participants found many of the management issues raised in the documents provide continue to pose significant barriers to implementation. There has been little progress in addressing the key elements of success.

Logistics:

The group agreed that issues such as stockouts, limited and irregular supplies, challenges with prescribing policies and practices are the same today as they were over 20 years ago. No doubt there are areas of improvement, but the underlying challenge of ensuring accessible, affordable supplies to poor communities living in remote areas still exists persists. Examples of innovative supply chains involving the private sector to support pharmacies, shops and social marketing programmes were discussed, but these have yet to be implemented on a larger scale. A major barrier common among programmes is project-based funding rather than national support, such as a national system support with a budget line. An additional issue, common among even national logistic systems is weak implementation. All participants felt that a small profit from the distribution of supplies for the community health worker (CHW) is a motivating factor in both performance and ensuring adequacy of supplies. Supply chain disruptions then become demotivators. ***Participants felt that the issue of supplies has to be addressed at the national level and requires creating a budget line for purchase of family planning commodities and systems must be in place to support their effective distribution. Distribution, however, need not be centralized.***

Community Mobilization

The group felt that all the recommendations, issues and guidance raised in the documents were relevant and useful for today's community health programmes. However, several issues although relevant, needed updating such as the balance between home visits and health post activities. In addition, it was felt that there needed to be some recommendations on developing networks of community health workers/agents. ***Updates are needed to appropriate ways of facilitating community mobilization.***

Integration within the health system

The group discussed the importance of relationships between the CBD worker and the clinic worker, including the difficulty of hierarchical relationships. Supportive supervision is essential for the CBD worker, and must be facilitated by the CBD programme. However, there are often financial and human resource constraints to ensuring adequate supervision. Further, clinic workers are not prepared in pre-service training to work with CBD workers and to provide the supervision needed. It is important that the roles of clinic workers in relation to the CBD workers are clearly delineated. CBD workers may have higher career expectations than are possible in the system, and thus motivation is lowered. Career development opportunities for CBD workers with good performance need to be considered and built into programmes. Policies need to be put into place to support CBD programmes and planning at the district level must accommodate financial and human resources needed to support the programmes. ***CBD programmes are often not well integrated into the health system, and improving this needs to start with policies and planning, and encompass clear roles and responsibilities, adequate supervision and opportunities for advancement for the CBD worker.***

HIV and Family Planning Linkages Group

The benefits of linking HIV and Family Planning (FP) services were discussed such as prevention of mother-to-child transmission; prevention of unintended pregnancy, healthy spacing and timing of first or subsequent pregnancy (where desirable). Opportunities for community health workers to provide information on FP services and counsel individuals about HIV prevention care and treatment arise. Challenges exist where referrals cannot be made or utilized because of the distance to health centers, attitudes by providers and/or the lack of knowledge about how to offer high quality HIV and FP services. Stigma and discrimination associated with being HIV positive and socio-cultural norms and practices remain as major barriers to forming meaningful linkages that affect health-seeking behaviors and increase contraceptive use. ***Ensuring client privacy and providers' willingness and preparedness to address various health needs should be addressed at policy, programming, and community levels.***

Training

When discussing training it is essential to examine both pre and in-service training. Evidence has shown that supervision can play a significant role in predicting the success of community-based workers therefore it is essential to examine the training of supervisors as well. In general, participants felt the curriculum for community-based workers does not reflect current practice and need to be revised. For clinicians' pre-service training for their role as supervisors and community mobilization is inadequate and does not sufficiently prepare them for work in communities. Participants agreed that it would be good to train community workers and clinic workers together if possible, so they can, model work in the field. Although most clinical training has a community component, the significance of this training is not emphasized in the programme and it is not until practitioners are in the field that they realize the importance of working with community members. Participants suggested that clinicians with public health training would make excellent speakers in pre-service classes and might help reinforce the importance of these skills. Another issue for the community worker is that curricula need to be harmonized. It was noted also that it is often difficult to modify curriculum in clinical programmes. However, for the community worker, curriculum development is more flexible and feasible. ***A revision of curriculum for both community health workers and for clinic staff is necessary.***

