

## MIYCN/FP Integration Working Group Meeting Notes

October 8, 2014 | 9:00 am – 3:00 pm | JSI Office

### Attendance

---

31 people from 17 organizations participated in the working group meeting.

- 1) Mona Bormet – Christian Connections for International Health
- 2) Laurie Winter
- 3) Elaine Charurat – MCSP
- 4) Joan Jennings – Save the Children
- 5) Sanjanthi Velu – Johns Hopkins University
- 6) Judy Canahuati – USAID/DCHA/Food for Peace
- 7) Marjolein Moreaux – SPRING
- 8) Melanie Sie – USAID
- 9) Heather Chotvac – PSI
- 10) Kristina Beall – SPRING
- 11) Sadie Healy – Jhpiego/MCSP
- 12) Elizabeth Sasser – Jhpiego
- 13) Ghada Khan – GWU
- 14) Albertha Nyaku – PATH
- 15) Devon Mackenzie – MCSP
- 16) Nancy Harris – JSI
- 17) Kellie Stewart – USAID
- 18) Peggy Koniz-Booher – SPRING
- 19) Lisa Nichols – Abt Associates
- 20) Hannah Merchant – JSI/APC
- 21) Vanessa Mitchell – JHU
- 22) Leah Elliott – FHI360/APC
- 23) Stacey Lissit – PLAN Intl USA
- 24) Cori Mazzed – Childfund Intl
- 25) Justine Kavle – PATH
- 26) Clifton Kenon Jr. – USAID
- 27) Anne Pfitzer – MCSP
- 28) Elizabeth Tully – JHUCCP/K4Health
- 29) Holly Blanchard – MCSP
- 30) Chelsea Cooper – MCSP
- 31) Heather Forrester – E2A

## Highlights

### Welcome & Review of Minutes from Previous Meeting – Peggy Koniz-Booher and Kristina Beall, SPRING

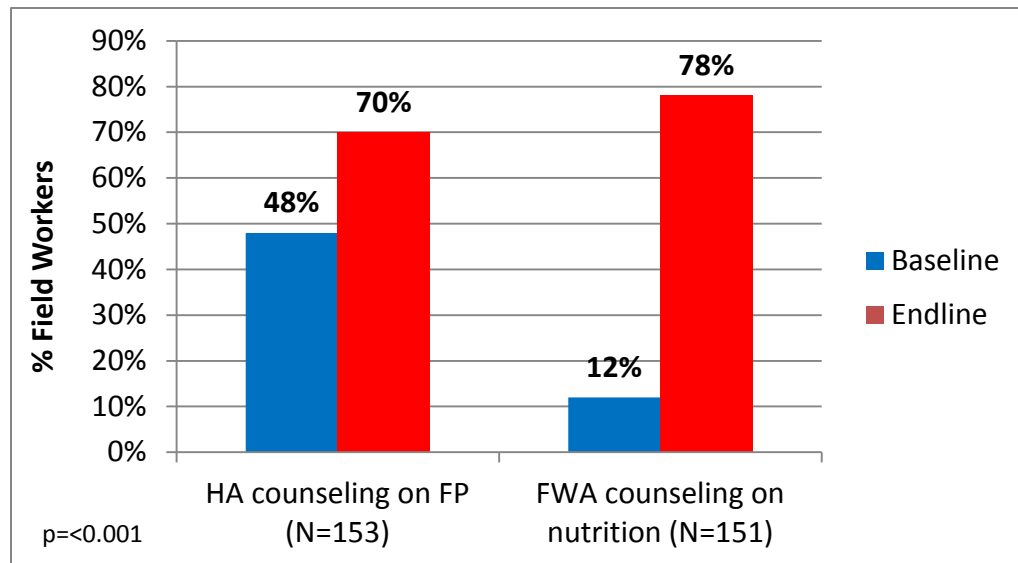
- Welcome to all the working group members attending the meeting
- Overview of working group – rotates between SPRING at JSI and MCSP at Jhpiego
- Meets roughly every six months
- Review of meeting minutes from last meeting (see previous meeting notes) – big push from last meeting was revamping the MIYCN-FP Toolkit for presentation at the CORE group spring meeting

### Lessons from the Field: Bangladesh Knowledge Management Initiative (BKMI) – Vanessa Mitchell, Johns Hopkins University

