ROMANIA

Reaching the Poor: Scaling Up Integrated Family Planning Services

INTRODUCTION

During the 1970s and 1980s under the Ceausescu dictatorship, family planning and abortions were highly restricted in Romania as the government pursued a rigidly enforced pronatalist policy. After the fall of the regime in 1989, such policies were reversed. Desire for small family size resulted in low fertility rates, but modern contraceptives were not readily available or affordable, and there was a dramatic lack of access to family planning (FP) services for all of Romania but especially in rural areas and for the poor. As in many Central and Eastern European countries, abortion became the most prevalent method of birth spacing and fertility control.

In the late 1990s, the ongoing process of Romanian health reform introduced the family doctor (a general practitioner) as the gatekeeper for the health system, and began the shift from a vertical model based on medical specialists to a primary health care (PHC) system. The continuous development of the private sector in the mid-1990s, together with the government network of FP clinics in urban areas (210 urban FP clinics around the country), led to an improvement in access to modern contraceptives for the urban population. But the incidence of unintended pregnancy, the abortion rate, and maternal mortality due to abortion remained high compared to most countries in Europe, and access to modern contraceptives continued to be extremely limited, particularly in rural areas. By 1999, the new category of health providers, family doctors, were offering a considerable range of services, but not family planning, due to lack of training and the absence of enabling regulations and norms to provide this new service.

Why It Matters

In the 1990s access to family planning was extremely limited in rural areas of Romania and abortion was the most widespread method of birth control. Under the JSI-led Romanian Family Health Initiative (RFHI) integrated family planning coverage has expanded nationwide to over 2000 rural communities. The central and district governments manage the program and supervise service providers, an efficient logistics system is procuring and distributing contraceptives, and innovative behavior change campaigns and IEC materials have led to more informed choice-making. Surveys show that rural modern contraceptive use increased from 21% in 1999 to 33% in 2004, while rural abortion declined from 2.4 to 1.1 in the same period.

In 1999, a USAID-funded project implemented family planning as an integrated component of primary care services in 36 primary health care units in 3 districts. Under the project, family doctors provided FP services and dispensed free contraceptives. The success of this pilot project laid the groundwork for national scale up, which was implemented by the Romanian Family

to expand and improve FP and other reproductive health (RH) services, and to work at the policy and service provision levels to ensure that FP/RH services are fully integrated into the framework of Romanian health reform.

The scaling up of integrated FP services through primary care providers was carefully planned to ensure a balance between quality of care, equity/coverage, and cost efficiency. Special care was taken to reduce inequalities affecting the poor and most vulnerable, including minorities. However, scaling up was not simply a replication of key activities in new geographical areas; rather, it was a challenging exercise to simplify the approach used at model sites and strengthen the districts for decentralized management and sustainability of services. At the center of RFHI's strategy was the Three Pillars Approach, which focused on creating key conditions at the same place and time: trained providers; contraceptive supplies; and IEC/BCC (demand creation activities).

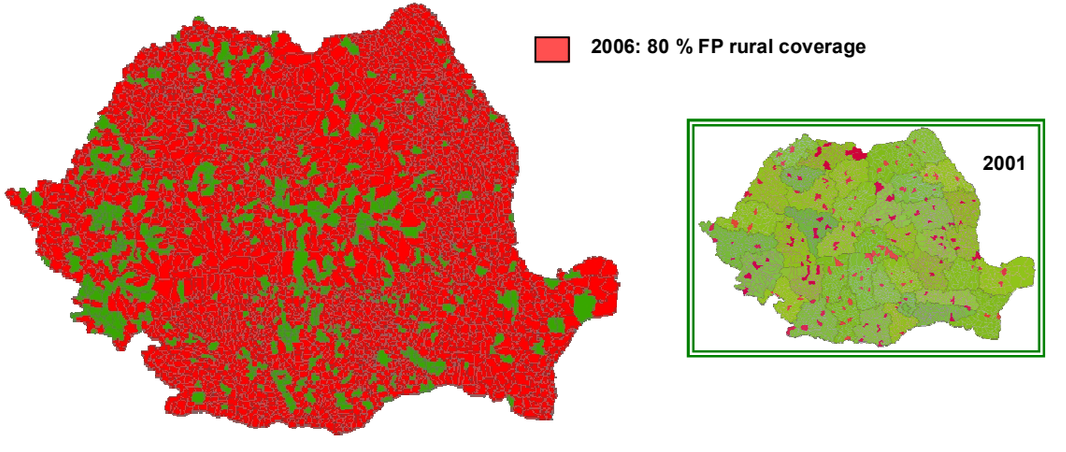
ment, and BCC activities. Data on providers trained and PHC clinics that provide FP services and contraceptives form part of a national training database that is used to produce geographic information system (GIS) maps (**Figure 1**).