Motivation Group

Motivation as a critical element of CBRHP was a theme throughout the workshop. The main discussion in the small group involved payment of community-based workers. For the most part, the group agreed that there should be some form of salary if the workers are expected to work full time. However, it was not clear who would actually pay the worker? In Ethiopia, the government pays, but in Mali, health centers are run by the community management teams (ASACO), they would have to be the ones to pay these workers. Concern was raised that it would be too much for the community to bear. Otherwise, volunteer workers are working part time and have a paying job to actually support themselves. In several of the countries other forms of "payments" were offered to motivate workers. Bikes and other equipment are often offered, but they eventually break and usually there is no support to fix them. In Ghana, some of the workers are paid and in addition are given rural hardship stipends, fridges, solar systems, motorcycles, or radios. All are great incentives, but

cost a lot. Other ways to motivate workers are through training and one-on-one supervision. However, without payments or tangible items motivation may exist immediately after training, but decreases as time goes on. Everyone agreed that all community workers should not automatically be considered volunteers. However, there is an important role for volunteers who can support the paid health agents and reinforce the notion that health is the responsibility of the community. Each community needs to find what works for them. ***What seems to be most important is that community health workers (paid or not) feel an integral part of the overall health system as well as the community.***

Personnel tasks

The issue of "what do community-based workers do?" is constantly evolving and largely dependent on the context and needs of the community in which they work. Evidence shows that a well-defined job description which is communicated to health professionals and community members plays an important role in predicting programme success. However, communities often prefer curative services and governments usually prefer preventive services which are more cost effective and in most cases require fewer skills. Education level of workers plays a role in dictating which services may be offered through community workers as well as concerns regarding the safety and security of workers and community members. ***Giving workers too many or too few job tasks creates problems. Needs of the community should be monitored and adjustments made to ensure CBRHP meet the needs of those they serve.***

Supervision

As with other components there have been few improvements in supervision strategies for CBRHP. Issues of geography, lack of financial resources, and low motivation limit the content and frequency of supervision visits. Supervision visits often focus on issues of reporting and rarely involve skills building or support. ***The group recommended developing precise supervision plans including who, what, when, and where visits are to take place.***

Day 3: June 13, 2007

The day was dedicated to field visits during which the participants could:

- See tools for data collection at the level of the "relais" ("community volunteer")
- Observe an IEC/Behavior Change Communication (BCC) activity by a *relais*
- Review IEC/BCC tools
- Study the local partnerships supporting the *relais*
- Observe women's groups that support income generation activities and health at the same time
- Study the involvement of different partners in the implementation of the "relais" strategy
- Identify the difficulties linked to the implementation of the "relais" strategy
- Study the management of inputs at the level of the community "relais"

All groups visited local officials at the health reference centers as well as a CSCOM (community health center).

The groups had fruitful exchanges and found that the CSCOMs are well organized, the personnel is there and the “relais” are well integrated into the CSCOM team.

Discussions brought out key points. The team saw that the « relais » master the different components of the programme and noted:

- Effective involvement of the community
- Engagement of health center personnel with the community
- Dynamic interaction between the two
- IEC tools are available and maintained
- Limited “relais” dropouts
- Other sources of revenues exist for the « relais »
- Motivational problems and sustainability issues exist
- Increasing male involvement in FP
- In some cases, insufficient personnel (only 1 nurse in the center) having clinic activities and having also to carry out supervision
- In one case, retrained traditional birth attendants act as “matrones” working in health center
- Empowerment of women through training and outreach activities which elevated their status in most communities

Day 4: June 14, 2007

Field Visit Presentations

Each group presented feedback from the previous day’s field visits.

Innovative Initiatives in FP

Mali Experience on SDM

Working with the MOH, the Institute for Reproductive Health/Georgetown University started a project to introduce the Standard Days Method in September 2006. SDM is a natural method, simple, effective and less expensive without side effects. It is particularly liked by religious communities and was felt to be particularly appropriate for Mali. Fifty-four national and regional trainers were initially trained and subsequently district level trainers and providers were trained in Gao and Kidal. So far there have been 305 acceptors in Bamako. During the discussion, Ethiopia shared their experience and stated that acceptance has also been low. They felt that the need is to focus on capacity building particularly in terms of improving the quality of counseling which is key to its success.