- Background and overview of program and objectives:
  - USAID-funded project started in 2011 under K4Health; transitioned to being under the Health Communication and Capacity Collaborative (HC3)
  - Objective: strengthen health, population, and nutrition (HPN) strategic behavior change communication and knowledge management initiatives in Bangladesh – build capacity to design and implement SBCC activities at national and community level
  - At national level, working with three units in the Ministry of Health – health education, family planning, and nutrition unit
    - Each unit in its own silo and separate from the others, FP is in its own directorate
    - Health Population and Nutrition Sector Development Plan in place but not being implemented
    - Placed three advisors in each unit to build SBCC capacity; created cross-sectoral BCC working group; hold HPN coordination meetings every two months with the three units
- HPN alignment workshop in November 2012 identified the following target outcomes:
  - Harmonization (coordination) of BCC/IEC messages, activities and national policies
  - SBCC Capacity Development to nurture a high performing workforce for SBCC, from grassroots to policy
  - Community Engagement (audience focus) to ensure that activities reflect the community's needs and priorities
- eHealth pilot project: HPN e-toolkit with job aids, leaflets, posters, and other BCC materials
  - Gold-standard package of HPN integrated resources, vetted by the MoH
  - Disseminated to 300 field workers on netbooks to provide up-to-date HPN information, skills building in counseling, and videos for counseling
  - Cadres of field workers:
    - Health Assistants are FWs that counsel on general health but not on family planning
    - Family Welfare Assistants (FWAs) are FWs that focus on FP only

- Results:
  - Field workers' knowledge levels improved across HPN, empowerment and confidence increased, integrated messaging skills improved

### Integrated Messaging by Field Workers



- Mothers more likely to seek HPN info from field workers, HPN knowledge levels improved, behavior change in complementary feeding
- Challenges: Staff turnover, prioritizing coordination across silos, how to keep the resources on the tablets updated as time goes by
- Next steps: Continue to build SBCC and KM capacity, begin planning HPN BCC national campaign, advocate for integration within each unit's 5-year operational plans, develop an M&E system for integrated indicators, and scaling up digital resources on a national level (MoH to provide 24,000 tablets to HAs)
- Q&A:
  - **Comment:** The project has done a good job fostering Ministry ownership; SPRING has a project in Bangladesh and staff refer to this initiative as a Ministry of Health activity not a BKMI activity.
  - **Q:** The MaMoni project encountered a lack of traction with LAM at Ministry level, has that been the experience with BKMI? **A:** There has been more discussion within the MoH on LARCs and PMs, though exclusive breastfeeding is also at the top of the agenda.
  - **Q:** What integration indicators are currently being tracked? **A:** We are not at the point yet where we are able to track this, though currently working on developing indicators and integrated BCC campaign at the national level will require those indicators.
  - **Q:** If both workers can integrate this messaging, could they go down to just one worker instead of channeling different topics through different community workers? **A:** It is more of a political issue since the field workers stem from different units in the Ministry, more advocacy needs to be done.

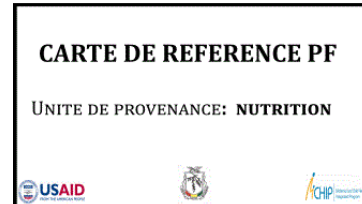
- **Q:** Can you describe the process used to validate use of the notebook and field worker understanding of the content, communication to the community? **A:** Conducted course assessments (multiple choice questions) and tracked scores at different points throughout the pilot, and scheduled observational visits to observe counseling.
- **Q:** How did you measure increase of knowledge in FP and nutrition among field workers? **A:** We asked technical questions at both pre and post-test.
- **Q:** How did you encourage the government to get so motivated that they wanted to purchase tablets and scale up at the national level? **A:** We put the Ministry at the forefront of everything we did – they were present in the field during monitoring visits, gave presentations, and were part of the whole process from development of instruments to collect pre and post data and vetting materials for the toolkit to helping write scripts for the e-learning courses. They received a lot of press and visibility which has helped in advocating for scale-up.

