

# MIYCN/FP Integration Working Group

## Meeting Notes

23 February 2016 | 9:00 am – 3:00 pm | SPRING Office

### Attendance

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25 people from 16 organizations participated in the working group meeting.

Attendees and remote participants included:

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| 1) Kristina Granger (SPRING)           | 14) Jane Ebot (USAID)                   |
| 2) Peggy Koniz-Booher (SPRING)         | 15) Linda Sussman (USAID)               |
| 3) Sarah Cunningham (SPRING)           | 16) Clifton Kenon (USAID)               |
| 4) Alix Harou (SPRING)                 | 17) Kathryn Reider (World Vision)       |
| 5) Altrena Mukuria (SPRING)            | 18) Edward Scholl (E2A/Pathfinder)      |
| 6) Nathalie Albrow (SPRING)            | 19) Anushka Kalyanpur (IMC)             |
| 7) Anne Fitzner (MCSP)                 | 20) Lauri Winter (Freelance Consultant) |
| 8) Devon Mackinzie (MCSP)              | 21) Nancy P. Harris (APC/JSI)           |
| 9) Agnes Guyon (JSI)                   | 22) Lauren Arrington (Jhpiego)          |
| 10) Elizabeth Tully (K4Health)         | 23) Suchitra Rath (Ekjut)               |
| 11) Sarah Fohl (K4Health)              | 24) Reena Borwankar (FHI 360)           |
| 12) Heather Clark (Population Council) | 25) Tembi                               |
| 13) Ingrid Weiss (URC)                 |   |

### Highlights

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**Welcome & Review of Minutes from Previous Meeting** – Kristina Granger, SPRING

- Welcome and introductions of working group members attending the meeting.
- Review of meeting minutes from last meeting (see previous meeting notes) – at last meeting:
  - PRB and HPP presented a Literature Review on FP, Nutrition, and Food Security Linkages.
  - FHI360/FANTA presented a Review of FP, Nutrition, and Food Security Integrated Programs. This is in the MIYCN-FP toolkit.
  - Population Council gave a presentation on the Progesterone Contraceptive Vaginal Ring (PCVR).
  - K4Health presented a session on promoting MIYCN-FP.

Follow up points:

- Reena sent out FANTA's Review of FP, Nutrition, and Food Security Integrated Programs to the CoP listserv. It is also available on the [MIYCN-FP Toolkit](#).

**Overview and Discussion of Commentary: A Fresh Look at the Level of Unmet Need for Family Planning in the Postpartum Period, Its Causes and Program Implications – Devon Mackenzie, MCSP**

*Session Summary: The objective of this session was to brief the group on a recent commentary about LAM and build group consensus around the recommendations of the brief. The group reviewed the brief, and determined the following: LAM should still be promoted as an option and providers should allow couples to make family planning decisions. The group is in agreement LAM should be treated as part of modern contraceptive methods. In addition, there is a need for training around LAM, and providers should have correct information about its practice and efficacy.*

The presentation provided an overview of the key points in the article – Cleland, J., Shah, I.H., Benova, L. (2015). A Fresh Look at the Level of Unmet Need for Family Planning in the Postpartum Period, Its Causes and Program Implications. *International Perspectives on Sexual and Reproductive Health*, 41(3), 155-162:

- It is well accepted that inadequate birth spacing has a negative effect on maternal and child health.
- While contraceptive use has increased over the past few decades, there has not been much change in interbirth intervals. According to DHS data, 25% of second and higher-order children are born within two years of a sibling, compared with about 29% a decade earlier.
- There has been a rise in efforts to promote postpartum family planning (PPFP).
  - The 2001 Ross and Winfrey article found that 65% of women have unmet FP needs during their first year postpartum (PP).
  - The new article by Cleland, Shah, and Benova notes that most couples want to space children by 2 years and women have frequent contacts with the health system during pregnancy and in the postpartum period, so demand for and access to FP should be high.
- The standard way that DHS calculates unmet need uses a retrospective approach based on whether the most recent birth was intended; it also ignores abstinence as a factor.
  - Ross and Winfrey used a prospective approach to capture unmet need, and include women who may be amenorrheic/abstaining, unless they are using a method of FP.
  - The Cleland paper restricts unmet need only to women who have resumed menses and sex, who wish to delay their next child by 2 years, and who are not practicing contraception.
- This calculation was applied to 16 DHS data sets in 4 regions. The prospective method calculates a very high unmet need, the Cleland paper calculates a much lower estimate, and the DHS estimate is in between.
- LARCs/PMs in early postpartum should be a priority as a high method continuation with long-term protection, even after abstaining and lactational amenorrhea has ended. An early uptake of pills/injectables may be counterproductive due to low continuation when the risk of pregnancy returns.
- Amenorrheic, breastfeeding women have a very low chance of pregnancy in first 6 months postpartum (3%), and this rate rises to 6% after 12 months postpartum for women who are not using FP. This calculation is likely lower for women who are exclusively breastfeeding.
- Reasons for non-use of FP: breastfeeding (BF) and amenorrhea. Women consciously delay contraception until menses return.
- When unmet need calculations are applied to different periods of postpartum, unmet need among women in the postpartum period is often highest at the two year mark.