Madagascar Experience with Injectables

After holding an initial stakeholders meeting, the MOH held community level meetings to introduce DMPA in two regions for the pilot phase. The two regions presented different socio-cultural contexts. Two districts were chosen for each region, one more accessible and the other not very accessible. The pilot lasted 7 months to allow for two injections. In the meantime, information and advocacy meetings were held with health officials and local authorities.

A three day training was held for selected CBD agents who were already trained in other methods. Sessions were held for CBD agents and clients. Agents were supplied with a starting stock and were monitored after 1 month. Systematic supervision by health workers and technicians working with NGOs was conducted at least twice a month. Agents submitted activity reports every month. The project is currently in its evaluation phase.

Discussion on this topic was very interesting and lively. Participants were anxious to know about the competency level of the CBD agents. Also, in Ethiopia problems arose when agents that were trained in Depo-Provera (DMPA) then started doing other injections that they were not trained to administer. It was agreed that supervision was very important and that an adequate level of basic training must be a prerequisite if only a short three days is all that is being offered for injectables.

Working with Religious Leaders on Family Planning

A network of religious leaders was trained to work with other religious leaders that are preaching in the mosques and convince them to promote family planning based on what the Koran says. The project has shown strong involvement by the Malian religious leaders. The main messages relate to how family planning is important for the well-being of the population.

The programme has achieved a lot but it has not been easy. Convincing religious leaders required a very delicate approach. Their objective was to share what they have learned and shed light on the subject. It was important not to create problems and divide the people.

The project emphasized that many verses in the Koran can be interpreted to support family planning. In particular the Koran says that:

- you shouldn't jump into the water with your eyes closed;
- you should only have as many children as you can feed;
- if you have a child, you must care for it.
- it is forbidden to not take care of your family.
- God also wants to have strong men and women, not sickly ones,

All of these verses are used to support the case for family planning.

The programme has supported conferences, works with the Koranic schools, works with women religious leaders and Muslim associations. The Imams and the Koranic schools are key entry points for convincing others. There are now regional networks in all regions and at the district level. These networks provide the basis for scaling up the project activities throughout the country.

The participants asked many questions and were particularly interested to see how this approach could be used with other religions...as in Ethiopia.

The Market Place (country stands) and meeting with resource people

Countries presented their materials and participants had the opportunity to discuss individual programmes or meet with resource people.

Question/Answer Session with Country Teams

In the plenary, participants were given an opportunity to ask questions to each country team. This session was extremely lively and allowed for more in depth discussion and clarification of issues that had not been covered previously in sufficient detail.

Some highlights of the discussions were:

Cameroun:

Cameroun is working on lower their high fertility rate. There have been many obstacles. Cameroonians were in favor of having a lot of children particularly to help families on the farms. However modernization is changing the situation. . Another issue was that the government even gave allowances to families with many children. However, now family planning is more accepted. Although natural methods are favored by religious groups, modern methods are used and promoted as well.

In addition, some barriers to CBD agents also still exist. Health professionals are reluctant to accept these non-clinician workers. There are also cultural barriers, funding challenges and some past negative experiences that influence their acceptability today. In particular, some health posts were actually being managed by CBD agents who began to consider themselves being the same as doctors. Part of this problem was that there was limited supervision to know exactly what services they were providing and the quality of those services.

In the 90s Cameroun began with CBD agents and then UNFPA assisted the MOH to expand the programme. Currently there are 350 community workers in 11 districts. The MOH plans to increase to more districts over the next few years.

Madagascar

Discussions first focused on approaches for motivating CBD agents. The CBD agents actually sell a number of other products as well as contraceptives and get 50% profit on all that is sold. Another positive factor is that there are 2 workers per site which offers a more supportive environment. Finally, it is important to note that all of the workers have other sources of income such as agriculture, livestock, trade, etc. which they are not expected to give up.

