REPORT

WORKSHOP ON IMPROVING QUALITY CARE IN FAMILY PLANNING IN THE PACIFIC

Convened by:

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and

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NOTE

The views expressed in this report are those of the participants in the Workshop on Improving Quality Care in Family Planning in the Pacific.
1. INTRODUCTION

The International Conference on Population and Development (ICPD) Programme of Action put forth goals to be met by 2005 and 2010 in three major areas: access to reproductive health services; infant and maternal mortality reduction; and universal access to primary education. To date, the Pacific island countries have fared well in most of these areas, although more effort is needed to increase the contraceptive prevalence rate and reduce maternal mortality.

In order to improve the contraceptive use rate, it is necessary to review policies and practices, based on recent developments in contraceptive technology. Moreover, there is also a need to establish strategies to overcome the problems of accessibility to services and difficulties in securing consistent contraceptive supply.

This workshop was, therefore, designed to complement the United Nations Population Fund (UNFPA)-funded WHO-executed projects in 10 Pacific island countries by upgrading health care workers knowledge of medical eligibility criteria of contraceptive use and by improving the accessibility of contraceptives by revising national strategies and service standards.

1.1 Objectives

At the end of the workshop, the participants will have:

(1) become familiar with the reference book "Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use";

(2) upgraded their knowledge of medical eligibility criteria for contraceptive use;

(3) identified areas for revision of the national strategy and service standards of family planning according to the new medical eligibility criteria, adapting to national priorities, needs and resources; and

(4) developed a country action plan to train health professionals.

1.2 Participants and resource persons

The workshop was attended by 19 participants from 9 countries namely, Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. Two members from Ministry of Health and Environment of Marshall Islands were invited, but were unable to attend. One consultant from the Institute of Community and Family Health, and one temporary adviser from Centers for Disease Control and Prevention (CDC) were present as resource persons. There were eight observers including Australian Agency for International Development (AusAID), Secretariat of the Pacific Community (SPC), Reproductive and Family Health Association of Fiji, Suva Health Office, Tonga Family Health Association, a sexual health educator from Canada, the Methodist Church in Fiji and the Seventh Day Adventist Church. Representatives from the Ministry of Health, Nadi Hospital, Lautoka Hospital, Fiji School of Medicine and Fiji School of Nursing were also present at the opening of the workshop. Nine members of the secretariat represented the WHO Regional Office and the United Nations Population Fund. Overall, 46 people attended the workshop (Annex 1).
Dr Airambiata Metai of Kiribati was the chairperson, with Dr Junilyn Pikacha of the Solomon Islands as vice-chairperson and Dr Timaima Bakani Tuiketei of Fiji as rapporteur.

1.3 Organization

The resource persons and members of the secretariat met several times to review the workshop methodology in order to make it as participatory as possible, including case study exercises, role plays and field visits. The major purpose of the workshop was to update participants' knowledge of the medical eligibility criteria for contraceptive use in order to provide guidance to decision-makers for reviewing their family planning policies, strategies and guidelines for service delivery. It was also designed to improve the competence and confidence of the service providers as they assist users with their contraceptive choices. Hence, the participants were constantly encouraged to make the comparison and/or to clarify the differences between their current practices and WHO-recommended practices. The agenda and timetable are attached as Annex 2 and Annex 3.

The participants were asked to present their country situation in two ways: (a) through poster competition; and (b) through key country presentation. The poster competition provided the summary of demographic trends and gave the opportunity to share the experiences and progress of UNFPA-funded WHO-executed projects. For the "key country presentation," each country made a presentation on one or two contraceptive methods, focusing on their current practices as based on their service delivery guidelines. The country presentation was followed by brief lectures from the resource persons, open discussions and case study exercises, in order to highlight the differences and to identify the need to review the service standards.

Group work was also organized to allow the participants to review their service standards and to develop the national training plan in view of updating and disseminating the medical eligibility criteria.

1.4 Opening ceremony

The workshop was opened by Dr Li Shichuo, WHO Representative in the South Pacific, on behalf of Dr Shigeru Omi, the Regional Director of WHO's Western Pacific Regional Office. He welcomed the participants and thanked the Ministry of Health of Fiji and the United Nations Population Fund (UNFPA) for co-sponsoring the workshop. He referred to ICPD and observed that despite the governments' strong commitment to meeting ICPD goals and the overall improvement in the availability and accessibility of reproductive health and family planning services, the need for spacing or limiting the number of births remains unmet. Moreover, current policies and family planning service practices may be outdated or based on long-standing theoretical concerns that have never been substantiated, thus limiting the quality of and access to services. He stated that, through the use of the WHO reference book on medical eligibility criteria, the workshop would help upgrading knowledge about medical eligibility criteria and also provide the opportunity to identify the possible barriers and review the current national strategy and service standards.

Ms Catherine Pierce, UNFPA Representative and Country Technical Services Team (CST) Director, also made opening remarks emphasizing the commitment made at ICPD to make quality reproductive health services universally available by 2015. She highlighted the low contraceptive use rate in the Pacific island countries and expressed her expectation that the workshop would explain why it is so low and provide insight on why the discontinuation rate is high. The importance of informed, free choice was stressed, especially given the young age structure in the Region. Honest, informed approaches and good inter-personal relationships backed by technical confidence are key components to quality of care.
Dr Lepani Waqatakirewa, the Director of Primary and Public Health, Ministry of Health Fiji, also gave a welcome speech. He summarized the Fiji situation since ICPD, giving examples of the introduction of Norplant and revitalization of vasectomy for the expansion of contraceptive choices. At the same time, Fiji has strengthened the system of community-based distribution and also put effort into improving services for adolescents' reproductive health. He introduced the activities of adolescent health centres in Suva and Lautoka, where a field visit was arranged. Teenage pregnancy and abortion continue to be issues of concern and he appreciated the opportunity to work towards improving the access and quality of care in family planning.

2. PROCEEDINGS

2.1 Summary of presentations

A summary of presentations as well as activities are given here. Full papers or other reference materials are available at the Reproductive Health Unit of the Western Pacific Regional Office.

2.1.1 Overview of reproductive health situation in the Pacific and challenges for family planning strategy

The first presentation was given by Dr Pang Ruyan, Regional Adviser of Reproductive Health, WHO Western Pacific Regional Office. She focused the presentation on: (i) population and development; (ii) maternal and child health; (iii) adolescent health and development; (iv) Sexually-transmitted infections/Human immunodeficiency virus/Acquired immunodeficiency syndrome (STI/HIV/AIDS); and (v) information system.

In line with the ICPD goals and the Millennium Development goals, the importance of providing quality care in reproductive health services was emphasized. Reproductive health problems in the Region are related to rapid population growth, decreased economic expansion, growing poverty, environmental degradation, rapid urbanization and rising social problems.

Global and Regional issues related to pregnancy and childbirth were also highlighted. They were illustrated with comparative statistics on the maternal mortality ratio (MMR), total fertility rate (TFR), age-specific fertility rate and contraceptive prevalence rate (CPR), identifying the major causes of maternal deaths with the outcomes of pregnancy. Possible reasons for low CPR in the Pacific island countries were identified as: cultural and religious barriers; lack of counselling and education; limited choice and access to contraceptives; outdated knowledge and skills; and insufficient supervision and monitoring.

As for adolescent health, most problems faced by adolescents are similar among the Pacific island countries. Reduced budget for education and insufficient employment opportunities both have influence on early initiation of sexual activity, and there are not enough health services that are able to cater for the needs of the young people. With a high teenage rate, the young population is expected to increase substantially in most countries. Population, development and quality of life will continue to be a major concern in these countries. Together with the high prevalence of sexually transmitted infections, including HIV/AIDS, providing quality care in reproductive health for the adolescents will be a key strategy. The work done through UNFPA projects was emphasized.
Improving the reproductive health information system and the provision of health services was also raised. Lack of data, insufficient capacity to analyse and use the data; and incomplete institutional mechanisms for information collection and utilization were the main challenges seen in this area.

The recommendations made in this session were as follows:

(1) UNFPA should follow up the update of the “Manual on Collectors and Users of Reproductive Health Statistics for Health workers – Linking Figures to People” (UNFPA-funded project executed by the Secretariat of the Pacific Community (SPC), field tested in Fiji). The manual is to be finalized and adapted by each country for implementation, especially for front-line health workers.

(2) WHO should assist in the development of user-friendly health information system for standardization of data collection and analysis at national level, if countries require.

(3) There is a need to strengthen capacity-building and competency in the Pacific island countries for peripheral health workers. They need to be empowered to analyse the health indicators and the reproductive health data that they collect.

(4) There is a need to conduct reproductive health research and evidence-based activities to support policy changes in reproductive health.

2.1.2 Overview of medical eligibility criteria.

The presentation was given by Dr Kathryn Curtis, Centers for Disease Control and Prevention (CDC), United States of America. She introduced two reference books: Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use (MEC), and Selected Practice Recommendations for Contraceptive Use (SPR). She explained that these were scientific-evidence based guidelines, that address misconceptions regarding who can safely use contraception and also contraindications in order to reduce medical barriers and to improve access and quality of care in family planning.

MEC was updated in 2000 in response to continuing monitoring of the science and new evidence and information obtained through a WHO multi-country study. She explained the differences in the previous version and the 2000 update (e.g. the relationship between latex condom and STI/HIV prevention is now more emphasized; heavy smokers have been redefined from 20 cigarettes/day to 15 cigarettes/day due to recognition of the ill-effects of smoking; multiple cardiovascular risks are addressed). There are more precautions in some cases (e.g. association of gall bladder disease and progestins; sterilization for young clients more likely to result in regrets; use of Combined oral contraceptives (COCs), Progestogen only pills (POPs), implants by hypertensive clients). On the other hand, there are fewer precautions for some methods. There is no restriction for the use of POPs and implants for adolescents (concerns about bone density is now considered primarily for Depo-Provera); COCs and progestins can still be used even in case of vaginal bleeding while awaiting diagnosis.