- Implications:
  - Strategies for PFP need to take greater account of prevailing behavior and beliefs.
  - In areas with short BF protection, programming should promote early contraception uptake.
  - In areas where lactational amenorrhea extends through the 1<sup>st</sup> year postpartum, programming should a) promote early uptake of LARCS/PMs, b) counsel women on LAM and transition by 6 months, and c) advise women on the return to fertility.
- Is LAM counseling a poor investment? Most women in Africa with children under 6 months still breastfeed at least 6 times per day, and have a low chance of pregnancy.
- Alternative: Post- amenorrheic Strategy – Programming could explain to women the risks of relying on lactational amenorrhea and leave FP decisions up to women themselves. Frequent breastfeeding is less effective than LAM, but is a 3-6% chance of pregnancy acceptable?
- There seem to be two opinions:
  - Whether a woman is exclusively breastfeeding or partly breastfeeding, it seems reasonable for a woman to rely on lactational amenorrhea with some protection against pregnancy
  - Waiting for the end of amenorrhea before starting to use contraception is not acceptable.

#### Comments:

- These two opinions are not mutually exclusive. Proper LAM counseling includes switching to another method by 6 months.
- However, there is low uptake of LAM, and counseling takes a lot of time and effort for providers.
- Often providers tell mothers to wait for menses to return before using a FP method.
- Most women are actually using LAM and do not know that they are following this method, so the number of women using LAM may be underreported. The group is also not sure where the data comes from, as other sources have reported higher numbers.
- If a woman wants to use breastfeeding as a FP option, it should be done correctly. A 6% chance of pregnancy is not acceptable.
- PP unmet need as defined in the Cleland paper may be better described as “risk of pregnancy.”
- In Mali, MCHIP taught LAM and interviewed midwives on LAM. The midwives said that they always counseled on LAM and it always worked. In other settings where there is less time, this may not be counseled properly, and there also may be providers with doubts about LAM as a modern method.
- The community based approach using community health workers (CHW) has been very effective at teaching LAM.
- Another implication is cost-saving: in countries where there may not be guaranteed access to contraception, proper breastfeeding methods can provide 6 months of protection.
- There is also an issue with determining whose is responsible in the health system for LAM counseling.
- There is a need for training on criteria and efficacy, as well as overcoming mistrust of LAM.
- Information on LAM should always be included in the package of methods made available to women, even if a provider believes that LARCs or other methods may be more effective.
- Is there evidence that linking the transition from LAM and immunization timing is helpful? There is evidence that this is a promising practice rather than a proven practice. FHI360 published a paper in Global Health Science and Practice on this. There is some evidence, but there is also some resistance

from immunization camps, who want to avoid integrating during campaigns to mitigate misunderstanding of immunization.

- How does Zika affect this? This is perhaps an opportunity to promote postpartum LARCs in this environment if resources are available.
- LAM should still be promoted as an option and providers should allow couples to make a decision. The group is in agreement that this should be part of modern contraceptive methods. In addition, there is a need for training, and providers should have correct information.

Follow-up points:

- Devon will send around the [USAID commentary promoting LAM as a modern contraceptive method](#).

### **Using a Participatory Learning and Action (PLA) model to improve the health of women, newborns and children: nutrition and child spacing - Suchitra Rath, Ekjut**

*Session Summary: The objective of this session was to share results from the Ekjut project, which uses a community Participatory Learning and Action model in India to promote MNCH, nutrition, and child spacing. The group was very interested in the program results, which have shown the ability to reach the most marginalized groups and have high impact.*

Presentation:

- Introduction: SPRING is working with Digital Green (DG) on a three arm community video trial. One arm will involve community mobilization, and Ekjut is providing technical support on this arm. Peggy recently observed a community meeting, facilitated by Ekjut, where FP was promoted as part of MIYCN through community theatre and a facilitator. The focus of this meeting was child spacing.
- Ekjut is a civil society organization working with rural, marginalized and tribal communities in Jharkhand, Odisha, Madhya, Pradesh and Bihar in India, and uses a PLA model.
- Definition of community mobilization: “A capacity building process through which community members, groups or organizations plan, carry out, and evaluate activities in a participatory and sustained basis to improve their health and other conditions, either on their own initiative or stimulated by others.”
- The meeting cycle involves 4 phases, described below.
- Phase 1: Identify and prioritize problems by understanding current practices, identifying maternal and newborn problems, and prioritizing problems to address through the “voting game.”
- Phase 2: Plan strategies by listening to stories presented by community facilitators. Discuss implications and decide upon indicators and a larger dissemination strategy. This model involves meeting groups of 20-25 participants who disseminate their findings to other villagers.
- Phase 3: Put strategies into practice by assigning responsibilities and measuring progress. In the third phase, participants are provided with information and messages to implement strategies properly.
- Phase 4: Evaluate together by sharing challenges and successes. This stage includes a wider dissemination meeting.