**Introducing Demand Generation I-Kit for Underutilized, Life Saving Commodities –**  
Sanjanthi Velu, Johns Hopkins University

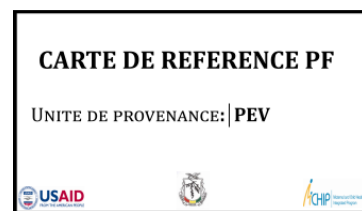
- Toolkit will help partners develop comprehensive SBCC strategies to increase demand for RMNCH commodities. Aim is to provide resources and tools to help Ministries of Health, NGOs, CBOs and other implementing partners in country, who may lack the resources, skills, staff or training, to develop and implement SBCC strategies for these commodities.
- Provides tools to develop communication strategies and materials and adapt and integrate content on 9 priority life-saving commodities (out of 13 identified by the UN Commission on Life Saving Commodities for Women and Children). Also contains four cross-cutting guides on incorporating gender, media selection, using ICT, and public-private partnerships.
- Members of the working group are encouraged to share the I-Kit with their implementing partners and any other stakeholders who may be interested and who might need to develop demand generation strategies for these commodities.
- Next steps: a virtual dissemination package is being developed and will be shared with the members of this working group next month, with a request for them to share with colleagues.
- Comments:
  - Iron and folic acid not included, but is a continual problem
  - The MIYCN-FP working group should consider focusing more on ORT and zinc and integrating that as well, since diarrhea has a large impact on nutritional outcomes
- For more information on the Demand Generation I-Kit for Underutilized, Life Saving Commodities, please contact Sanjanthi Velu ([svelu1@jhu.edu](mailto:svelu1@jhu.edu)) or Heather Chotvacs ([hchotvacs@psi.org](mailto:hchotvacs@psi.org)).

**Lessons from the Field on EPI/Nutrition/PPFP Integration: MCHIP Guinea – Abdoulaye Diallo, Jhpiego, Guinea**

- In Guinea, integration began in 2011 in collaboration with the MoH, with PPFP services integrated in several service delivery areas: Delivery ward, ANC, nutrition, and EPI units
  - Developed training and data collection tools
  - Trained providers from EPI and nutrition units
  - Conducted follow-up training visits
  - Collected and analyzed routine data



- Integration processes with clients:
  - Group educational sessions or individual counseling used to discuss PPFP with women in both EPI and Nutrition units; provider asks woman if she is ready to receive more information
  - If client is interested, referral card given to client after vaccination and nutrition services and she is directed to the FP unit where she is counseled on PPFP and offered a method
  - Records captured in EPI, Nutrition, and FP units



- Process findings from seven health facilities in Conakry (Oct. 2013 – June 2014):

	Total # of mothers accepting FP referrals	# (%) of mothers accepting FP referrals who went to the FP provider that day	# (%) of mothers accepting FP referrals who went to the FP provider and accept an FP method that day	Total # (%) of LARC
<b>EPI unit</b>	<b>195</b>	<b>177 (91%)</b>	<b>125 (71%)</b>	<b>55 (44%)</b>
<b>Nutrition Unit</b>	<b>155</b>	<b>135 (87%)</b>	<b>86 (64%)</b>	<b>22 (26%)</b>
<b>TOTAL</b>	<b>350</b>	<b>312 (89%)</b>	<b>211 (68%)</b>	<b>77 (36%)</b>

**3117 women received information on PPFP at EPI/Nutrition unit**

- Results of integration: Comparing new contraceptive users by month (Oct 2012- June 2013 vs. Oct 2013- June 2014), average rate of increase was 57 new clients per month (3% contribution to FP uptake), though Ebola outbreak has led to reduction in new contraceptive users. The % of LARC (36%) corresponds to the overall percentage of new users (LARC) in the MCHIP project supported health facilities in Guinea.

- Q&A:
  - **Q:** We could see that the Ebola outbreak was a big constraint, what is the program currently doing to try to mitigate that issue? Is the issue that healthcare providers are pulled away from their routine services, clients are afraid to come to facilities, stock-outs...? **A:** We provided healthcare providers in our supported facilities with mobile phones and have been conducting supportive supervision via mobile phone to get regular information. FP commodities are available but yes, clients are afraid to come to public facilities due to the Ebola virus, they are either going to private clinics or staying home. There is the fear that if you go to the hospital, they will kill you. Even the health providers themselves are afraid to go to work, leave early. Jhpiego is also working with the MoH in the fight against the Ebola Virus Disease outbreak by reinforcing the infection prevention practices at the health facility level.
  - **Q:** How was the three-day integrated training you mentioned organized? **A:** We conduct training on PFP counseling and train trainers, then make sure that providers in the different units are identified in collaboration with the MoH for training. We emphasize that women don't always come to the hospital for their own sakes, they often come for the child, so their entry point to the facility may be the EPI or nutrition units. We make sure that these units are communicating FP info.
  - **Q:** On the referral cards, they seem like they are at the facility level. Are there any referral linkages at the community level? **A:** The referral cards are accepted within the health facility and in fact providers accompany clients to the family planning unit.
  - **Q:** What are your thoughts on why there are a lot more referrals originating in EPI as opposed to Nutrition? **A:** The main entry point is actually EPI; a woman receives a message/referral card at the EPI units, then may travel to the Nutrition unit after but does not get an additional referral card if she already has one. Another issue is with record-keeping to ensure that these records are properly documented. Many clients after being counseled do not adhere to an FP method on the same day, they go home first to share FP information with their husbands or friends before making any decision.