A particular point for discussion questioned the legal/policy grounds for allowing unlicensed providers to sell drugs. In many countries, this practice is illegal outside officially recognized pharmacies. In response, the Madagascar team answered that because the CBD programme and the agents are an integral part of the health system and the drugs are part of the health center's available drugs provision of DMPA through this channel follows approved policy.

Ethiopia

With 100% female workers (under the Health Extension Programme) and 16 essential packages of services, making FP only 1/16th of their portfolio, the question arose of how they can expect to reduce the high unmet need in the country. In fact, the Health Extension Programme (HEP) relies heavily on collaboration with the other long-standing health volunteer agents (CBRHAs and others) that they will be able to

address specific family planning issues. The HEP was started because an evaluation showed significant problems with accessibility to services. This new programme, combined with the existing volunteer community workers should be offer an effective approach to meeting these needs.

Another issue that was discussed was the fact that Ethiopia provides free contraceptives. Their feeling is that it wouldn't be something people would pay for. The questions concerned how this can be sustainable since donors currently provide the contraceptives and donors will not be around forever. The MOH has begun to discuss and plan for ensuring contraceptive security in the future. In addition they've started a social marketing programme.

Ghana

Ghana's programme relies heavily on the interaction between volunteers and paid community health nurses. Volunteers cannot provide Norplant, Intra-Uterine Device (IUD) or Emergency Contraception (EC) but refer to properly trained nurses and midwives. The coordination and collaboration between these two types of health workers provides comprehensive service at the community level.

There is also a strong feedback process for all agents and health providers to discuss the work that they're doing. This, along with other strong community and cultural activities provides great motivation for the workers.

Mali

Although Mali had not presented their approach to working with youth, participants were interested in knowing more about their model programmes. There's a programme in Bamako as well as several programmes with non-governmental Organizations (NGO) that focus on youth. There is a long history of peer support programmes for youth in Mali. Many of the programmes work with the schools and provide condoms. We also noted during some of the site visits that peer educators sometimes became community health volunteers when they outgrew the youth programmes or when they ended.

Country Teams Identify Needs and Priorities

Each country identified needs and priorities as a first step to developing their country action plans. The following table summarizes some of the key areas identified by country teams which need to be addressed to strengthen different aspects of their community-based reproductive health programs:

The day ended with a cocktail and local music.

Day 5: June 15, 2007

This last day focused on finalizing and presenting country action plans, next steps and the closing of the workshop by the representative of the Ministry of Health.

Summary of Country Action Plans

COUNTRY	Strengths	GAPS	Opportunities	Priority ACTIVITIES
Cameroon	<ul style="list-style-type: none"> • Funding available • Training modules exist • Trainers exist 	<ul style="list-style-type: none"> • Integrate TBAs into program with the objective of re-converting them to community workers • Conduct OR on selection of oral contraceptive pill acceptors by community health volunteers using the checklist • Find a durable mechanism to motivate community health volunteers 	<ul style="list-style-type: none"> • African Development Bank Project • UNFPA, UNICEF, WHO assistance programs 	<ul style="list-style-type: none"> • Identify villages • Identify TBAs • Train TBAs on CB services
Ethiopia	<ul style="list-style-type: none"> • Government priority strategy • Government responding to demand • Partners' commitment • Existing knowledge & practices • Supportive dev. programs in place 	<ul style="list-style-type: none"> • Low capacity for resource utilization, limited absorption capacity • Inadequate advocacy • HR crisis • Information system gaps • How to mobilize and coordinate donor resources • Gaps in providers' skills (district health staff and HEWs in particular) 	<ul style="list-style-type: none"> • Policy support • Decentralized system • Govt budget allocation increasing • Community involvement through dialogues and ownership, cost sharing • Supportive donor and task force groups in place—partners' good will • Readiness to change based on evidence • Recent strategies in place to support strengthening systems: health financing, human resource strategies, HMIS, logistics, forecasting 	<ul style="list-style-type: none"> • Resource mobilization from partners • Procurement and distribution of equipment/supplies • Supportive supervision for HEWs
Ghana	<ul style="list-style-type: none"> • Existence of training institutions • Some experience in costing • Receptive community members /leaders • Well developed guidelines and protocols 	<ul style="list-style-type: none"> • Inadequate support for training • Weak monitoring and supervisory systems in some districts • Poor communication, feedback, and audit systems • Evaluation • Need to strengthen community involvement and resource mobilization 	<ul style="list-style-type: none"> • Potential for expansion • Political will • Receptive development partners • Stable political system 	<ul style="list-style-type: none"> • Build capacity of management staff & community leaders in CHPS planning • Strengthen existing monitoring and supervisory systems • Strengthen communication, feedback, and audit systems in CHPS implementation at all levels • Evaluate progress in 18 months in achieving goal – to have at least 2 functional CHPS zones in each of the 138 districts in Ghana