SPR gives answers to 23 questions on contraceptive use. These questions include: when to start, when to re-administer; how to manage problems; what exams or tests should be done routinely; follow-ups; and how to be reasonably sure a woman is not pregnant. She explained the need for routine exams or tests. Pelvic exam is mandatory (category A) for Intrauterine device (IUD) insertion and female sterilization but not for hormonal methods and barrier methods (category C). For hormonal methods only examination of blood pressure is considered important (but not essential) and all other exams/tests do not contribute substantially to safe and
effective use of method. Such recommendations would be important to removing unnecessary barriers to accessing family planning services.

She explained that these documents are reference tools for the preparation of service delivery guidelines, which will require adaptations based on local needs.

Issues raised:

(a) More male involvement is needed in family planning strategies, but there is very little information about it in MEC and SPR because the concerns are mainly medical and technical involving women.

(b) MEC guidelines have been used in more than 40 countries and three reviews have been undertaken – two in America and one in Africa. The use of MEC and SPR does not necessarily mean that there will be an increase in family planning coverage.

2.1.3 Poster competition

The purpose of this activity was to share experiences and report on the progress and achievements of UNFPA-funded WHO-executed projects.

Dr Khine Sabai Latt, WHO Western Pacific Regional Office, gave the introduction and announced the four Selection Committee Members (Dr Rufina Latu, Dr Kathryn Curtis, Ms Christina Richards, Dr Khine Sabai Latt). Each country was given 15 minutes to present their poster, and all the participants gathered by country groups to assess and vote for the four best posters.

The activity proved to be very effective in giving the overall picture of achievements and problems faced by each country. Issues such as difficulty of accurate data collection, analysis and interpretations were pointed out in some poster presentations.

The winners of the competition were: i) Best poster exhibit – Tuvalu; ii) Best content – Kiribati; iii) Best design – Fiji; and iv) Best oral presentation – Tonga.

2.1.4 Combined oral contraceptives (COCs)

(1) Cook Islands

The presentation was done by Ms Teokotai Areai, Ministry of Health.

She explained the types of COCs available in the Cook Islands, the mechanism of action, absolute contraindications, accessibility (who dispenses), affordability (prices), the disadvantage (side-effects and barriers), the data recording system, the follow-up, management of missed pills (seven day rule), changing from COC to another method and the trends of contraceptive use.

Issues raised were:

(a) There is a reduction in the COC acceptance rate in Cook Islands and there may be a need to review their contraindications (e.g. herpes and atroblastic diseases).

(b) Screening and distribution are done by doctors and nurse practitioners. Weight, blood pressure, pelvic exam, cervical smear, STI test are generally done prior to
prescription. The participants from the Cook Islands did not consider pelvic exam to be a barrier.

(c) The usual practice in the Cook Islands is to use low-dose (30 mcg) COC for young clients and first time users. The resource persons advised that the current recommendation is to use low-dose for all age. High dose (50 mcg) should be used primarily as an emergency contraceptive.

(d) It was agreed that appropriate information, education and communication (IEC) materials coupled with pro-active counselling are also needed to improve awareness and assist the users in management of missed pills or coping with side effects.

(e) Capacity-building and competency training for counselling were recognized by all as important pillars of quality of care.

(f) Vanuatu has a manual for nurses, that was supported by the SPC and endorsed by the Government, but it needs revision/updating. They hope to address this with UNFPA for the next project cycle.

(2) Fiji Islands

The presentation was done by Dr Timaima Tuiketei, Ministry of Health.

She explained the advantages and disadvantages of COCs, the history of family planning in Fiji, the statistical trends of contraceptive coverage, COCs available in Fiji, the current standards and medical criteria, the regimen and management of missed pills and side-effects, recording system and follow-up procurement logistics, major challenges and future directions.

Issues raised:

(a) It is anticipated that more adolescents in Fiji will use COC. Consent forms exist for adolescents (for all contraceptives) mainly to protect the health workers. Policy makers should be conscious that such consent forms could be potential barrier for adolescents accessing health services.

(b) First-time users are given one packet and are requested to return for the next three packets for assessment. This procedure is not considered a barrier in Fiji, as clients are not required to return to the same clinic.

(c) COCs can be dispensed at pharmacies, but non-health professionals such as community-based distributors (CBDs) and village health workers can only distribute for repeat users. The Fiji Government is reluctant to allow non-health professionals to dispense to first-timers, because they think it requires greater knowledge.

(d) The importance of keeping track of long-term contraceptive users when calculating CPR was pointed out by participants. Long-term contraceptive users should be included in the family planning coverage until they are out of child-bearing age (CBA).

(e) Norplant target groups in Fiji are young people who want to complete their tertiary studies and couples who have completed their families, but do not want an invasive contraceptive procedure such as sterilization. Female sterilization is still the most common method in Fiji but the decrease in coverage from 35.15% (1996) to 29.96%
(2000) is thought to be attributed to the increasing popularity of Norplant since its introduction in 1996. There are now having problems with Norplant supply.

(f) Standardizing CBA across the board to 15 to 49 years, as in other countries, but Fiji awaits the results of the national CBA research before changing because of logistics and policy implications.

(g) The importance of conducting specific family planning research to strengthen evidence-based policy. It was also suggested that the "Manual for collectors and users of reproductive health statistics" could be adopted at local level to integrate reproductive health initiatives into the existing reporting system.

Dr Ramos gave an overview of COCs: the four categories used in the MEC, classification of examinations or tests, and advise on follow-ups. Special emphasis was placed on the management of missed pills.

She also clarified questions on the use of COC by women who are not exclusively breastfeeding and women who manifest vaginal bleeding. She explained that after six months postpartum, a woman could use COC without waiting for the return of menstruation as long as she is sure of not being pregnant. As for vaginal bleeding where examination is difficult, COC can still be given if abortion can be ruled out. In the case of dysfunctional bleeding, it can even be regulated by COC. In the case of infection, COC can be given until diagnosis is made in order to prevent a double burden of infection and pregnancy.

Noticing some hesitation in readily prescribing COCs in both countries, Dr Curtis also stressed the safety and the beneficial effects of COCs (e.g. protection against ovarian and endometrius cancers).

2.1.5 Progestogen only pill (POP), emergency contraceptives, Norplant

(1) Kiribati

The presentation was made by Dr Baranika Temariti, Ministry of Health.

She described the service delivery in urban versus rural markets, advantages and disadvantages to users, the trends by year, the current guidelines and practices on medical eligibility, the recording and follow-up systems, the supply channel, major barriers and recommendations.

Issues raised were:

(a) WHO recommended not starting hormonal contraception before 6/52 weeks, especially if the woman is breastfeeding, not only because she does not need it but also because of possible effects on the baby's liver. However, each country policy should be decided taking the country situation (e.g. geographical barriers) and the costs and benefits into consideration.

(b) AusAID called attention to another implant, IMPLANON. It has only one rod and is effective for only three years. However, the implication of high cost should be noted.

(c) IUD insertion at immediate postpartum period have a high rate of expulsion. Each country should make its own decision in terms of their own policies and what they would like to do.
(d) There was a long discussion on the religion barrier myth - whether this is a real barrier or service providers creating such barriers. The religious groups who were present as observers stated that the religious leaders in the Pacific are now young and educated and this should be addressed positively. They emphasized that religion should not be a barrier to people’s health and that we should all see the magnitude of the problem. It is a matter of getting together to discuss how to work together. All the participants agreed that religious groups should be considered as a resource.

(e) Continuity of care and the counselling of women were identified as important elements of quality of care (i.e. a woman pregnant with her seventh child should be counselled for long term family planning at the time of pregnancy).

(f) Attitudes, competencies (especially counselling and communication skills of health providers) and appropriate equipment technology should be addressed.

Dr Ramos gave a brief explanation of emergency contraception pills and the use of IUD as emergency contraception.

Issues raised were:

(a) The dose of microgynon for emergency contraception is 100mcg ethinyl oestradiol.

(b) An IUD can be inserted at any time if there is no contraindication. After 5/7 days, there is no need to use other back-up methods.

2.1.6 Injectables

(1) Federated States of Micronesia

The presentation for Micronesia was done by Dr Kesusa Bermanis, Pohnpei State Hospital.

She described the advantages and disadvantages of Depo-Provera and Norplant, the contraceptive prevalence rate, current guidelines on medical eligibility, contraindications, availability/accessibility/affordability, recording system, channel of supply and major barriers.

Major issues raised were:

(a) The signing of the consent form for any type of contraception except for condoms (if under 18, also by parents), which has been in existence for more than a decade was pointed out to be a possible barrier in providing quality services. The representatives from the Federated States of Micronesia will discuss the issue within the Ministry of Health when they return to the country.

(b) The current practice of giving Depo Provera at 2/52 weeks postpartum may not be appropriate as the mother is not in need at this time and also because it may be difficult to ensure the mother returns for next dose.

(c) The importance of spreading the notion of "birth spacing" to the people (especially men) was raised by the religious group. The general understanding of family planning is to "stop having children completely," and that causes resistance since the mentality of people is to continue having children until at least one son is born.
(2) Samoa

The presentation was made by Dr Malama Tafunai, a private practitioner, who represented a private sector perspective.

She showed the numbers of users of Depo-Provera, taken from the records from the Family Welfare Center at the National Hospital, and from the nongovernmental organization (NGO) “Family Health.” She explained the reasons why injectables are the most preferred method of family planning, and some of the reasons why they are disliked. The MEC is currently being used as a guideline. She introduced the assessment and recording method using their Case Record card.

Issues discussed were:

(a) There is a need to tap into the existing network to strengthen collaboration with local reproductive health partners, and improve quality of care through continuing education for service providers and outreach activities including men’s workshops, involvement of church groups and road shows.

(b) More than 90% of rural families in Samoa do not have a regular source of income, which could be a barrier to accessing care and to quality of service.

(c) The transient nature of the people makes follow-up extremely difficult, but at some clinics attempts are being made to keep a register.