- Evidence of impact on newborn mortality from 3 studies on PLA:
  - 2005-2008 The Ekjut Trial (cRCT) – 45% reduction in neonatal mortality rate (NMR)
  - 2008-2011 Replication in Trial Control Areas – 35% reduction in NMR
  - 2010-2012 PLA through ASHAs (cRCT) - 178 Accredited Social Health Activist (ASHAs) conducted meetings in 5 districts. 32% reduction in NMR, especially in the most marginalized group (71% reduction), where impact is highest. 36% reduction in MMR.
- Summary of 3 studies:
  - Newborn mortality reduction significant
  - Worked in high mortality underserved settings
  - Poorest/marginalized saw highest gains
  - PLA impacts are sustainable
  - Facilitators can be a range of actors
- Other systematic reviews/meta-analysis shows similar outcomes for MMR and NMR.
- A possible mechanism for these findings is that when women are well informed, they are more likely to seek help for obstetric complications.
- The Community Action Research to Improve Growth and Nutrition (CARING) in Rural India uses both home visits and participatory group meetings, and used mobile phones for data collection rather than paper questionnaires.
- During Home Visits: There is at least one visit in the 3<sup>rd</sup> trimester and then a visit every month until the child is 2 years old. The facilitator uses MUAC and counseling cards (in Hindi and Odiya) and demonstrates food preparations, hand washing, etc.
- Women's Groups Meetings: These follow the PLA phases. Prioritized problems included closely spaced pregnancies. Facilitators talk about locally available contraception and discuss the disadvantages and advantages of different methods. All of these meetings are open to all. The meeting Peggy attended included adolescent boys and girls as well as adult men and women.
- One group per 500 population is optimal.
- The Ekjut Trial was published in the Lancet and received the Trial of the Year Award in 2011. The group has WHO endorsement and received the WHO Health Champion award in 2015.
- PLA grew out of the Warmi work in Bolivia and the PDCA (Plan Do Check Act) cycle as a foundational element of this work and CAC (community action cycles).
- This method really reaches the most marginalized populations, which not many methods have successfully done.

#### Questions and Discussion:

- How does Ekjut engage adolescent girls? Are there separate groups with adolescents and is something Ekjut has considered for future programming?
  - All meetings are open for all in the community. Members who attend PLA groups disseminate the information they learn. There are not separate groups yet, but Ekjut will start some separate groups using the PLA approach for improving adolescent health and nutrition.
- Will Ekjut put together a toolkit for this approach?
  - This is no standardized curriculum, but Suchitra shared a module with Peggy that was developed for the Government of Odisha.

- Were facilitators ASHAs?
  - This depends on the trial. In one trial, ASHAs were used as facilitators. In another trial, they used other facilitators from the communities, even men. Facilitators are appointed by being nominated by the community.
- In places where facilitators were not ASHAs, are there supervisors or mentors for community-based facilitators?
  - Yes.
- In the trials before 2012, Ekjut followed up after a year and saw that there was continued change. USAID is not often able to support research into ongoing change. Where has funding come from?
  - Previous research was supported in part by The Gates Foundation, as was the Caring Trial. The Ekjut Trial was funded by Health Foundation, the Replication Trial was funded by PLF (Pick Lottery Fund), and the CARING trial was funded by MRC/DFID/Wellcome Trust. The Digital Green trial is Gates Foundation-funded. Peggy will share Audrey Post's email; Audrey is from the London School and has helped with some of the design of these RCTs.
- Regarding the skits and prioritization and voting of topics, are skits performed before voting for all topics or do participants vote based on background knowledge?
  - The Ekjut team does some formative work to determine existing problems and makes a list of these. There is also a blank card during voting for other problems that were not included on the predetermined list. The participants vote on these problems, and the voting process allows the community to own the process. Participants listen to the skits for chosen problems and determine the root causes and strategies; this is not dictated by a presenter.
- For the Gates RCT, how does Ekjut plan to merge or synergize the community based methods?
  - The current DG model may not be as inclusive to reach the most marginalized or mothers in the 1000 days. In adding the PLA model, it is hoped that the PLA process will determine the video content, and may help to be more inclusive.
- Once indicators are chosen, how are they tracked, and what role does literacy play in this process?
  - There is prospective data collection throughout the study period, for example, a community that is working on childhood undernutrition. There is formative research with focus group discussions, key informant interviews, and stakeholders to determine problems linked to childhood undernutrition. Problems are identified and prioritized in the first phase to engage members in discussion. Phase 4 has around 1 or 2 meetings, where participants decide which strategies were effective, where there were challenges, and which strategies should be carried forward. At the evaluation meeting, the community votes on the best method (shown on slide 12 with rock voting).
- Comment: "Women are not vessels that we fill." This model is really about facilitation.

#### Follow Up Points:

- Peggy will share Audrey Post's email.

## Update on LAM Commentary – Kristina Granger, SPRING

***Session Summary: The objective of this session was to give the group an update on the LAM Commentary, which is being prepared by a small group from among the MIYCN-FP group. Anyone interested in reviewing the current version can reach out to Kristina Granger do so.***

- Within this working group, there is a smaller group that is focused on reinvigorating the promotion of LAM between the nutrition and family planning communities.
- The group has developed a very short commentary on promoting LAM. This activity was undertaken before the Lancet series, and is going to be targeted to the Lancet Global Health journal, which accepts commentaries of up to 800 words.
- The promotion of LAM falls in both MIYCN and FP camps, so the group wanted to target this to a journal that appeals to both audiences.
- The group has produced many drafts over the past 8 months. Anyone interested in reviewing the current version can do so.
- The group would like cross promotion if the commentary is published, and may create a social media toolkit with talking points.