Impact was measured by contraceptive prevalence rates (CPR) through the Population RH Surveys conducted in 1999 and 2004. Couple-years of protection (CYP) provided by rural family doctors (offering free and low-price contraceptives) was used as a proxy indicator for national CYP coverage between population-based RH surveys.

Process-Level Results

- Access to family planning services for the poorest population has increased. There are now more than 5,105 family doctors and 3,063 nurses in 42 districts trained to provide basic FP services. Romania now has 2,285 "communes" in rural areas with at least one trained family doctor who provides FP services and offers free and low-cost contraceptives to the

Figure 1: National coverage with trained family planning providers, September 2006 compared to September 2001 (baseline)



enable trained family doctors and nurses to provide FP services. Evidence-based protocols were also included which reconfigured the legal and regulatory framework to permit the implementation of the program at the national level. To assure that access to FP services is universal, the MOHF contracted with the National Health Insurance House (NHIH) to provide the entire Romanian population, regardless of insurance, the right to use FP services free of charge.

- A national logistic management information system (LMIS) was created to track the distribution of contraceptives donated by USAID and UNFPA and from the MOHF. The LMIS has increased national capacity to monitor reproductive health achievements, as well as ensure contraceptive distribution.
- The MOHF now has a specific budget line to fund the procurement of contraceptives and other related activities. The MOHF increased resources allocated to the FP program from $100,000 USD in 2001 to over $1.3 million in 2005 (see **Figure 2**).
- The MOHF, district public health authorities, and even providers, now have the ability to plan and

sions now function in all districts and have strengthened the allocation of resources locally. These commissions act as local consultative committees. They have facilitated the participation of NGOs and local government agencies in FP/RH strategy development and implementation.

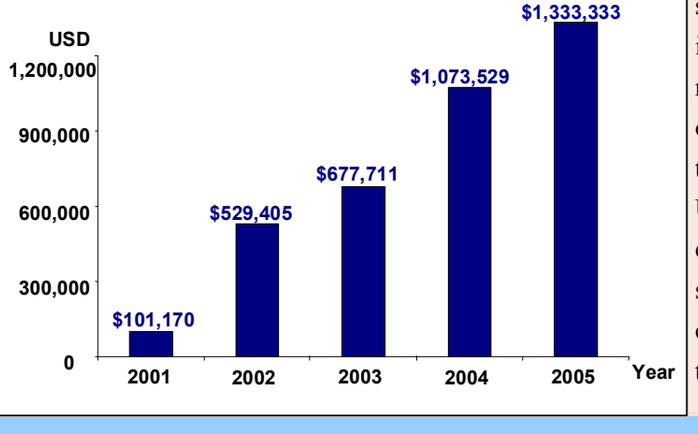
Impact-Level Results

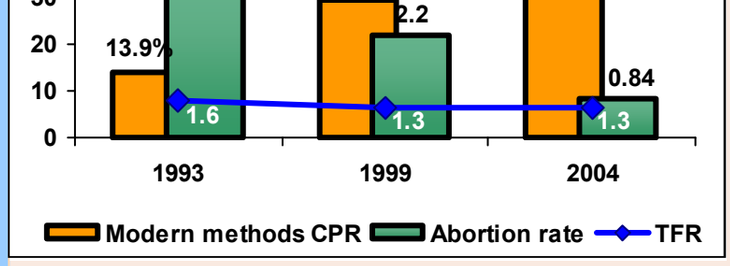
Comparisons between previous reproductive health surveys (RHS) and the 2004 survey showed the following results: a significant increase in contraceptive prevalence rates among women of reproductive age in union from 29.5 percent in 1999 to 38.2 percent in 2004, a decrease in the total abortion rate from 3.4 in 1993 to 0.84 in 2004, and a stable total fertility rate of 1.3 between 1999 and 2004 (see **Figure 3**). In addition, abortion-related maternal mortality decreased 36.8 percent between 1999 and 2004 (from 0.19 to 0.12 per 1000 WRA).