(d) The importance of maintaining confidentiality with adolescents and maintaining privacy in the local context was stressed.

(e) The Samoan representative once again highlighted the interest in Norplant.

2.1.7 Case study exercises

With the facilitation of Dr Ramos, eight scenarios were given, and the participants were encouraged to make decisions on the cases using the updated knowledge of the medical eligibility criteria and by using the MEC reference book. The participants discussed answers and other related issues during the open forum. The importance of history-taking to make proper assessment of the client before making the appropriate decisions and giving advice was stressed.

2.1.8 Overview of COCs, POPs, depot-medroxy-progesterone acetate (DMPA) and Norplant

Dr Ramos gave a summary of the family planning methods covered so far. She reminded the participants of the issues:

(a) four MEC categories;

(b) when to initiate the method, how to switch from one method (hormonal or non-hormonal) to another (hormonal or non-hormonal), the management of missed pills, and management in case of breastfeeding;

(c) advice on DMPA re-injection interval; and

(d) comparison between Depo-Provera and Norplant and their side effects.
It was stressed by Dr Curtis that the three main progesterone-based contraceptives (Norplant, Depo-Provera and POP) have different MEC ratings and different actions. For example, Depo-Provera works on preventing ovulation and will have hypo-estrogenic effect which means it will not be suitable for clients with diabetes or hypertension, whereas Norplant can be used in those clients.

2.1.9 Intrauterine device (IUD)

(1) Solomon Islands

The presentation was made by Dr Junilyn Pikacha and Ms Judith Seke, Ministry of Health and Medical Services.

They presented the health workers concerns about IUD, such as the lack of instruments and trained nurses and the high prevalence of pelvic infection.

The experience of developing the "Solomon Islands Family Planning Handbook for Health Personnel" and the checklists for IUD users (History/Physical Exam/Pelvic Exam/Speculum Exam) were shared. Their current practice for counselling and post-insertion advice for clients, follow-up and indications for removal were also explained. Also discussed were contraceptive availability, recording and reporting system, major barriers, channel of supply and their vision on future direction.

Issues raised were:

(a) The reasons why clients dislike the method included painful intercourse after the IUD insertion, especially for men. The recommendation was to advise the providers not to cut the IUD thread short.

(b) The importance of treating any STI or underlying cause for bleeding was stressed repeatedly.

(c) The infection control procedures (such as non-touch loading and the use of double gloves) during IUD insertion, vulval and cervical swab were reminded and emphasized.

(d) The resource persons stated that a routine prophylactic antibiotics after IUD insertion is not necessary because of cost implications and the risk of acquiring resistance. However, if the local situation does not permit laboratory tests or strict aseptic procedures, then the antibiotics can be given according to the country’s protocols.

(e) The checklist and supervisory competency based tools for health providers were introduced by the Solomon Islands. The usefulness of a standard guideline was stressed and the experience of development process and operationalizing the use through training and capacity-building was shared.

(2) Tonga

The presentation was made by Sr Sela Paasi, Ministry of Health.

She presented the key features of family planning services, the trends in CPR, the family planning method mix, key features and types of IUD used, the trends in IUD users by year and by age, the availability/accessibility/affordability of IUD, the medical eligibility and insertion
procedures, concerns of users and providers, the barriers, and the strategies for improving services in IUD.

Issues raised were:

(a) The Copper T is recommended more than Lippes Loop because of the simpler insertion technique due to its smaller size. Also, there is increased effectiveness of the copper. The global trend is to use the medicated device. Furthermore, the current Lippes supply is from the old stock and the transition from Lippes to Copper T is inevitable.

(b) IUD is a very safe method and there have been no reports of ill effects of IUDs in utero.

(c) Strategies should be focused mainly on capacity-building and reviewing guidelines with input from the Continuing Medical Education (CME) guidelines.

(d) Good networking between the Government and the NGOs on family planning services was highlighted.

2.1.10 Permanent Methods

(1) Tuvalu

The presentation was done by Ms Eline Soloseni, Princess Margaret Hospital.

She presented the health overview, types of contraceptives available in Tuvalu, trends of permanent methods by year, current practices for male and female sterilization (checklist and examination procedures), recording system, the barriers, challenges and recommendations.

Issues raised were:

(a) Religion was highlighted again as a barrier but all agreed that it is necessary to have a strategy in place to address religion positively. The Adolescent Reproductive Health Project has opened up the network with the churches and this has given a positive perspective.

(b) There was active discussion around the issue of male involvement strategies. Kiribati shared their experience of involving male health promoters who visit each household with pamphlets (spend at least 30 minutes to explain and counsel every man), the use of radio to sensitize the people, and the provision of outreach vasectomy services.

(c) The importance of giving accurate information on vasectomy and the use of innovative IEC analogies (e.g. vasectomy is like watermelon without seeds) to counteract misconception of vasectomy was emphasized.

(d) The importance of counseling cannot be over-emphasized for the permanent methods, as reversion to fertility is usually difficult and not 100% guaranteed.

(e) The issue of a consent form as a barrier was raised again, but this time with gender perspective. The consent form for vasectomy is only signed by the man, but the consent form for female tubal ligation requires the husband’s consent. The rationale for this seemed to be unclear.
This session was followed by Dr Ramos summarizing the medical eligibility criteria of IUD and permanent methods.

The different categories for sterilization were clarified with examples.

A – Accept  – no medical reason to deny sterilization
C – Caution – routine setting, with extra preparation and precaution
D – Delay – procedure delayed until the client is assessed
S – Special – procedure to be aseptic, appropriate technical equipment needed to provide general anaesthesia

2.1.11 Fertility awareness methods, lactational amennorrhoea method (LAM)

(1) Tuvalu

The presentation was made by Ms Filoiala Sakaio, Princess Margaret Hospital.

She presented the current practice, the follow-up methods, the problems encountered and the strategies for improvement.

Issues raised were:

(a) For the rhythm method, it is essential to calculate the days properly. WHO also introduced “the necklace” (Standard Days Method) which can also be used by the couple to remember the “safe period.”

(b) For the Lactational Amennorrhoea Method to work, the woman must have all three conditions: exclusively breastfeeding, amennorrhoeic and within six months postpartum.

(c) The reporting of CPR was also discussed and whether the natural method should be included or not. Those who use the Natural method are generally not included in the CPR, but it is recommended to use two line methods (i.e. indicate both modern methods and traditional methods in calculating CPR).

2.1.12 Barrier Methods

(1) Solomon Islands

Presented by Ms Alice Watoto, Ministry of Health and Medical Services.

She presented the condom use rate, but explained the difficulties in obtaining reliable data. Contraceptive availability, concerns expressed by users and providers, current guideline on medical eligibility (Solomon Island FP Handbook for Health Personnel) and major barriers were also explained.

Issues raised were:

(a) AusAID brought up female condoms as another barrier method option. Although there are aspects that are disliked by some users, the Australian experience proved this method to be promising.
(b) The formula for calculating condom coverage is confusing. The calculation of couple year of protection (CYP) is based on 120 units/couple/year, but the normal calculation for CPR is that one male uses 144 condoms in a year. WHO/UNFPA were requested to come up with the accepted formula to standardize the CPR calculations.

(c) The difficulty of including condoms in the CPR calculation was raised (e.g. the issue of dual protection rate, use of condoms more as STI prevention than family planning). WHO was requested to discuss this with Headquarters.

(d) The issue of condom vending machines was also discussed with participants sharing experiences.

2.1.13 Overview of the Adolescent Reproductive Health (ARM) Project

This presentation was given by Dr Rufina Latu, Secretariat of the Pacific Community. She presented the objectives of the projects, the project organization, the implementation framework (ARM issues and ARH components), highlights of success stories of the programmes (in-school, out-of-school, media initiatives), and the challenges and success factors.

2.1.14 Logistics of Contraceptives

The presentation was given by Dr Pang Ruyan, Regional Adviser in Reproductive Health, WHO Western Pacific Regional Office. She focused the presentation on what contraceptive logistics mean, the significant problems with contraceptive supplies, management of contraceptive supplies, maximum/minimum inventory control system and the calculation, assessing the supply status, good warehousing practice and calculation of CYP.

Contraceptive logistics includes transporting, storing and record keeping in order to maintain adequate supply levels. The key components of quality of care in family planning are the provision of a full selection of contraceptive methods that are of good quality (not expired) at all times without interruption. From this viewpoint, it is important to ensure good contraceptive logistics to improve quality of care in family planning.

The essential logistic data (e.g. stock on hand, rate of consumption and losses and adjustment) were explained together with the use of tools such as the stock card and daily activity register.

The explanation of the various calculation formulas used to estimate the minimum/maximum stock level and order quantity were also given as well as the possible ways to use the logistics data in analysing the trends, forecasting future demands and calculating the CYP.

(1) Vanuatu

Following Dr Pang's presentation on logistics, Ms Lily Naviti, Ministry of Health, gave a presentation on Vanuatu situation. She explained why there was a need to establish a logistics management system in Vanuatu, what were the process of establishment, the current system, the process of procurement, the monitoring system, the initial results and the conclusions.

The development of their logistics management system was based on identified needs, where there was a major supply shortage resulting in delay in delivery and unmet needs of the clients, which eventually had an effect on overall CPR. Now, with the improved logistics system, they are able to better estimate the requirements, minimize delays, ensure availability of
supplies, strengthen management of other medical supplies, and, above all, meet the clients needs. The results have been rewarding.

2.2 Role-plays

2.2.1 Meeting adolescents needs.

A brief introduction was given by Ms Sachie Iiyama, Associate Professional Officer, WHO Western Pacific Regional Office, with a role-play conducted by Ms Iemaima Havea and Dr Vijayalakshmi Garimella on meeting adolescent's needs. The role-play included a health worker and an adolescent to highlight confidentiality, choice of FP methods available and counselling on HIV/AIDS/STI with multiple partners.

Issues raised were:

(a) There is no contraindication for adolescents to use Norplant or Depo-Provera but they will need to have proper counselling.