**Group Think: Revisiting Communication Approaches for LAM + Transition** – Chelsea Cooper, Elizabeth Sasser, and Holly Blanchard, MCHIP

This session included an initial review of recent literature on LAM and transition. Reflecting on the challenges identified in the literature around LAM and transition and participants' own programmatic experiences, the group brainstormed barriers to practice of LAM and timely transition, motivators for optimal practices, and optimal communication platforms for reaching women, families, and gatekeepers.

The MCSP team then presented a conceptual model developed based on global learning, to inform their work on reimagining communication approaches for PFP/LAM, return to fertility, and nutrition in Tanzania. It was decided that the SBCC sub-group would also take on further discussion about reimagining communication approaches to respond to the challenges/barriers.

- Review of recent literature on LAM and timely transition to other modern methods (see notes from previous working group meeting)
  - **Q:** How do you track and capture LAM as a method at the facility level?
  - Comment: It is an issue since LAM is not a commodity, can't count it the way you can count provision of CycleBeads, for example.
  - Comment: Indeed, in some countries, the national HMIS does not track LAM at all, or it is grouped in with traditional methods. Unless that changes, we are not going to be able to get good data.
  
- Brainstorming: How to encourage mothers to practice optimal LAM + transition? E.g.:
  - Practice HTSP **and** healthy infant feeding
  - Understand risk of pregnancy when offering other nourishment besides breast milk
  - Transition as soon as (or before) complementary feeding begins
  - Encourage health workers to proactively and routinely offer PFP during MNCH contacts
  - Encourage husbands, mothers-in-law to support continuation of BF and using FP
  
- Barriers to practice of optimal LAM + transition:
  - Provider bias; LAM not perceived as effective
  - Lack of understanding about return to fertility and pregnancy risk after delivery; lack of knowledge of LAM criteria
  - Social norms around large family size; son preference
  - Fears that breast milk is insufficient
  - Time required for exclusive breastfeeding
  - Fear that hormonal methods will affect breastfeeding/breastmilk
  - Lack of support from spouse/family members
  
- Motivators for the practice of optimal LAM + transition:
  - LAM is free
  - Health benefits for baby as well as mother
  - Culturally acceptable and religiously acceptable
  - Does not require direct permission from husband
  
- Platforms for communicating about LAM + transition:
  - Mobile phones, SMS, eHealth, Mass media, community video
  - Mother/breastfeeding support groups
  - Grandmothers' and men's groups (PATH and Save the Children have worked with grandmothers)
  - Community health worker home visits
  - Community mobilization meetings
  - Health facility providers
  - Savings and loans groups
  - FBOs and religious leaders
  - LAM ambassadors/champions

- Discussion and suggestions
  - Follow-ups at 6 weeks are encouraged for methods like PPIUD; could do similar for LAM to take down contact info and find out how it is going, encourage women to transition when needed
  - Targeted SMS or voice messages at various intervals to remind women to encourage exclusive breastfeeding, transition
  - Explore ethnographically what words people use in their own cultures (most women probably are not discussing “LAM + transition” in their own lives)
  - Encouraging spousal communication around fertility, spacing is important
  - Display aggregate data on LAM, PPF in the facility as a motivator
  - MCSP Tanzania has developed framework to re-envision the way we communicate PPF & MIYCN information, identify social cues to transition to other modern FP