SCALE-UP PROCESS

To scale up the integration of family planning into primary health care nationwide, the RFHI built on the experiences, achievements, and challenges uncovered during the two year pilot work implemented by JSI. The RFHI implemented its scale-up strategy in two stages, initially targeting 10 of the 42 districts. Nationwide implementation was driven further by the enthusiasm of the MOHF and demand from other districts that requested to participate in the program. UNFPA implemented the same program strategy in 8 districts simultaneously. The scale-up strategy addressed some of the most critical challenges to improving Romanian health care, through the following approaches:

Figure 2: Financing for public sector contraceptive procurement, Romania MOHF





portive policies and legislation, standards, and protocols, through a series of multisectoral working groups: strategy, training, LMIS, and IEC/BCC. In addition, a series of national conferences fostered policy dialogue and participatory consensus building among multiple partners. This participatory approach among stakeholders was the critical factor in achieving policy improvements. Furthermore, by strengthening and empowering district authorities to manage the family planning program, districts are now able to tailor or add new services that meet the specific needs of their population.

STEP 1: ***Creating a policy environment favorable to FP-PHC integration*** RFHI's overall approach to policy activities was rooted in the idea that policies must support practical efforts to strengthen service delivery, and, therefore, required broad consultation with multiple stakeholders, including providers and program managers from the local and district levels, and representatives from national institutes, the College of Physicians, and NGOs. This approach ensured that policies were informed by conditions in the field rather than academic studies and theoretical models.

In 2001, a national conference highlighted lessons learned from the pilot phase, including concrete ideas about new or revised policies that were needed. In order to scale up and institutionalize the innovations tested and evaluated in the pilot sites, a national steering committee was established among the main partners to prioritize and address policy barriers, in collaboration with providers and program managers from district and local levels.

STEP 2: ***Implementing a multisectoral approach***
Health reforms involving the integration of services and the new decentralization of health management provided opportunities and challenges that could only be met through coordination among all stakeholders. This coordination allowed the MOHF, donors, NGOs, and other implementing partners to collaborate in identify-

STEP 3. ***Coordinating program implementation following a Three Pillars Approach*** At the center of RFHI's strategy is the Three Pillars Approach, which focuses on creating the following three conditions at the same place and at the same time: 1) a trained provider, 2) contraceptive supplies, and 3) IEC/BCC materials and activities to create demand. A lesson learned from the pilot phase was that clinics not only need trained providers, but also contraceptive supplies and IEC/BCC materials to sustain and increase demand, and providers need to be trained on how to manage the contraceptives and use the materials. The timing of district and national communication campaigns was coordinated with the training schedule to ensure that BCC activities did not build demand in areas where the providers were not yet trained or had the necessary supplies.

STEP 4: ***Training health care professionals and conducting supportive supervision*** To address the technical complexity of scaling up with limited local training and supervision capacity, a training of trainers approach was adopted. Trainers were identified in each of the Romanian districts, and a curricula was developed for patient

to the clinics in each district, usually organized at public venues facilitated by the district public health authorities, thereby decreasing the training expense. This decentralized approach enabled more providers to be trained while spending less time away from their clinics. It also transferred new training skills, particularly in participatory training methodology, to district trainers, who were accredited as trainers by the Post-graduate Institute for Training Health Professionals.

To complement the training and to maintain quality, a standard supervision visit methodology and checklist was developed. Supervision visits became a problem-solving intervention employed to identify, assess, and address obstacles in program implementation at the provider level, and to provide on-site and in-service technical assistance for trained providers distributing free contraceptives.