(b) There are many studies which support there is no link between increased RH/FP knowledge and promiscuity among adolescents.

(c) Many Norplant studies done do not show any mood changes, depression or any other adverse problems. Norplant is safe when used by adolescents.

(d) There was interest in Norplant's introduction to countries like Samoa, Solomon and Vanuatu. This has implications for a programme development in terms of introducing new methods of contraception into the existing RH services. Certain procedures and processes are required as mandatory to ensure a successful programme. This should include a study observation tour, national approval, back-up resources/services and other related issues within the health authorities of various countries.

(e) It was recommended that UNFPA/WHO consider assisting interested countries in introducing of Norplant for adolescents with technical assistance and capacity-building. The need for Norplant supplies by UNFPA was expressed. It was explained that supply could be funded specifically from the national regular country programme and not from the UNFPA/ARH Project because of donor implications.

(f) It was also suggested that UNFPA/WHO strengthen capacity-building and competency on counselling and communication skills for health providers, particularly with ARH issues.

2.2.2 Informed choice and male involvement

The role-play on this issue was facilitated by Sr Vika Tikinatabua, Dr Litili O’fanoa and Ms Iemaima Havea. The role play was an interaction among a husband, wife and family planning service provider. It highlighted the provision of accurate information, the importance of correcting misconceptions and counselling for family planning choices.

A brief presentation on this was given by Dr Khine Sabai Latt, summarizing issues such as: understanding informed choice; benefits and making informed choice strategy; ensuring informed choice; encouraging informed choice; evolution of informed choice; family planning decision-making; and evaluating informed choice.
It was stressed that when making informed choice, always ask the client for their reproductive and family planning intentions, give accurate information, and help the client to make the right decision of which method he/she will use. Compliance is more likely to be higher if the client has the method s/he wants through informed choice. Correct informed choices and information must be available and given to males to increase their involvement and notion of shared responsibility.

2.3 Field trip

One of the objectives of this workshop was to identify areas for revision of the national strategy and service standards of family planning. A field trip was organized to see the situation in Fiji. The participants were able to compare with their own country and discussions between different countries enabled them to identify how and what improvement could be made in the future.

The aims of the visit were: i) to review the service standard and the protocol in the clinics; ii) to observe the management and the use of contraceptives and equipment; iii) to learn about best practices in promoting male involvement in family planning; iv) to learn about the provision of services to adolescents; and v) to learn about family planning counselling.

The participants were divided into four groups and each group visited a different clinic.

(1) Namaka Health Center – the participants noted that the clinic was very well organized and the nurses knew their work. It was noted that the clients were referred to the main clinic for Depo-Provera.

(2) Nawaicoba Nursing Station – the participants appreciated the good organization and the services provided.

(3) Nadi Health Center – the participants were impressed by the work of the staff.

(4) Lautoka Health Center – the location was very good and the participants were very impressed with the work of the peer educators.
2.4 Group Work

2.4.1 Service Standards

Dr Pang Ruyan outlined and introduced the group work activity and the expected outcomes. The participants were divided into three groups and each group was to work on one particular contraceptive method. The questions to be addressed in this exercise were:

- Do we need service standards? do we have service standards?
- What are the recommendations for the contents of the service standards?
- What actions can participants take when they return to their countries?
- What are the difficulties might be faced, and how can they be solved?

Group work presentations are attached as Annex 4.

2.4.2 Recommendations and training plans

Each country was asked to come up with draft training plans on improving quality care in family planning through the use of the new MEC and SPR. The draft plans are attached as Annex 5.

Many of the countries were planning workshops to update their country manuals/guidelines based on MEC and SPR. However, it was stressed that thorough preparation meetings would be needed within each country with their technical people. To review the differences between the current practices and the recommendations of MEC and SPR. The adaptation should not be done in a rush, but with the full understanding of the recommendations and the country situation.

It was also suggested that private doctors be involved in the training.

For the training of family planning techniques (e.g. vasectomy and Norplant), there are not enough cases for training opportunities in the Pacific island countries. There is the possibility of training in China, Indonesia or Thailand, if requested by the countries.

2.5 Workshop Evaluation

Out of 20 respondents, 12 thought they had become familiar with the reference book "very well" and eight said "satisfactory."

Out of 20 respondents, 15 thought they acquired updated knowledge on medical eligibility criteria "very well" and five thought "satisfactory."

Out of 19 respondents, 15 thought they had identified areas for revision of the national strategy and service standards according to the new medical eligibility criteria "very well" and five thought "satisfactory."

Out of 19 respondents, 10 thought they had developed a country action plan for training "very well", eight thought "satisfactory" and one thought "not very well."
All participants thought they were able to express the ideas and exchange knowledge and experience, except one participant who arrived late due to flight problems.

All respondents thought that new skills/concepts were learned during the workshop. The updated knowledge on the medical eligibility criteria was appreciated for "broadening the criteria to make access easier." There were positive comments on other activities such as: "field trip helped me a lot as I saw excellent ideas that will help me in rearranging the clinics and adolescent health center in my country", "country presentations highlighted the concepts of family planning and the health indicators which each country has to set goals, objectives and strategies to achieve and implement."

All respondents felt that the upgraded knowledge of medical eligibility criteria would help to improve the quality of care in family planning in their countries. They became "more aware of medical eligibility; see areas to improve to educate other service providers; are more aware of the importance of collating accurate information to reflect in contraceptive prevalence rate." They also became conscious of the need to "develop checklists and standards, and upgrade caregivers knowledge/skills through workshops and in-service training."

Suggestions for improvement included issues such as "involve locals in the planning", "conduct similar workshop regularly", and "provide updates on newer contraceptives which may not be available at the time, but will enable the countries to plan for what is coming and become familiar with new ideas."

3. CONCLUSIONS

1. Updating of contraceptive standards and guidelines

All participating countries are using some form of service standards and guidelines for the various contraceptive methods, but these documents need to be reviewed and updated using the new Medical Eligibility Criteria (MEC) and Selected Practice Recommendations (SPR) as references.

2. Development of competency skills and capacity-building

The need to improve and strengthen competency skills and capacity-building was identified in the provision of quality of care in FP services. The training programmes will address the following key issues:

   (a) update technical information on a broad range of contraceptive methods using MEC and SPR as reference;
   (b) encourage the use of innovative IEC approaches and methods;
   (c) improve communication and counselling skills amongst health providers;
   (d) provide specific competency skills of health providers (e.g. IUD insertion technique, Norplant insertion and removal); and
(e) improve FP data management including collection, compilation, analysis, interpretation and utilization of data.

3. Reproductive health information

Problems of inaccuracies and shortfalls in RH data collection, compilation, analysis, utilization and interpretations at all levels have been identified. In view of this, the following actions should be addressed to improve and strengthen FP programme evaluation, review and planning:

(a) review the existing FP recording and reporting mechanisms of RH information at all levels to identify and rectify areas of inaccuracies;

(b) consider the possible use of the “Manual on Collectors and Users of Reproductive Health Statistics for Health workers – Linking Figures to People” (UNFPA);

(c) provide countries with Management of Information System software to standardize the compilation and analysis of RH information at the national level; and

(d) improve capacity in the management of RH data and the development of RH indicators.

4. Strengthening of existing FP services and introduction of new methods

Some barriers to quality of care in FP are the shortage of trained staff: non-availability of some modern contraceptive methods; inadequate equipment and facilities; inadequate provider competency skills and attitudes; inadequate information communication and counselling; and the lack of motivation and promotion for these methods.

In order to improve this situation, the following need to be addressed:

(a) strengthen the provision of existing long-term contraceptive methods (e.g. IUD and Depo-Provera);

(b) strengthen the promotion, counselling and provision of permanent methods, especially vasectomy; and

(c) introduction of new methods (e.g. Norplant and vasectomy) should take country policies into consideration and also ensure method accessibility and user continuity. WHO will give technical assistance to facilitate the process.

5. Reproductive health research

The importance of and the need for research to further improve the quality of FP services and formulate evidence-based policies were acknowledged.
6. Other issues

6.1. Poster competition and country presentation

These activities proved useful in encouraging the participants to re-evaluate their existing RII statistics thoroughly and critically analyse their data. This participatory method was much appreciated.

6.2. Field visit experience

The field visits to the four health facilities in the western division in Fiji was perceived as a good example of the "South-to-South Cooperation" concept. A number of observations and lessons learned were gained from these visits that could be applied in other Pacific Island countries.

6.3. Male involvement

Male contraception acceptance rate is low in all the countries, except for Kiribati where they have a programme to promote vasectomy. There is a need to promote active male involvement in RH programmes through the following activities:

(a) effective IEC campaign using innovative health promotion models.

(b) involvement of male health providers to give accurate information, through person-to-person interactions; and

(c) thorough counselling, especially for permanent methods where reversions are usually difficult, to regrets of acceptors.

6.4. Logistics and supply of FP methods

The importance of and the need for good logistics management system was recognized as a mechanism to improve the availability and accessibility of the FP supply.

6.5. Religion as a perceived barrier

Religion had been identified as a barrier to contraceptive use and the acceptability in FP services in a number of countries. However, this was not well substantiated and appeared to be more of an opinion and perception of health providers rather than a reality. Two church ministers from Fiji also actively participated in the workshop, which opened the path for dialogue between religions and reproductive health providers.

It was agreed that health providers should no longer regard religion as a barrier, but as a resource for improving FP services as the means to improve people's reproductive health.