COUNTRY	Strengths	GAPS	Opportunities	Priority ACTIVITIES
Madagascar	<ul style="list-style-type: none"> Experiences in community health: RH/IMCI, etc. Political commitment: built into communal and village activities Commitment of partners 	<ul style="list-style-type: none"> Absence of a community health referral framework: Policy, Strategic Plan, Operational Plans. 	<p>Existence of different policies for the various programs</p> <ul style="list-style-type: none"> Existence of community based agents Integration of the Ministry of population into Ministry of Health, FP and Social Security 	<ul style="list-style-type: none"> Establish a Pilot Committee tasked with community based activities at the central level. Conduct a situational analysis on community health <p>Develop guiding/framework documents: National Health policy; National Strategy</p>
Mali	<ul style="list-style-type: none"> Trainers already trained IEC support validated Data collection tools available for replication Policies, norms and procedures available Training and supervision tools existent Contraceptive products available 	<ul style="list-style-type: none"> Insufficient human resources (providers and CBDs) both in terms of quantity and quality: <ul style="list-style-type: none"> a. Low educational level of CBDs b. Quality of information unreliable c. Supervision tools are not harmonized d. PNP technical cards are non-existent at community level e. Contraceptive stockouts Availability of inputs (materials, contraceptive products, treated nets, management and communication support). Follow-up/Supervision of community based agents and providers. 	<ul style="list-style-type: none"> Political will Availability of funding for programs underway Commitment of partners Increasing support/interest of the international community for community based services Lessons learned from other countries during this workshop Mali would like to conduct an OR study on men involvement in FP with financial support from WHO and other partners. 	<ul style="list-style-type: none"> Strengthen capacities (trainings and refresher trainings of providers and CBDs) <ul style="list-style-type: none"> - Train 100 providers - Train 250 new CBDs in FP - Train 4000 community members on SDM - Train 40 managers in contraceptive logistics <p>1. Provide products and tools</p> <p>2. Follow up /supervision of all CBDs</p>

Sources: 1. Country action plans; 2. Session topics and presentations; 3. Discussions with country team members

NEXT STEPS

Immediately following the workshop:

- Resource organizations will analyze plans and follow-up activities
- Resource organizations will meet to discuss roles and responsibilities for follow-up
- Representatives of resource organizations will feedback to colleagues and discuss specific support available.

Within the next month:

- All participants will be invited to participate in the Knowledge Gateway, specifically as members to the Community Health RH Services COP
- Draft Report will be finalized by workshop organizers and posted on Knowledge Gateway for comment.

Within the next 3 months:

- Through WHO/country level, resource organizations will discuss specific activities to be carried out and the approach for requesting specific technical assistance.
- Complete country descriptions

Within the Next 18-24 months

- Follow-up workshop hosted by Ethiopia (funds permitting)

RECOMMENDATIONS

Key issues and recommendations from the Mali Community-based Reproductive Health Programmes Workshop