## Updates on the Progesterone Vaginal Ring (PVR) – Heather Clark, Population Council

***Session Summary: The objective of this session was to brief the group on the PVR, as well as the most recent results of acceptability and willingness to pay studies, and seek group feedback potential areas for integration. A number of potential integration points and areas for further study were identified, and the results of the study will be shared with the group when published.***

### Presentation:

- The PVR is user-controlled, flexible, and made of silicone. It can be used for 3 months before replacing, and diffuses natural progesterone (less than one would receive on a birth control pill). Four rings can be used successively for up to 1 year postpartum. It is self-inserted and removed (a clinician instructs for the first insertion, and a patient self-inserts before leaving the clinic).
- The PVR prevents ovulation and extends postpartum amenorrhea.
- It is safe for breastfeeding mothers and infants and is up to 98% effective if used correctly.
- Side effects include: vaginal discharge, bleeding, abdominal pain and discomfort. If a woman feels the ring, it is inserted incorrectly and needs to be inserted farther.
- Benefits: It is safe and easy, user-controlled, lengthens birth intervals, and promotes breastfeeding and infant health (a woman must BF 4 times/day for this to be effective).
- There is potential for integrated service delivery with an application of the continuum of care approach, integrating promotional materials and counseling services along with EBF, etc.
- The ring contains only progesterone, so to be effective woman needs to continue to breastfeed. This adds to the effect of progesterone, which alone would not prevent pregnancy. After 6 months, the chances of fertility returning after 6 months increase. The required breastfeeding frequency is 4 feeds

within a 24 hour period. This is the minimal amount promoted and may encourage women to breastfeed at this frequency.

- PVR was added to WHO guidance documents and the WHO prequalification process has been initiated by the manufacturer.
- PVR is manufactured by a company in Chile and registered as Progering in 8 LAC countries.
- Acceptability and Willingness to Pay studies have been completed in 3 African countries (Nigeria, Kenya, Senegal). They are also in Phase 3 clinical trials in India comparing the PVR to the IUD (results currently being written). Registration in Nigeria is likely in 2016.
- Acceptability Studies:
  - Prior evidence on Ring Acceptability: Positive features include ease of use, new technology, convenience, user control, high satisfaction. Concerns include hygiene, potential need to clean ring, expulsions, removals. Uncertainties include partner response, women's reluctance to touch genitalia for FP. Unknowns include service provision requirements, including feasibility, provider training, etc..
  - Acceptability Universe: Women, partners, providers, community policy makers, etc.
  - Study design: Women 6-9 weeks postpartum, 18-35 years old, who were presented with a range of FP options. If a woman chose PVR, informed consent was sought and screening was conducted. The study enrolled 58 PVR users and 58 non-users in each country. The study included in-depth interviews with 5 PVR users and their husbands.
- Profile:
  - 20-29 years old, urban or peri-urban, secondary or university, married or cohabiting, 42% not working.
  - 92% had discussed pregnancy spacing with their partner. 80% wished to space more than 2 years. 50% had never used a FP method.
  - Reasons for PVR choice: 35% user controlled, 31% few side effects, 10% short-acting, 6% aided breastfeeding (encouraged BF continuation), 6% easy to use. This was a closed-choice questionnaire.
- Acceptability at 3 and 6 months:
  - Only 4% at both 3 and 6 months reported expulsion (in most cases reinserted).
  - Around 50% at both 3 and 6 months felt the PVR slipping and pushed it back in.
  - At 3 months (62%) and at 6 months (87%) never felt PVR during sex.
  - Most reporting no change in frequency of sex and no change in sexual pleasure.
  - Regarding future intentions, at 6 months 96% likely to use, and at 3 months (87%) and 6 months (98%) would recommend PVR.
  - Providers did mention that their partner may feel the ring, so most discussed this with their partner.
  - At 6 months 90% said that the family supports PVR use.
- Conclusions:
  - Profile: new and young users.
  - PVR is acceptable to women and partners.
  - Women have no problem inserting or using.
  - Men support PVR.
  - There are a limited number of expulsions and slippage.
  - There is no issue regarding hygiene.



- Women were instructed that, if desired, they could remove the PVR for up to two hours, rinse and re-insert. If removed for more than two hours, the women were not permitted to continue use. This is consistent with the packaging instructions for the product in LAC.
- Willingness to Pay (Senegal):
  - The study involved 3 groups of stakeholders (consumers, providers, and procurers) across 3 sectors (public, private non-profit, private commercial).
  - The price range is \$3-5 per ring, but this is an evolving price point. Right now, the volumes produced are quite low. If this is introduced in Nigeria, India, and Mexico at the same time, it may change the price.
  - Is there an attempt to introduce PVR in developed countries, which may subsidize rates? In many developed countries, the market for women who follow these breastfeeding practices would be very low.
  - Would breast pumping impact the efficacy of the ring? This has not been studied. The mechanism is perhaps different, but there is no evidence as of yet.
- See slides for results of the Willingness to Pay study.
- Currently, Population Council is focusing on service delivery, curriculum development, and assisting with registration and WHO prequalification.