This calls for a more positive partnership with the church networks in the improvement and strengthening of RH programmes in the countries.
### ANNEX 1

**LIST OF PARTICIPANTS, CONSULTANT, TEMPORARY ADVISER, OBSERVERS AND SECRETARIAT**

1. PARTICIPANTS

<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Position</th>
<th>Contact Details</th>
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<tbody>
<tr>
<td><strong>COOK ISLANDS</strong></td>
<td>Ms Natalie Ngapoko Short, Director of Public Health, Ministry of Health, P.O. Box 109, Rarotonga</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telephone: (682) 29110. Facsimile: (682) 29100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ms Teokotai Areai, Midwife in-charge of A/N, F/P, P/N, Ministry of Health, P.O. Box 109, Rarotonga</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telephone: (682) 29664. Facsimile: (682) 23109</td>
<td></td>
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<tr>
<td><strong>FIJI</strong></td>
<td>Dr Timaima Bakani Tuiketei, Deputy Director, Public Health, Ministry of Health Headquarters, Dinem House, Amy Street, Toorak, Suva</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Telephone: (679) 3306 177. Facsimile: (679) 3306 163</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Vijayalakshmi Garimella, Principal Medical Officer, Oxfam Clinic, CWM Hospital, Ministry of Health, Dinem House, Amy Street, Toorak, Suva,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telephone: (679) 3125 435</td>
<td></td>
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<tr>
<td><strong>KIRIBATI</strong></td>
<td>Dr Airambiata Metai, Director of Public Health Services, Ministry of Health, P.O. Box 268, Bikenibeu, Tarawa</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Telephone: (686) 28396. Facsimile: (686) 28152</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Baranika Temariti, Registrar in obstetric/gynaecology, Ministry of Health, P.O. Box 268, Bikenibeu, Tarawa</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Telephone: (686) 28100 or 28872. Facsimile: (686) 28152</td>
<td></td>
</tr>
<tr>
<td><strong>MICRONESIA, FEDERATED STATES OF</strong></td>
<td>Mr Dionisio E. Saimon, UNFPA Project Assistant Coordinator, FSM Department of Health, Education and Social Affairs, P.O. Box PS 70, Palikir, Pohnpei FM 96941</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telephone: (691) 320 2619. Facsimile: <a href="mailto:fsmunfpa@mail.fm">fsmunfpa@mail.fm</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Kesusa Maria Bermanis, Assistant OB/Gyn Physician, Pohnpei State Hospital, Department of Health Services, P.O. Box 2422, Pohnpei FM 96941</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Telephone: (694) 320 5812</td>
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</tbody>
</table>
Annex I

SAMOA
Dr Semo Koro, Acting Manager for Reproductive Health and Family Planning, Health Department, Apia
Telephone: (685) 21 212 ext. 231. Facsimile: (685) 22 905

Dr Malama Tafunai, Private Practitioner, Obstetric/Gynaecology, Tupua Tamasese Meaole Hospital, Private Mail Bag, Apia
Telephone: (685) 26 527. Facsimile: (685) 22 905

SOLOMON ISLANDS
Dr Junilyn Pikacha, Director of Reproductive Health, Reproductive Health Division, Ministry of Health, P.O. Box 349, Honiara
Telephone: (677) 24260. Facsimile: (677) 24260
E-mail address: repro@solomon.com.sls

Ms Judith Seke, National Reproductive Health Coordinator, Reproductive Health Division, Ministry of Health, P.O. Box 349 Honiara
Telephone: (677) 24260. Facsimile: (677) 24260
E-mail address: repro@solomon.com.sls

Ms Alice Watoto, Nursing Officer, Ministry of Health and Medical Services, P.O. Box 349, Honiara
Telephone: (677) 20830. Facsimile: (677) 20830

TONGA
Dr Litili O'fanoa, Director of Health, Ministry of Health, P.O. Box 59, Nuku'alofa
Telephone: (676) 23200. Facsimile: (676) 24291.
E-mail address: mohtonga@kalianet.to

Sr Sela Sausini Paasi, Acting Supervising Public Health Sister, Ministry of Health, P.O. Box 59, Nuku'alofa
Telephone: (676) 23200. Facsimile: (676) 24291.

TUVALU
Mrs Filoiala Sakaio, Public Health Sister, Public Health Unit, Princess Margaret Hospital, Funafuti.
Telephone: (688) 20482. Facsimile: (688) 20750.

Mrs Eline Soloseni, Senior Staff Nurse, Public Health Unit, Princess Margaret Hospital, Funafuti.
Telephone: (688) 20482. Facsimile: (688) 20481

VANUATU
Mrs Lilly Naviti, Reproductive Health and Family Planning Coordinator, Directorate of Public Health, Ministry of Health, Private Mail Bag 009, Port Vila
Telephone: (678) 22512. Facsimile: (678) 26204
E-mail address: landre@vanuatu.gov.vu

Dr Thomas Sala Vurobaravu, Obstetrician and Gynaecologist, Vila Central Hospital, Private Mail Bag 013, Port Vila
Telephone: (678) 26018. Facsimile: (678) 26018.
E-mail address: tvurobaravu@yahoo.com
Annex 1

2. CONSULTANT

Dr Rebecca Ramos, Institute of Community and Family Health, 11 Banawe Avenue, Quezon City, Philippines
Telephone: (63 2) 743 6645. E-mail address: ramosr@pacific.net.ph

3. TEMPORARY ADVISER

Dr Kathryn M. Curtis, Division of Reproductive Health, Centers for Disease Control and Prevention, MS K-34, 4770 Buford Highway NE, Atlanta, GA 30341-3724, United States of America
Telephone: 770 488 6397. E-mail address: kmc6@cdc.gov

4. OBSERVERS/REPRESENTATIVES

AUSTRALIAN AGENCY FOR INTERNATIONAL DEVELOPMENT (AusAID)
Ms Christina Richards, Education Analyst, G.P.O. Box 887, Canberra, ACT 2601, Australia
Telephone: 02 6206 4846. Facsimile: 02 6206 4870
E-mail address: Christina_Richards@ausaid.gov.au

METHODIST CHURCH IN FIJI
Reverend Iliesa Naivalu, Assistant Secretary, Department of Christian, Citizenship and Social Services, P.O. Box 357, Suva
Telephone: 331 1477

REPRODUCTIVE AND FAMILY HEALTH ASSOCIATION OF FIJI
Sr Vika Tikinitabua, Family Planning Project Officer for the South Pacific, Elery Street, Suva
Telephone: 330 175. Facsimile: 330 178

SEVENTH DAY ADVENTIST CHURCH
Pastor Ilisoni Lalakobau, Church Pastor, Seventh Day Adventist Mission, P.O. Box 297, Suva
Telephone: 3361 022. Facsimile: 3361 446
E-mail address: sdafiji@is.com.fi

SECRETARIAT OF THE PACIFIC COMMUNITY
Dr Rufina Latu, Advisor for Population Advocacy, Reproductive Health IEC and Adolescent Reproductive Health, Private Mail Bag, Suva
Telephone: (679) 370 733. Facsimile: (679) 370 021

SUVA HEALTH OFFICE
Sr Suluei D. Duvaga, School Health Sister, P.O. Box 30, Suva
Telephone: 3314 988 ext. 203. Facsimile: 3315 568
Annex 1

5. SECRETARIAT

WHO/WPRO

Dr Pang Kuyan (Responsible Officer), Regional Adviser in Reproductive Health, WHO Regional Office for the Western Pacific, Manila, Philippines
Telephone: (63 2) 528 9876. Facsimile: (63 2) 521 1036.
E-mail address: PANGR@wpro.who.int

Dr Li Shichuo, WHO Representative in the South Pacific, P.O. Box 113, Suva, Fiji
Telephone: (679) 3300 727. Facsimile: (679) 3300 462 and 3311 530.
E-mail address: lis@fij.wpro.who.int

Mrs Lorraine Kerse, Human Resource Development, P.O. Box 113, Suva, Fiji
Telephone: (679) 3300 727. Facsimile: (679) 3300 462 and 3311 530.
E-mail address: kersel@fij.wpro.who.int

Dr Khine Sabai-Latt, Short-term Professional, Reproductive Health, WHO Regional Office for the Western Pacific, Manila, Philippines
Telephone: (63 2) 528 9878. Facsimile: (63 2) 521 1036.
E-mail address: LattK@wpro.who.int

Mrs Sachie Iiyama, Associate Professional Officer, Reproductive Health, WHO Regional Office for the Western Pacific, Manila, Philippines
Telephone: (63 2) 528 9876. Facsimile: (63 2) 521 1036.
E-mail address: IiyamaS@wpro.who.int

UNFPA/Sub-Regional Office

Ms Catherine S. Pierce, UNFPA Representative for the South Pacific, United Nations Population Fund, Sub-regional Office, Private Mail Bag, Suva, Fiji
Telephone: (679) 3308 022. Facsimile: (679) 3312 785
E-mail address: cpierce@unfpa.org.fj

Ms Urmila Singh, Assistant Representative, United Nations Population Fund, Sub-regional Office, Private Mail Bag, Suva, Fiji
Telephone: (679) 3308 022. Facsimile: (679) 3312 785.
E-mail address: usingh@unfpa.org.fj
WORKSHOP ON IMPROVING QUALITY CARE IN FAMILY PLANNING IN THE PACIFIC