1. Political and financial support for CBRHP is critical to the success and long-term sustainability of these programmes. Country level champions (MOH or NGOs) with the support of regional and international partners play a critical role in advocating for continued support for large-scale implementation.
 - **Country teams, in collaboration with partners, should disseminate widely the short country programme briefs to better inform the international community of the critical role CBRH/FP programmes play in improving sexual and reproductive health. Country teams and partners should work together to develop or strengthen advocacy strategies for MOH decision-makers and international donors.**
2. Local capacity to collect and analyse programme process and impact indicators is key to strengthening implementation and building flexible programmes which can adapt to changing local needs.
 - **Country teams, with support and technical assistance from partners, should strengthen programme capacity to collect and utilize programme data.**
3. Participants identified staff motivation as a critical issue for all CBRHP.
 - **Country teams will share experiences on effective approaches for motivating and retaining community health workers.**
 - **Partners should consider supporting activities to document and test motivation strategies.**
4. Each country is in the process of expanding CBRH programmes and has requested information on systematic strategies to scale-up.
 - **Partners need to consider supporting activities that distribute materials, disseminate relevant information and offer technical assistance to strengthen scale-up strategies.**
5. Country teams expressed an interest in learning additional ways to mobilize communities to assume more active roles in ensuring an effective CBRHP. The importance of sharing experiences and ways to support community-based health workers was reinforced.
 - **Country teams should focus on concrete activities and approaches to improve community participation, outreach and resource mobilization that can be addressed during the next 12 months as follow-up to the June workshop.**
 - **Partners should continue to facilitate experience-sharing on effective community mobilization activities.**
6. Participants appreciated the opportunity to meet with and exchange experiences with other countries involved in implementing CBRHP. In a number of cases, specific countries were interested in specific aspects of another country's programme.

- ***Country teams should continue to exchange information through the IBP Knowledge Gateway's community of practice.***
 - ***Partners should assist in facilitating this inter-country forum and provide opportunities for targeted ongoing discussions and field visits to foster country exchange and expand global learning and knowledge.***
7. The breadth and depth of experience shared at the workshop cannot be adequately captured in the Workshop Report. This experience and other lessons learned from programme implementation represent a valuable resource to expanding global learning and knowledge for the international community.
- ***Partners should continue supporting activities that document and disseminate country experiences and lessons learnt to improve the scale-up of CBRH/FP programmes.***



**Community Based Reproductive Health Programme Workshop
Bamako, Mali, 11-15 June 2007
Hotel Nord – Sud**

To contribute to improved Maternal, Newborn, and Child Health (MNCH) through Community-based Reproductive Health Service delivery, with focus on family planning.

Specific objectives

1. Foster innovation through sharing of country experiences, lessons learnt, and challenges in implementing community-based reproductive health services, in particular family planning.
2. Identify opportunities to strengthen implementation of cost effective community actions for improvement of reproductive health.
3. Identify mechanism for continued country exchange and follow-up

Expected Outcomes

1. Experiences shared on implementing community-based programmes, with specific focus on reproductive health.
2. Key elements of country experiences documented.
3. Recommendations for programmatic guidance and support material.
4. Opportunities for strengthening implementation of cost effective community-based programmes identified.
5. Action plan for applying follow-up activities.
6. Identification of mechanisms to facilitate country exchange and follow-up.

Sunday, 10 June 2007

17:00-19:00 Registration

Monday, 11 June 2007

Moderator: Mali

Rapporteur: Madagascar, Ghana

08:00-09:00 Registration

09:00-10:30 **Welcome and Official Opening of Workshop**

WHO Representative Mali

UNFPA Representative Mali

Mission Director USAID Mali

Minister of Health Mali

Review Workshop Objectives and Agenda

Shawn Malarcher and Suzanne Reier, WHO RHR

10:30-11:00 **Tea and Coffee**

11:00-11:30 **Key Note Address: Community-based Reproductive Health: A Historic Perspective**

Ayorinde Ajayi, Population Council

11:30-12:00 **Introduction of participants**

Cheik Touré, IntraHealth Mali

Country teams are invited to introduce themselves and identify their own expectations of the Workshop

12:00-1:00 **Country presentations: Why support community-based programmes?**

Mali Presentation: Community Based Distribution

Binta Keita, MOH Mali

Ghana Presentation: Community Health Planning and Services (CHPS)

Discussion

13:00-14:00 **Lunch**

14:00-15:30 **Country presentations: Why support community-based programmes? (Continued)**