### **Promoting the Re-launched MIYCN-FP Toolkit – Liz Tully, K4Health**

- Toolkit launched in May 2012; updated and re-launched at CORE group meeting May 2014
- Web statistics (Sept. 20, 2012 through Sept. 20, 2013 vs. Sept. 21, 2013 through Sept. 21, 2014) showed increase in sessions, users, page views, and average session duration
  - Stats may be a little skewed since users updating the Toolkit also factor into it
  - SBCC materials still topping the most frequently viewed pages
  - MIYCN-FP brief, SBCC materials still the most frequently accessed resources
  - Toolkit spikes around the March 12<sup>th</sup> MIYCN-FP working group meeting, May 6<sup>th</sup> CORE group meeting
- Promotion and dissemination ideas:
  - Presentations, demos, TA, distribute postcards, virtual gatherings
  - Link to Toolkit from your organizations (MCHIP a top source of traffic along with CORE group, DHS)
  - Listserv announcements when updates made to the Toolkit
  - Social media, blog posts (K4Health, FHI360 degrees blog), campaigns (WABA’s World Breastfeeding Week 1<sup>st</sup> week in August; UNICEF has a new publication, could working group tap into this energy to promote Toolkit and integration)
    - Dissemination sub-group will send around sample promotional language

### **Introduction to Sub-Group Work and Small Group Report Out – Devon Mackenzie, MCHIP**

- Sub-groups discussed action plans for the coming year and assigned next steps:
  - Dissemination (Kristina Beall and Liz Tully):
    - i. Update sample promotion language
    - ii. Identify international days (e.g. World Contraception Day, Breastfeeding Week, etc.)
    - iii. Alert group when a day is approaching to encourage promotion and provide sample tweets and posts to share with communications teams from each org.



- iv.
- Documentation of Field Experiences (Holly Blanchard):
  - i. Keep abreast of FANTA's desk review of field programs to add key information and new content to the Toolkit
  - ii. Write a case study on Kenya or Rwanda MIYCN-FP program experiences
  - iii. Look at literature on efficacy of 'diarrhea corners'
  - iv. Call for more examples of integration that can be vetted by the group and showcased in the toolkit
  - v. Do webinars on using toolkit
- Engaging HIV (Peggy Koniz-Booher and Anne Pfitzer):
  - i. Develop short interview guide for 3-5 SPRING and MCSP field staff to give their perspectives on the 3-way integration of MIYCN, FP and HIV/PMTCT, then compile responses to review at next meeting (or potentially to develop as a blog)
  - ii. Reach out to HIV colleagues to join the community of practice
- HTSP and Engaging Adolescents (Heather Forrester):
  - i. Disseminate upcoming E2A publication on HTSP, nutrition, and outcomes on newborn neural development to the working group
  - ii. Connect with Population Council on their work on empowerment of adolescents (including nutrition and FP integration) and highlight lessons learned for the working group
  - iii. Bring organizations together to discuss best practices in MIYCN-FP in regards to adolescents
- M&E (Devon Mackenzie and Jennifer Yourkavitch)
  - i. Solicit feedback on M&E briefer from projects using it, such as the MCSP Tanzania project, and update as needed
  - ii. Referring back to the LAM measurement guide that Justine Kavle and the working group developed several years ago, discuss LAM measurement and operationalize this theoretical document and link it to country experiences
- SBCC (Chelsea Cooper):
  - i. Add in considerations for MIYCN-FP at each stage of the SBCC development process (1-2 additional pages added on to the table)
  - ii. Develop a brief highlighting PPF and transition to a modern method, synthesizing global evidence and looking at where the gaps are that are needed for the future, with the aim of preparing an editorial that could be submitted to a journal synthesizing some of these points
  - iii. Engage with the CORE SBC working group and link between groups and products

### **Closing and Next Steps – Peggy Koniz-Booher, SPRING**

- The working group will develop answers to some frequently asked questions about the MIYCN-FP Toolkit.

- Page assignments:
  - Holly: Does the toolkit have advocacy materials to advocate within one's own organization (e.g. if working at a nutrition-focused agency that is reluctant to do anything FP-related)? How have people overcome resistance within their programs?
  - Kristina/Devon: To what extent does the working group align with global policies such as A Promise Renewed? How is MIYCN-FP linked with partnerships and approaches like 1,000 days or the Essential Nutrition Actions?
  - Anne: Competition between LAM vs. LARC -- does emphasis on LAM take focus away from other FP methods and integration opportunities such as FP uptake after delivery, use of long-acting methods?
  - Heather & Albertha: Are there MIYCN-FP resources or approaches used with adolescents?
  - Chelsea: What specific approaches are used for MIYCN-FP activities – is it more often that FP is integrated into nutrition, or what forms of integration are most common?
- Next steps: Review drafts over email and finalize for posting on the Toolkit FAQ page at next meeting.