Nadi, Fiji
29 July-2 August 2002

AGENDA

1. Opening ceremony
2. Workshop orientation
3. Overview of reproductive health situation in the Pacific and challenges for family planning strategy
4. Overview of Medical eligibility criteria manual
5. Poster competition
6. Contraceptive methods
   (a) Combined oral contraceptives
   (b) Progestogen only contraceptives, emergency contraceptives, Norplants
   (c) Injectables
   (d) Intra-uterine devices (IUDs)
   (e) Permanent methods (male and female)
   (f) Fertility awareness methods, lactational amenorrhoea method
   (g) Barrier methods
7. Meeting adolescents’ needs
8. Service standards review
9. Adolescent reproductive health programmes
10. Informed choice
    Male participation
11. Logistics of contraceptives
12. Country recommendations to improve quality care in family planning and development of training plan
13. Evaluation of workshop
14. Presentation of training plan and country recommendations to improve quality care in family planning
15. Conclusion
16. Closing ceremony
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<tr>
<th>Time</th>
<th>Monday, 29 July</th>
<th>Tuesday, 30 July</th>
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<td>Daily recap</td>
<td>Contraceptive method 4 - Permanent methods - Male and female/intra-uterine devices (IUDs)</td>
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<td>1) Presentation by key countries - Tuvalu (Permanent method); Solomon Islands and Tonga (IUDs)</td>
<td>Contraceptive method 5 - Fertility awareness methods, lactational amenorrhoea method</td>
<td>Presentation of training plan and country recommendations to improve quality care in family planning</td>
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<td>1) Presentation by key countries - Cook Islands and Fiji</td>
<td>2) Lecture/discussion</td>
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<td>Election of workshop officers</td>
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<td>1030-1100</td>
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<td>COFFEE BREAK</td>
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<td>Conclusion</td>
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<td>Introduction/expectations</td>
<td>Case studies</td>
<td>Contraceptive method 6 - Barrier methods</td>
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<td>(IUD, permanent methods)</td>
<td>1) Presentation by key countries - Solomon Islands and Tonga</td>
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<td>Overview of reproductive health situation in the Pacific and challenges for family planning strategy</td>
<td>Group work: Service standard</td>
<td>2) Lecture/discussion</td>
<td>Adolescent reproductive health programmes - Marshall Islands and Vanuatu</td>
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<td>1) Presentation by key countries - Kiribati and Marshall Islands</td>
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<td>2) Lecture/discussion</td>
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<td>1330</td>
<td>Overview of Medical eligibility criteria manual</td>
<td>Role play - &quot;Meeting adolescents' needs&quot;</td>
<td>Field trip</td>
<td>Role play - &quot;Informed choice&quot; and &quot;Male participation&quot;</td>
<td>Logistics of contraceptives</td>
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<td>How to use the document and programme implications</td>
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<td>1530</td>
<td>Poster competition</td>
<td>Case studies</td>
<td>Field trip</td>
<td>Group work</td>
<td>1) Country recommendations to improve quality care in family planning</td>
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<tr>
<td>to</td>
<td></td>
<td>(COC, POC, EmOC, Norplant, Injectables)</td>
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<td>2) Develop training plan</td>
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<td>Field trip</td>
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<td>Evaluation of workshop</td>
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<tr>
<td>1700-1800</td>
<td>Panel discussion on UNFPA programme implementation (only with Project Coordinators)</td>
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<td>Daily meeting of organizers</td>
</tr>
<tr>
<td>1900</td>
<td>Get-together</td>
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Group work “Service Standards”

Fiji/ Kiribati/ Cook Islands

**SERVICE STANDARDS – COMBINED ORAL CONTRACEPTIVES**

All 3 countries need a standard practice manual on Family Planning.

**COOK ISLANDS** - Already have guidelines but no manual.

- They need to review, develop and update.
- They will have workshop in November for Outer Island staff. Inservice will include the update for guideline and standard copies will be given to the participants for piloting.

**FIJI** - Already have a manual.

- Need for review and update.
- In October, this will be discussed in the National Forum on Reproductive Health.
- First you will have Working Committee.
- October, you will create awareness and give updated version to participants.
- Final revised version may be available in a years time.
- Incorporate the manual into Under and Post Graduate Nursing and Medical School Curriculum.

**KIRIBATI** - No manual on Family Planning.

- They will need working group – Health Professionals/Consultants
- By March 2003 - the manual should be ready
  - April 2003 - pre-test
  - May 2003 - a bigger forum with policy makers, Region heads and NGO to review it
- June 2003 - new release

**NEEDS FROM 3 COUNTRIES**

- Consultant
- Financial support for - Review
  - Production of Manual
  - Workshop
  - Printing cost
  - Distribution
  - Training service providers
Annex 4

Group work “Service Standard” FSM, Vanuatu, Samoa

SERVICE STANDARDS – INJECTABLES

First: Yes there is a need.

Second: FSM/Vanuatu have “Protocols” and manuals Samoa – unsure, thought staff spoken to say – No

Third: 1) Overview of contraception and why
2) For injectables what available
   - how work
   - benefits/disadvantage
3) Checklists
   • For Provider - Medical eligibility
   - Examination
   * Box for “counseling” done or not to be included
   * Format similar to Solomon Islands

i.e. Question | Y/N | Provider action

• For Client - Have you been counselled?
  SE – what to do
  STI/HIV risks
4) Procedure specifications
   - How to administer
   - Precautions

- Possible immediate/delayed complications and what to do.

Fourth: 1) Medical Eligibility
   - Category classification for different conditions
2) Examination
   - Weight
   - Blood pressure
   - Smear
   - Other if indicated
3) SE
   - What to do (weight, ammenorrhoea, bleeding)
   * should be part of counselling

Fifth: FSM/Vanuatu - Inservice training
- Develop service standard
- Consultant
Samoa
- Will try the above
Group work “Service Standard”

Tonga, Solomon Islands, Tuvalu

SERVICE STANDARDS - IUCD

Check List for:
1. History
2. Examination
3. IUCD Insertion Technique
4. Follow-up and Removal

HISTORY
• Age and Parity
• LMP and Menstrual History
• Sexual History
• Previous Family Planning method
• Reason for IUCD selection - spacing - completed family
• Previous STI
• PV discharge, abnormal bleeding

EXAM CHECKLIST
• General : Clinical anaemia
• Abdomen --> Palpate - masses - tenderness
• Pelvic
  a) Inspect vagina - growths - discharge
  b) Speculum - vaginal walls - cervix (discharge, colour, Cx Os)
  c) Bimanual - feel uterus and adnexa - size - mobility and consistency - tenderness - adnexa, fornices

By the end of History taking and Examination, the client is categorized into one of the “4 Medical Eligibility Criteria” categories.
Annex 4

INSERTION TECHNIQUE

• Principles:
  1) Observe aseptic technique
     ➢ Bed and Light
     ➢ Insertion kit
     ➢ Drapes and cleansing agents
     ➢ Gloves
     ➢ Trained provider to undertake procedure
  2) Basic equipment for insertion
  3) “No Touch” technique or “Double Glove” technique
  4) Follow strict instructions as per IUCD pack

• Counseling
  1) Pre-insertion counseling
     ➢ IUD action, effectiveness, side effects
     ➢ Discuss fears, concerns, misconceptions
     ➢ Assurance
     ➢ Explain insertion procedure
  2) Post-insertion counseling
     • Immediate minor side effects
       ➢ Bleeding
       ➢ cramps
     • Explain and discuss common side effects, especially increase in menstrual flow
     • Explain possibility of major side effects and complications
       ➢ Possible failure → pregnancy
       ➢ Expulsion
       ➢ Partner response
       ➢ Follow-up

IN-COUNTRY ACTION

• Organize workshop for service providers
  1) Review existing FP service
  2) Introduce and familiarize 4 checklists for IUD standards
  3) Discuss practicalities of utilising checklists and standards
  4) Update technical information on IUD
     ➢ Demonstrate insertion technique
     ➢ Include “counseling”
     ➢ Case management
  5) Participants to develop own workplan to “Promote IUCD insertion” in own setting
STRATEGIC DIRECTIONS – COOK ISLANDS

- Review/Develop/Update
  - RH/SH/FP/Policy/Documents
  - Guidelines
  - Standards
  - Procedures

- Capacity Building
  - Enhance staff competency skills
  - Provider bias
  - Attitude/Values
  - Counseling skills

- Need RH Programme Assistant for UNFPA-funded projects
  - Facilitate programme co-ordination
  - Implementation
  - Monitoring
  - Evaluation

- Special attention on Adolescent Health
  - Intensify adolescent health program
  - Counseling
  - Confidentiality
  - Accessibility/Availability
  - Continue new IEC initiatives
  - Strengthen advocacy and dissemination of information to adolescents
  - Intensify community awareness; incidence of teen pregnancy to encourage parental and community commitment to reduce teenage pregnancy

- Strengthen Management/Information System
  - Recording system
  - Information collection
  - Timely reporting
  - Data analysis
  - Plan for action
Title of Training: RH/FP Coordinators Meeting

Purpose of Training: Review FSM's existing RH/FP Manual and Service Protocol to upgrade and update the documents with the hope of improving FP services in the FSM.

Objectives of the training: By the end of the workshop, participants will be able to:

1. develop a revised and updated FP Manual and Service Protocol for the FSM, and
2. know the documents and can provide quality FP services based on completed Manual and Protocol.

Activities:
1a. Review existing FP Manual and Service Protocol for the FSM.
1b. Review WHO MEC and SPR documents,
1c. Brainstorm on areas requiring revision, and
1d. Discuss, agree and make changes.

2a. Develop and practice exercises during workshop
2b. Feedbacks provided after practice activities.

Duration: 1 week

Participants: RH/FP/MCH Coordinators, OB/GYN, Public Health Chiefs from the four (4) FSM States and National RH/SH/FP Project Staff.

Venue: Central facilities, Palikir, Pohnpei, FSM National Government

Budget: $US20,000 (Local Cost Request, Blue Form will be submitted to WHO)

Monitoring: National Project State will conduct on-site monitoring at State level periodically approximately twice a year.

State Project Staff will monitor activities on a daily/weekly/monthly/quarterly basis.

Monitoring at state level will utilize checklist developed during workshop; National Project Staff will use existing Monitoring Forms.

Evaluation: Written Evaluation to be developed by National Project Staff, and Feed Backs.