#### Questions and Discussion:

- One concern is that PVR may discourage LAM or EBF if women only believe they need to breastfeed four times a day for PVR; it may cause women to move away from EBF.
- Communication tools generated around PVR could include a generic package that needs to be adapted for local contexts with local graphics. There will be global and more localized messaging.
- The FP Practice journal wrote an article that educated women favor longer acting contraception, and this method targets women with discretionary spending.
- Is the diaphragm still used, or available? Caya manufactures these, and wants to move into lower-resource setting markets and expand availability. This has been approved for use with a gel. The diaphragm with a gel may be preventative for HIV. Eventually, contraceptive rings and prophylactic rings for HIV and STDs should be combined, which could lead to a range of options for women's needs.
- The NuvaRing needs to be refrigerated, so it is not a great option for these countries. There is another ring, going through FDA approval this year, that has both progesterone and estrogen, can be used for a year, and does not need refrigeration. This could be an option for transition if the ring is desirable for women. This transitioning could be potentially incorporated into service delivery and messaging.
- What are the points of contact for MIYCN-FP integration? A woman can insert the ring at 4 weeks, and the study target population was 6-9 weeks to reach women coming to the health center for immunization. It is likely that not every woman received FP information after delivery, so this was targeted to occur during the well-baby visit. The rural populations do not often go in for well-baby visits. A point of integration could be home visits from Community Health Workers in rural populations. This could be targeted for 6 months postpartum and transitioning from LAM. The 6 months mark is very academic and often has little meaning to mothers, so it could be tied to the

introduction of complementary food. In India, there is a visit from the community health worker and ceremony around the introduction of complementary food.

- Does the ring extend LAM, postpartum amenorrhea, or lactational amenorrhea? We need to be cognizant of wording: this is not replacing LAM, this as a lactational amenorrhea-extender. This does not extend the LAM *method*, but extends lactational amenorrhea. This may need to tie into discussion around the rebranding of LAM, because it is often misunderstood. Language is very confusing: there is LAM, which is the 3 criteria method, there is just breastfeeding, and there is lactational amenorrhea. This may need to be discussed in the LAM commentary and wording around this should come out of some of the language women are using now.
- This could also be a method that women choose, with or without LAM. This is not effective without breastfeeding, but can be used with or without LAM as a method.
- Whatever is included in the definition of LAM, it is important to not lose stakeholders in the BF community. Communications need to occur around marketing and promotion of LAM. When LAM was defined there were some issues around naming it, and there are still issues around understanding and promoting it.
- Is there any danger to using the ring if a user were pregnant? The amount of progesterone is so low that it would not be dangerous for pregnancy.
- Would it be dangerous to accidentally insert two rings? There is no evidence of this.
- Do women return at 3 and 6 month marks to get the next rings? This is one of service delivery topics Population Council is considering. This may be on a country-by-country basis. Rings could be sold by a pharmacy or CHW, but first insertion needs to be done with a provider who can provide counseling and ensure correct placement. In LAC, the ring is sold in pharmacies. This depends on post-marketing surveillance and country regulations. Women are expected to remove the ring themselves.
- After the study is there any thought of doing a reminder video for users? This could be on a mobile phone, but would depend on the setting. In clinics the study worked with, it may not be feasible to show a video. In these clinics, women were receiving information about family planning in the waiting room while waiting to see a provider. But this is a good point, and Population Council will think about ways to introduce information electronically and through other means. Everyone in the study seemed to have a cell phone, so something like this may be possible.
- Is there consideration for piloting this at a more community-based level? This would be great. Currently, there is no funding available. This also depends on the regulations within each country around who can provide and sell the product.
- The India study is also looking at nutritional outcomes with the PVR and the copper IUD. This looked at infant weight to show effect(s) on infant health. These results are still being written. Once these are published, it would be great to discuss in this group.
- Progesterone only methods can sometimes reduce milk supply, but there is no effect on this with the PVR.

Follow-up Points:

- The results of the India PVR study, once written, would be great to discuss in the MIYCN-FP group.

**Whiteboard Video on Family Planning and the SDGs – Liz Tully, K4Health**

*Session Summary: The objective of this session was to view the video with the group and discuss it. K4Health is available to produce future videos if needed, and can help with any ideas to share knowledge and results from this group.*

- [Link here.](#)
- Sarah Fohl will be attending these meetings for Liz moving forward.
- If the group has any ideas to help share knowledge and results, K4Health would like to help. There is also a LAM toolkit that was created and has not yet been utilized. Could this be integrated as a section within the MIYCN-FP toolkit?
- This video was very well-received at the FP meeting in Bali.
- The group could also create a video on LAM; those interested can talk to Kristina.
- K4Health is a service provider for USAID projects and can provide assistance in-kind, through their role on this working group.
- K4Health has a software to produce these videos. Liz can create a draft within a couple of days.
- How FP helps the SDGs is often discussed, but people do not often talk about how FP fits within integrated development.
- The mandate of the SDGs is to reduce poverty, which is akin to a mandate for integrated development.