Cameroon Presentation: Community-based Distribution

Ethiopia Presentation: Health Extension Programme
Teshome Regassa, MOH Ethiopia
Madagascar Presentation: Champion Commune
Bako Nirina Rakotoelina, MOH Madagascar
Discussion

15:30-16:00 **Tea and Coffee**

16:00-17:00 **Life after the Workshop**

Follow-up and Country programmatic description
Jeanette Kesselman, Extending Service Delivery Project (ESD)
Follow-up and Support
Garry Conille, UNFPA
Coordination and collaboration
Nagbandja Kambatibe, WHO AFRO Region
Implementing Best Practices
Maggie Usher-Patel, WHO RHR
Social Science Research
Shawn Malarcher, WHO RHR
Development of community-based family planning support materials
Sarah Johnson, WHO RHR

Tuesday, 12 June 2007

Chair:

Rapporteur:

08:30-08:45 **Rapporteur Report Day 1**
Madagascar, Ghana

08:45-09:45 **The Role of Evidence**

Monitoring, evaluation, and research: What makes a difference?

Ian Askew, Frontiers in Reproductive Health

Evaluation to improve programmes.

Diouratié Sanogo, Population Council

The role of monitoring to improve programmes

Mamadou Ballo, MOH, Mali

Research to strengthen programmes

Jack Galley

09:45-10:45 **Presentation and Feedback: Monitoring and Evaluation Plans (for community-based programmes) for each country**

Cameroon

*Ghana
Mequannent Tesfu, Ethiopia
Eugénie Rasamihajamanana, Madagascar
Mali*

- 10:45-11:00 **Tea and Coffee**
- 11:00-12:30 **Supporting and Sustaining Large-scale Programmes**
- Financing and costing large-scale programmes
Ian Askew, Frontiers in Reproductive Health
- Gaining political and financial support the case of Ethiopia
Abonesh HaileMariam, WHO Ethiopia
- Tools for scale-up
Virginia Lamprecht, USAID/W
- Planning scale-up
Suzanne Reier, WHO/RHR
- Discussion
- Optional Community-based Distribution in Zimbabwe Video*
- 12:30-14:00 **Lunch**
- 14:00-15:00 **Small Group Work: Essential Programme Management Components**
- Logistics
Community Mobilization
Integration with health system
Linkages HIV and Family Planning
- 15:00-15:30 **Essential Programme Management Components (continued)**
- Training and Competencies
Motivation
Worker Functions
Supervision
- 15:30-16:00 **Tea and Coffee**
- 16:00-17:00 **Report Back on Essential Programme Components**
- 17:00-17:30 **Preparation for field visits**

Wednesday, 13 June 2007

Field Visit to programme sites

Thursday, 14 June 2007

Chair:

Rapporteur:

08:30-08:45 **Rapporteur Report Day 2**

08:45-09:45 **Report out from field visit**

9:45-11:00 **New Frontiers for Family Planning**

Standard Days Method

Oumou Keita

Delivery of DMPA

Working with Religious Leaders

El Hadj Dramé

USAID Package of promising community practices

Cameroon:

11:00-11:30 ***Tea and Coffee***

11:30-12:30 **Country Consultation and Market Place**

Countries will have the opportunity to access expertise from other participants through individual consultation.

12:30-14:00 ***Lunch***

14:00-15:30 **Country Consultation and Market Place (cont'd)**

15:30-16:00 ***Tea and Coffee***

16:00-17:00 **Small Group work (by country): Identifying needs and priorities**

18:00-20:00 ***Cocktail***

Friday, 15 June 2007

Chair:

Rapporteur:

08:30-08:45 **Rapporteur Report Day 4**

08:45-10:00 **Preparation of country plans (and presentations)**

- 10:00-10:30 **Tea and Coffee**
- 10:30-11:30 **Presentation of country plans**
- 11:30-12:30 **Next Steps**
Suzanne Reier and Shawn Malarcher, WHO/RHR
Official Closing
Presentation of workshop synthesis
Rapporteur General, WHO Mali
Minister of Health Mali
- 12:30 **Lunch**



**Community Based Family Planning Programme Workshop
Bamako, Mali, 11-15 June 2007**

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