Responsible Agency: Four (4) State Department of Health Services and FSM Department of Health, Education and Social Affairs.
TRAINING PLAN: IMPROVING QUALITY CARE IN FIJI F/P SERVICES

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Duration</th>
<th>Participants</th>
<th>Budget</th>
<th>Monitoring</th>
<th>Evaluation</th>
<th>Responsible agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To provide Quality Care in F/P services and improve standards</td>
<td>Continuous in-service training in counseling and knowledge for service providers</td>
<td>5 days</td>
<td>Nurses and Doctors (10-15)</td>
<td>$15,000 (3 w/shops)</td>
<td>Follow-up reports</td>
<td>Increase CPR, new acceptors</td>
<td>MOH</td>
</tr>
<tr>
<td></td>
<td>Nonplant services to be extended to all the DIV</td>
<td>3 days</td>
<td>Doctors (6)</td>
<td>$4,000</td>
<td>Follow-up visits</td>
<td>Increase in Nonplant users</td>
<td>MOH</td>
</tr>
<tr>
<td>2. To create awareness to our male population</td>
<td>Vasectomy training for doctors</td>
<td>3 days</td>
<td>Doctors (6)</td>
<td>$4,000</td>
<td>Follow-up and reports</td>
<td>Increase in vasectomy acceptors</td>
<td>MOH</td>
</tr>
<tr>
<td></td>
<td>Male awareness</td>
<td>1 day</td>
<td>Males</td>
<td>$10,000</td>
<td>Increase male participation</td>
<td>Increase male acceptors</td>
<td>NGO</td>
</tr>
<tr>
<td>3. To involve religious bodies in awareness programs</td>
<td>Religious Leaders awareness program</td>
<td>1 day x 10</td>
<td>Religious leaders and community</td>
<td>$10,000</td>
<td>Follow-up and increase in demand</td>
<td>Number of participants with knowledge</td>
<td>MOH, NGO</td>
</tr>
<tr>
<td></td>
<td>Community awareness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Improve ARH services for youth</td>
<td>Youth awareness both for girls and boys</td>
<td>1 day x 10</td>
<td>Youth from Province</td>
<td>$10,000</td>
<td>Follow-up</td>
<td>Increase knowledge and informed choices</td>
<td>MOH, NGO</td>
</tr>
</tbody>
</table>

Total $53,000

COUNTRY RECOMMENDATION TO IMPROVE QUALITY CARE IN FAMILY PLANNING IN FIJI

1. Development of competency skills and capacity building
2. To update our manual
3. Improvement of statistics and RH data
4. Availability of FP methods
5. Reproductive health research
6. Male involvement
7. Logistic and supplies
8. Involvement of Religious body and NGOs
### Workshop "Improving Quality Care in Family Planning in the Pacific"

29 July – 2 August 2002 Nadi, Fiji

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE</th>
<th>TRAINING COMPONENT</th>
<th>DURATION (TIME LINE)</th>
<th>PARTICIPANTS</th>
<th>NUMBER OF PARTICIPANTS</th>
<th>VENUE</th>
<th>ESTIMATED BUDGET</th>
<th>MONITORING AND EVALUATION</th>
<th>RESPONSIBLE AGENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve quality of RH health care services in Kiribati</td>
<td>To upgrade and update the knowledge and skills of RH and FP service providers</td>
<td>Two components. Outside Kiribati and In-Kiribati.</td>
<td>Female doctor</td>
<td>One</td>
<td>Manila</td>
<td>US$18,000</td>
<td>Ensure the doctor qualified after 6 months. Have certificate</td>
<td>WHO/UNFPA/Kiribati/Institution</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outside Kiribati - a. Colposcopy and Scan</td>
<td>6 months (Sept 2002 to Feb 2003)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>c. Hand-on training on Norplant and IUCD insertion and removal</td>
<td>2 months for two nurses (September to October 2002)</td>
<td>Male and Female Senior nursing staff</td>
<td>Two</td>
<td>Bangkok</td>
<td>$US10,263 ($5132 each)</td>
<td>Ensure nurses are trained well and get certificate on FP</td>
<td>WHO/UNFPA/Kiribati/Institution</td>
</tr>
<tr>
<td>Sub-Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$46,263</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Kiribati - a. Workshops</td>
<td></td>
<td></td>
<td></td>
<td>All public Health staff</td>
<td>30 x 3 = 90</td>
<td>Tarawa</td>
<td>US$33,126. (US$11,042 each)</td>
<td>Monitoring during the workshops Report of 3 x 7 days workshop</td>
<td>MOH/WHO/UNFPA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>US$33,126</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>US$79,389</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## TRAINING WORKPLAN

**COUNTRY:** SAMOA

### TITLE:
Training of service providers to conduct "MEN'S WORKSHOPS"

### PURPOSE:
To update / educate service providers on how to conduct a "MEN'S WORKSHOP" to educate men on contraception, why use, and what choices available in a culturally and religiously sensitive way.

### OBJECTIVES:
1. To update mechanism of conception to service providers to enable them to be able to educate men on basic anatomy/physiology leading to conception
2. To update current contraceptive choices in Samoa for men and women
3. To update knowledge on condom use, why as a contraceptive choice, how to use, when to use, what to do if "accidents", how to access, advantages/disadvantages. Also educate on how to counsel men in a "user-friendly" way.
4. To update on "vasectomy" – why choose, advantages/disadvantages, how conducted i.e. procedure, how to access. Also how to counsel in culturally/religiously sensitive way.
5. How to counsel men in contraceptive choices in user-friendly way

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Activities</th>
<th>Duration</th>
<th>Participants</th>
<th>Budget</th>
<th>Monitoring</th>
<th>Evaluation</th>
<th>Responsible agencies</th>
</tr>
</thead>
</table>
| 1. To update mechanism of conception to service providers | * Lecture on basic anatomy and physiology  
* Q & A  
* Role Play | 1.5 hrs | 8 total but 2 x w/shops. One on each main island, 4 participants in each | $4,000 for 2 x w/shops | Pre-test + Post-test | MOH under RH project |
| 2. To update current contraceptive choices for men and women | * Lecture  
* Q & A  
* Role Play | 1.5 hrs | | | | |
| 3. To update knowledge on condom use | * Lecture  
* Q & A  
* Role Play | 2.5 hrs | | | | |
| 4. To update knowledge on vasectomy and how to counsel | * Lecture  
* Q & A  
* Role Play | 4 hrs | | | | |
| 5. How to counsel men | * Lecture  
* Q & A  
* Role Play | 1.5 hrs | | | | |
**TRAINING WORKPLAN – SOLOMON ISLANDS**

**NAME OF TRAINING:** FAMILY PLANNING DISTANCE EDUCATION

**PURPOSE OF TRAINING:** To improve quality of care in Family planning in Solomon Islands.

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>ACTIVITIES</th>
<th>DURATION</th>
<th>PARTICIPANT</th>
<th>BUDGET</th>
<th>MONITORING</th>
<th>EVALUATION</th>
<th>RESPONSIBLE AGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To improve and strengthen competency skill and capacity building of service providers in FP.</td>
<td>1.1 Revise &amp; update FP module</td>
<td>4 weeks</td>
<td>No participant</td>
<td>$???</td>
<td>Weekly meeting with consultant to see progress of development.</td>
<td>Accomplished task according to work plan</td>
<td>WHO consultant</td>
</tr>
<tr>
<td></td>
<td>1.2. Develop procedure book &amp; assessment guideline</td>
<td>4 weeks</td>
<td>No participant</td>
<td>$???</td>
<td></td>
<td></td>
<td>WHO consultant</td>
</tr>
<tr>
<td></td>
<td>1.3. Print module</td>
<td>2 weeks</td>
<td>No participant</td>
<td>$2,000</td>
<td></td>
<td></td>
<td>RH Division staff</td>
</tr>
<tr>
<td></td>
<td>1.4. Train FP coordinators on the use of FP assessment guidelines.</td>
<td>1 week</td>
<td>6 FP coordinators</td>
<td>$3,000</td>
<td>Correctly use the assessment guidelines</td>
<td>Able to train &amp; supervise nurses on attachment.</td>
<td>Dr J Pikacha</td>
</tr>
<tr>
<td></td>
<td>1.5. Practical attachment of Dis Ed. Nurses.</td>
<td>8 weeks</td>
<td>10 Distant Ed nurses</td>
<td>$7,000</td>
<td>Nurse on site of training.</td>
<td>Complete IUCD &amp; other FP/RH requirement.</td>
<td>J Seke</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Competent in IUCD insertion and other RH/FP skills</td>
<td>V Gagahe</td>
</tr>
</tbody>
</table>
## TRAINING PLAN:

### 2. NAME OF TRAINING: NON-SCALPEL VASECTOMY TRAINING

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>ACTIVITIES</th>
<th>DURATION</th>
<th>PARTICIPANT</th>
<th>BUDGET</th>
<th>MONITORING</th>
<th>EVALUATION</th>
<th>RESPONSIBLE AGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve and strengthen competency skill and capacity building of service providers in FP.</td>
<td>2.1 Selection of candidate for training</td>
<td>1 week</td>
<td>No participants</td>
<td>$0.00</td>
<td>In line with Human resource development training plan for MHMS.</td>
<td></td>
<td>RH Division Provinces</td>
</tr>
<tr>
<td></td>
<td>2.2 Complete FAF forms and submit to WHO</td>
<td>1 week</td>
<td>No participants</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3 Undergo training in non-scalpel vasectomy.</td>
<td>8 weeks</td>
<td>2 Doctors &amp; 2 RHI nurses (males)</td>
<td>$32,000</td>
<td></td>
<td></td>
<td>Doctors &amp; RHI nurses with WHO</td>
</tr>
</tbody>
</table>

Annex 4

Workshop "Improve Quality Care in Family Planning in the Pacific"
29 July – 2 August 2002 Nadi, Fiji
### TRAINING PLAN:

#### 2. NAME OF TRAINING: INSERTION AND REMOVAL OF IMPLANT

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>ACTIVITIES</th>
<th>DURATION</th>
<th>PARTICIPANT</th>
<th>BUDGET</th>
<th>MONITORING</th>
<th>EVALUATION</th>
<th>RESPONSIBLE AGENCY</th>
</tr>
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<tbody>
<tr>
<td>To improve and strengthen competency skill and capacity building of service providers in FP.</td>
<td>3.1 Selection of candidate for training</td>
<td>1 week</td>
<td>No participants</td>
<td>$0.00</td>
<td>In line with Human resource development training plan for MHMS.</td>
<td>In line with Human resource development training plan for MHMS.</td>
<td>RH Division Provinces</td>
</tr>
<tr>
<td></td>
<td>3.2 Complete FAF forms and submit to WHO</td>
<td>1 week</td>
<td>No participants</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3 Undergo training in implant.</td>
<td>8 weeks</td>
<td>2 Doctors &amp; 2 RH nurses</td>
<td>$30,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Workshop “Improving Quality Care in Family Planning in the Pacific”
29 July – 2 August 2002 Nadi, Fiji