Follow-up Points:

- Can the LAM toolkit be integrated as a section within the MIYCN-FP toolkit?
- Those interested in working on a LAM whiteboard video can follow-up with Kristina.

**Brainstorming Session: Roadblocks to Integration and Opportunities for Working Group – Agnes Guyon, SPRING**

*Session Summary: The objective of this session was to brainstorm integration barriers and determine how the group can foster integration moving forward. Some “roadblocks” include “stove-piping” of programs, CHW capacity, measurement issues, and miscommunication. Some opportunities include donor education on flexible funding, joint work-planning, advocacy, and evidence around value-added of integration.*

What are the road blocks for integration of FP and nutrition?	How can we foster FP nutrition integration in our programs?	Action points/follow-up items for the working group
-“Stove-piping” of programs -Programmatic & Funding (administrative streams different) -Limited resources (funding) -Streams of funding for	-Advocacy – donors (governments) -Donor education on the importance of flexible funding -Identifying champions within	-Many champions across USAID Feed the Future to be tapped -Expand WG members (ex: Food for Peace) -FP Voices (a channel to share)

What are the road blocks for integration of FP and nutrition?	How can we foster FP nutrition integration in our programs?	Action points/follow-up items for the working group
Nutrition/FP/FS -Donor funding/priorities -Capability of health systems (continuum of care) -Limited donor/vision/funding (priorities) -Vertical funding streams creating different incentives for donor managers and implementing organized -Donor closed-mindedness	donors & supporting their efforts -Invest in creating tools aimed at donors -Within USAID-funded and other donors, including integration of FS, Nut, FP, etc. (similar for FFP) -Funding for integration	
-HW understanding willingness to counsel (FP and or Nutrition) -Community/facility Linkages (or lack thereof) -CHW capacity (can they do everything) -Many things to integrate and methodological	-Develop clear integration strategies & program approaches -Joint work planning review (for service delivery integration) -Context for services, deliverers understand HW comprehension -Pre-services for HW in counseling/interpersonal communication -Building it deliberately into objectives, workplan, etc. -Mapping of points of integration and referencing specific approaches of tools (interactive tool-link to behavior) -Emphasize common outcomes/identify entry points/capitalize on continuum of care –target to decision makers	-Share existing Case studies -Sub-group (#1-0 Frame messages to audiences) -Social media Strategy -MCSP/SPRING (could we hire an Intern for this ?)
-Local staff to support/champion integration	-MICYN-FP Advocacy (Webinars to accommodate global staff)	-Operational research include into existing projects -Webinar for toolkits -Discussion Forum -Core Group Meeting -Organize multi-donors forum with interest

What are the road blocks for integration of FP and nutrition?	How can we foster FP nutrition integration in our programs?	Action points/follow-up items for the working group
-Nutrition sensitive focus (Ag focus, etc.) = not including FP -Measurement issues	-Inform existing platforms that address nutrition sensitive programming to more consistently include FP	
-Miscommunication between our communities - Expertise training in each specialized; divergent fields with public health	-Evidence on value added of integration -Expand/recruit new members to TWG -User-Informed program design -Invest in building the evidence (does integration make a difference) -Test and validate new integrated indicators (and advocate for incorporation into finding mechanisms) -Demonstrate cost-benefit of integrated programs -Expand/recruit new members to TWG	-SUN high level consultations -Effectiveness of different implementation design -Define a list of common indicators -FTF/FFP indicators FP

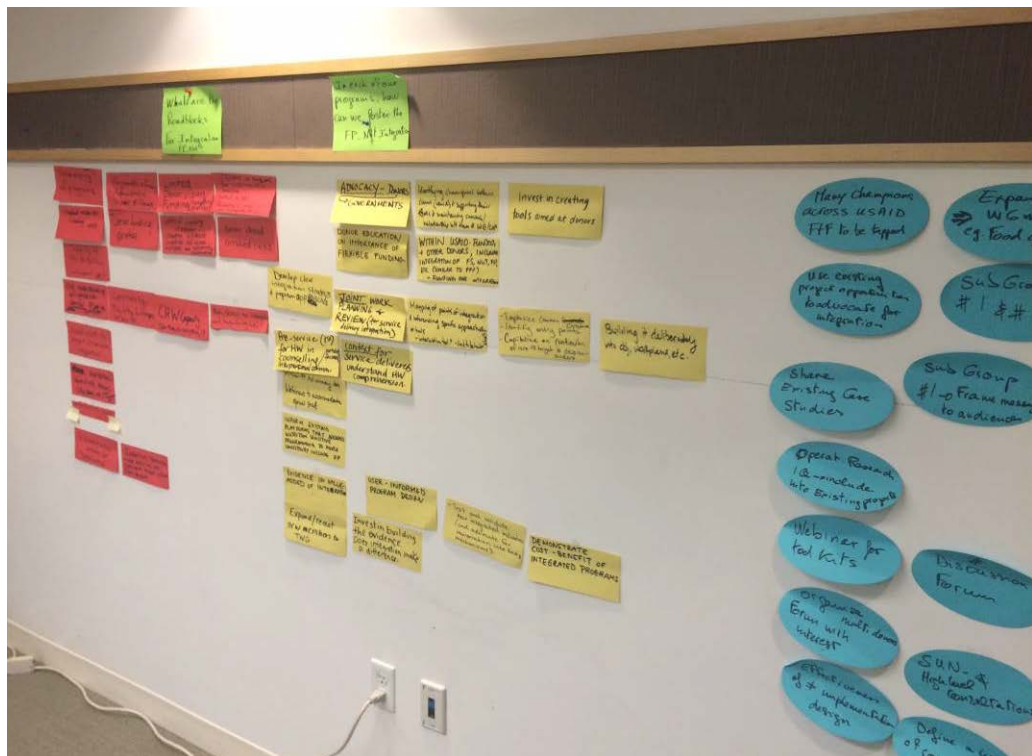
Follow-up:

- Reach out to Feed the Future colleagues for the next meeting (Linda Sussman has contacts)
- There are two page briefs (there in the toolkit)
- Documentation Dissemination

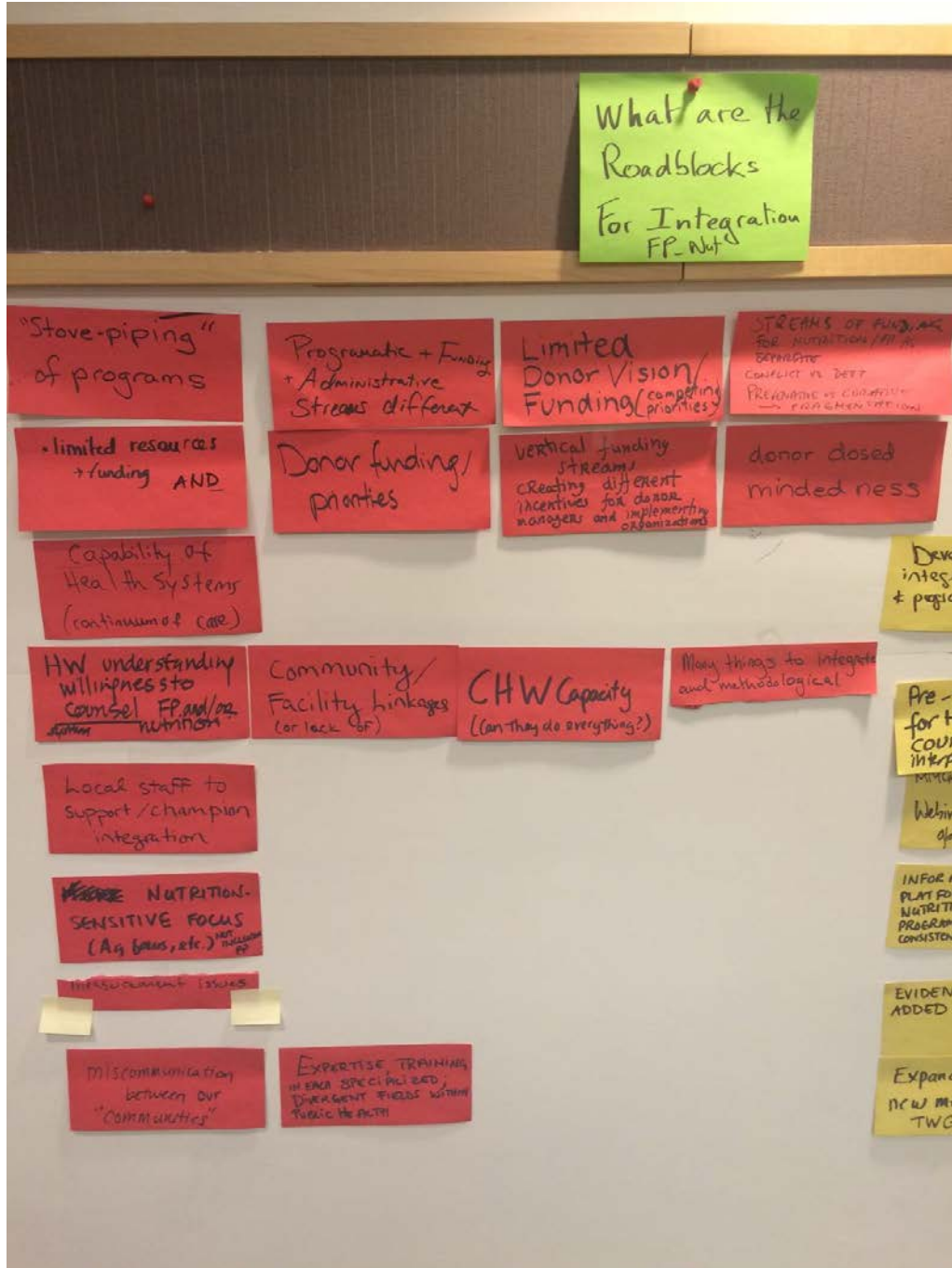
Parking Lot:

- LAM technical consultation
- Cross-promoting as part of a sustainable development
- Rebranding LAM

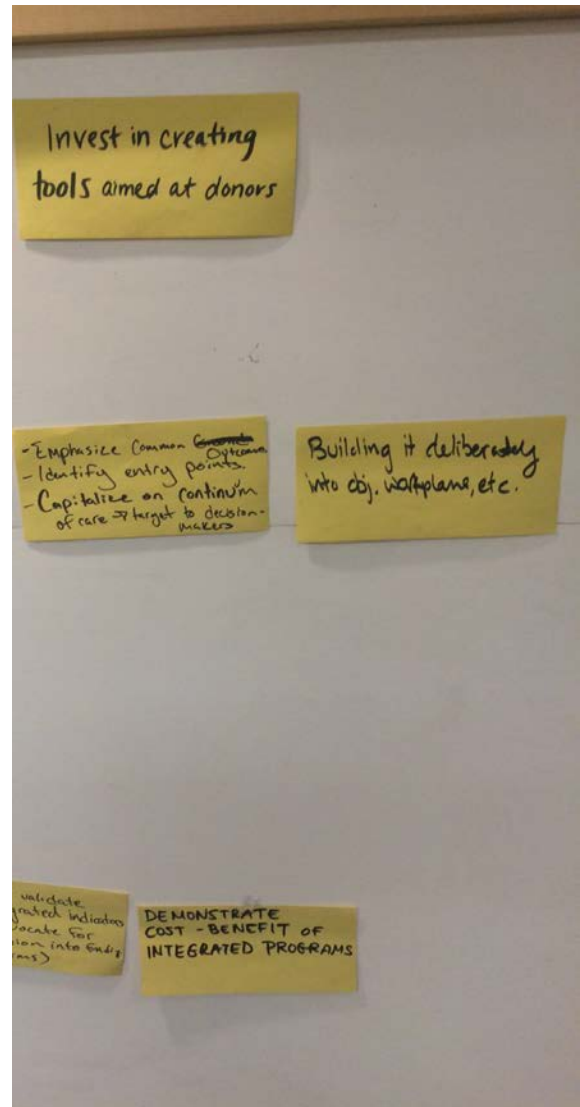
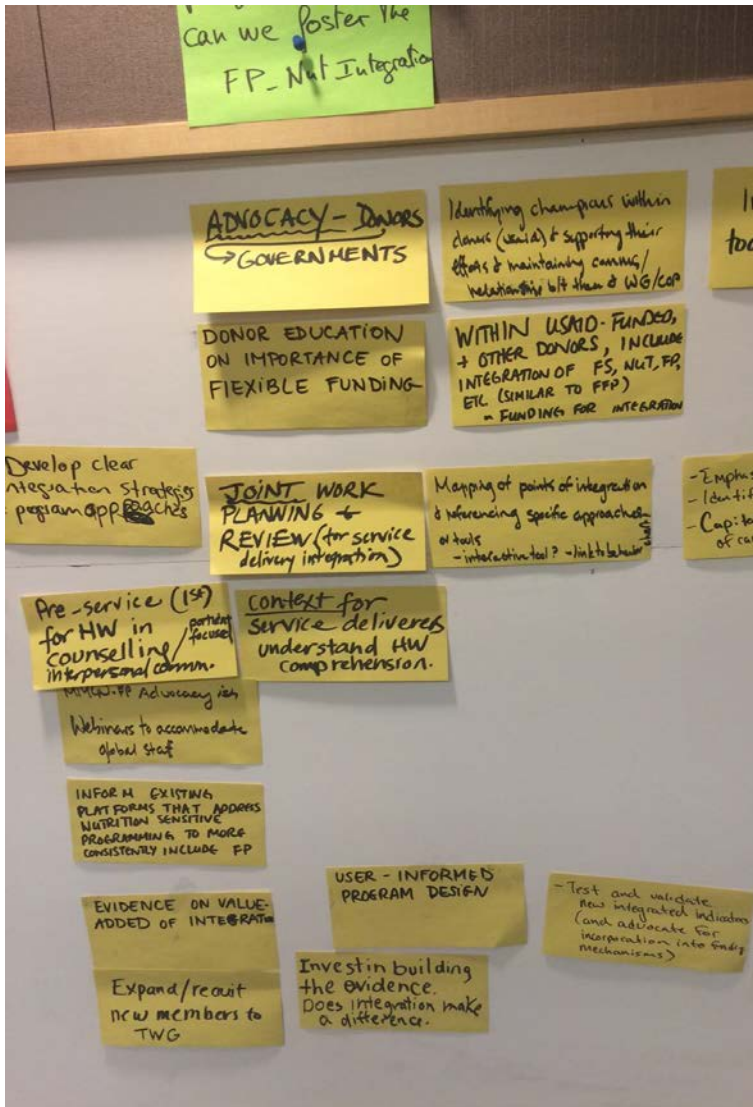
## Annex: Photos from Brainstorming Session



What are the road blocks for integration of FP and nutrition?



How can we foster FP nutrition integration in our programs?





Action points/follow-up items for the working group