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Annex 4
### Table: Training on the Use of the Revised Standard Guidelines in FP

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>ACTIVITIES</th>
<th>DURATION</th>
<th>PARTICIPANT</th>
<th>BUDGET</th>
<th>MONITORING</th>
<th>EVALUATION</th>
<th>RESPONSIBLE AGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>To revise &amp; update the SI FP handbook for Health personnel</td>
<td>3.1 Revise &amp; update the “Solomon Island Family Planning Handbook for Health Personnel”</td>
<td>4 weeks</td>
<td>No participants</td>
<td>$0.00</td>
<td>Inline with local situation and MEC &amp; SPR</td>
<td>Draft of the revised manual available</td>
<td>RH Division, MHMS (Judith, Alice &amp; Junilyn)</td>
</tr>
<tr>
<td></td>
<td>3.2 Print the revised manual</td>
<td>8 weeks</td>
<td>No participants</td>
<td>$18,000</td>
<td>Revised manual printed and ready for distribution</td>
<td>Revised manual printed and ready for distribution</td>
<td>RH Division &amp; Printery (Judith)</td>
</tr>
<tr>
<td></td>
<td>3.3 Draw up training plan for all provinces</td>
<td>1 week</td>
<td>No participants</td>
<td>$0.00</td>
<td>All provinces are included in the plan</td>
<td>Training plan completed</td>
<td>RH Division, MHMS (Judith &amp; Alice)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RH Division (Judith, Alice &amp; Junilyn)</td>
</tr>
<tr>
<td>To train service providers on the use of the manual.</td>
<td>3.1 Conduct 2 trainings per province in all provinces</td>
<td>1 week</td>
<td>All service providers</td>
<td>$30,000</td>
<td>No of training completed based on training plan,</td>
<td>-All service providers will have had training on the revised updates in the FP manual for health workers.</td>
<td>RH Division</td>
</tr>
<tr>
<td></td>
<td></td>
<td>training per province x 2 groups x 9 provinces = 18 weeks (18 trainings)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All provinces.</td>
</tr>
</tbody>
</table>

Training from Feb 2003 onwards. Budget in $USD.
### TRAINING WORKPLAN: IMPROVING QUALITY OF CARE IN FAMILY PLANNING  
**COUNTRY: TONCA**

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTIVITIES</th>
<th>DURATION</th>
<th>PARTICIPANTS</th>
<th>BUDGET</th>
<th>MONITORING</th>
<th>EVALUATION</th>
<th>RESPONSIBLE AGENCY</th>
</tr>
</thead>
</table>
| To upgrade knowledge of health service providers on Medical eligibility criteria (MEC) of contraceptive methods and selected practice recommendation (SPR) | 1. Conduct an update workshop on Contraceptive methods  
2. Logistics of Contraceptives | September December | Public Health Nurses, Health Officers, Doctors and TFHA clinic staff  
All service providers | $4992USD | Monthly reports Supervisory visits  
In-service training  
Case Management | Oral and written evaluation during the workshop | Min of Health in collaboration with TFHA |
| To review policies and practices and adopt new policies in view of recent developments in contraceptive technology | Develop and Pre-test checklist  
Printing checklists | By October | RH & ARH Coordinators, Nurse Practitioner  
Senior Nurse  
Midwife | $1500USD | Report to Manager | To be in place by December | MOH/TFHA |
| To increase CPR | Review FP Client cards, FP report card, FP Referral card and Follow up card  
Pretest and Print | By October | RH & ARH Coordinators, Senior Nurse Midwife, Nurse Practitioner, Public Health Nurse | $1023USD | Report to Manager | To be in place by December | MOH / TFHA |
TONGA – Country Recommendations on How to improve QOC in Family Planning

1. To adopt and adapt standards and guidelines according to MEC and SPR
2. To provide on going in-service and update training on Contraceptive Technology
3. To put in place a Competency based assessment of service providers on FP methods including IUD insertion.
4. To train health professionals on IUD insertion, Vasectomy, Norplant techniques and FP Methods
5. To conduct annual review meetings to review FP data and plan for subsequent years.
6. To improve logistics of contraceptives
7. To review reporting and recording system
8. To conduct training on Research skills to conduct research on FP methods and usage
9. To review family planning manual
10. To improve IEC materials and advocacy on Family Planning
11. To train service providers on Counselling skills.
12. To increase male involvement and church networking
13. To integrate Adolescent Reproductive Health activities into RH project activities.

Need WHO, UNFPA, SPC and other donors assistance to achieve the above recommendations.
### TRAINING WORKPLAN

**Title: Update of Technical Information on Contraceptive Methods including MEC & SPR**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Duration</th>
<th>Participants</th>
<th>Budget</th>
<th>Monitoring</th>
<th>Evaluation</th>
<th>Responsible agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To develop knowledge of service providers on using MEC &amp; SPR for contraceptives</td>
<td>1. To conduct a workshop for health service providers on MEC &amp; SPR</td>
<td>2 weeks (last week of October)</td>
<td>10 (Doctors and nurses)</td>
<td>$10,000</td>
<td>Supervisory visits to clinics. Monthly reports</td>
<td>Service providers are well versed with MEC &amp; SPR</td>
<td>WHO Project director</td>
</tr>
<tr>
<td></td>
<td>2. To review current practices and standards and update them</td>
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<td>3. Print and field test the updated manual</td>
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<td>4. Final print of manual</td>
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<td>2. To update the current practices and standards and include MEC &amp; SPR</td>
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<td>3. To develop competency skills of the service providers</td>
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**Title: IUCD and Norplant insertion and Removal/ Vasectomy**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Duration</th>
<th>Participants</th>
<th>Budget</th>
<th>Monitoring</th>
<th>Evaluation</th>
<th>Responsible agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To develop knowledge of service providers on IUCD insertion</td>
<td>1. To write a proposal to WHO</td>
<td>3 months in Manila (Feb 2003)</td>
<td>2 Nurses 1 Male doctor</td>
<td>$20,000</td>
<td>Make sure that these nurses and doctor attend the training</td>
<td>Trained, qualified IUCD and Norplant insertion and vasectomy</td>
<td>WHO MOH Project director &amp; coordinator</td>
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<td></td>
<td>2. Send fellowship</td>
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<tr>
<td>2. To provide competency skills for service providers</td>
<td>3. Participants undergo training</td>
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<td>3. To improve quality care on IUCD and Norplant insertion</td>
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<tr>
<td>Objective</td>
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</tbody>
</table>
| 1. To develop knowledge on how to conduct a survey | 1. To conduct workshop for nurses | 2 weeks (Nov 2002) | 10 Nurses and NGO (TUFHA) | $10,000 | Ensure that survey is conducted | Improved data management | MOI
Project director and coordinator E.D. TUFHA |
| 2. To improve data collection, compilation, analysis and interpretation | 2. To develop the questionnaires |  |  |  |  |  |  |
|  | 3. To conduct a survey |  |  |  |  |  |  |
# TRAINING WORKPLAN: VANUATU

**OBJECTIVE** | **ACTIVITIES** | **DURATION** | **PARTICIPANTS** | **BUDGET US** | **MONITORING** | **EVALUATION** | **RESPONSIBLE AGENCY**
---|---|---|---|---|---|---|---
**PURPOSE 1:**

**To establish and review contraceptive standards and guidelines**

1. Update knowledge of health workers on the use of MEC, SPR and contraceptive methods
   - **Activities:**
     1. National training for health workers (doctors, nurses, provincial key RH officers)
     2. Two urban and six provincial training for HWs on MEC, SPR and managing contraceptive supplies workshop
   - **Duration:**
     1. 1 week (Feb 2003)
     2. 8 trainings of 2 weeks in 2003-2004
   - **Participants:**
     1. 24
     2. 20/training
   - **Budget:**
     1. 10,000
     2. 24,000 WHO/AusAID or other funding agency
   - **Monitoring:**
     1. Health workers trained using the MEC and standard guidelines
     2. Health workers trained using the MEC and standard guidelines
   - **Evaluation:**
     1. 24 health facilities are using MEC and SPR by 2003
     2. Increase in CPR
   - **Responsible Agency:**
     1. Directorate of Public Health, MOH
     2. WHO Port Villa
     3. Ms. Lilly N.

2. Review current standards and guidelines
   - **Activities:**
     1. Review and update current manual handbooks:
        - National FP manual
        - FP handbook
        - FP component Health Worker’s Manual
        - Review existing FP recording and reporting mechanism
   - **Duration:**
     1. 2 weeks (April 2003)
   - **Participants:**
     1. 12
   - **Budget:**
     1. 5,000
   - **Monitoring:**
     1. Produce drafts
     2. Pilot study using drafts
     3. Final Copy
   - **Evaluation:**
     1. Increase in CPR
   - **Responsible Agency:**
     1. Directorate of Public Health, MOH
     2. WHO Port Villa
     3. WHO Manila

**PURPOSE 2:**

**Development of competency skills and capacity building**

1. A doctor is trained and commencing service delivery on Norplant as in the approved MOH FP Manual
   - **Activities:**
     1. Norplant training fellowship
   - **Duration:**
     1. 2 weeks (Dec 2002)
   - **Participants:**
     1. 1
   - **Budget:**
     1. 10,000
   - **Monitoring:**
     1. Number of users of Norplant is observed on the MIS
   - **Evaluation:**
     1. In Dec. 2003, there is a number of users of Norplant
   - **Responsible Agency:**
     1. Directorate of Public Health, MOH
     2. DOSHC
     3. WHO Port Villa
     4. WHO Manila
     5. Ms. Lilly Sala
     6. Ms. Lilly Andre