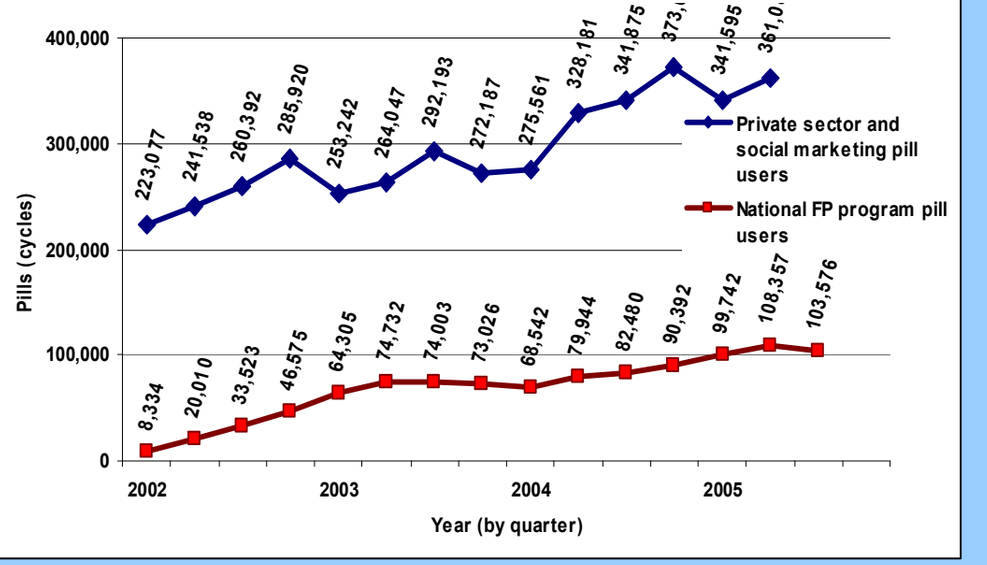
STEP 5: ***Providing and targeting free contraceptives*** Eligibility for free contraceptives was expanded to include all rural clients, who now receive their contraceptive supplies directly from their primary health care center. The provision of free contraceptives has made a significant contribution to increasing CPR and decreasing the rate of abortion. As use of free contraceptives has expanded, so has the private market for

ity of the national program.

STEP 6: ***Developing and implementing a logistic management information system (LMIS)*** To ensure availability of free-of-charge contraceptives, a national logistics system was tailored to local needs and coordinated at the district level to improve contraceptive forecasting, financing, procurement, and distribution at national, district, and provider levels. A set of eight forms (consumption records, stock keeping records, report and requisition forms, and step-by-step LMIS guides) were developed through a process involving stakeholders from all levels of the system.

STEP 7: ***Operationalizing the Demand Pillar***
One of the main challenges in scaling-up behavior change communication in the FP program was the shift from centralized—and in some cases donor-driven—activities to local implementation of strategies managed by local stakeholders. The National IEC/BCC strategy was developed by a multi-stakeholder IEC/BCC work-

Figure 4: Active users of pills from family planning program and private sector



The timing of district and national IEC/BCC campaigns was coordinated with the training schedule to ensure that BCC activities did not build demand in areas where the providers were not yet trained or supplied. A number of special approaches were designed and implemented to address population groups, including:

A family doctor providing counseling in a clinic in San Paul village.

- Designing the national logo to identify PHC clinics providing FP services.
- Launching the program "Among Us Women" in 2002. It reached 160,000 women through 9,500 IPC sessions in 957 factories across the country.
- Working with Roma NGOs to train Roma Health Mediators, who now provide reproductive health information and referrals to Roma communities and help Roma community members access health and other social services.
- Training community nurses as counselors and community outreach workers to leverage their position within the community, since most PHC nurses live in the communities and are seen as trusted friends who can influence health-seeking behaviors.

and Child Care. This unit was an innovative approach to better management of the National FP Program.

STEP 9: ***Assessing and strengthening managerial capacity at the district level*** District public health authorities' management capacity was strengthened through technical assistance from RFHI's NGO partner SECS, and multisectoral district mother and child health commissions. These were established to support DPHAs in planning, budgeting, monitoring and evaluation, resource mobilization and allocation, and other critical areas.

WHAT WORKED

- A pilot phase is vital in demonstrating new approaches, building local evidence that they work, and promoting local champions to advocate for policy changes that support national scale up.
- Primary health care providers are able to provide quality FP services, including counseling to their clients, after receiving adequate training.
- Focusing on integrated FP/RH services has worked well and successfully increased the use of modern contraception and reduced the number of abortions.
- The timing of the program was essential, since it leveraged and helped guide ongoing health sector reform. Scale-up was accelerated because the national and district governments were very supportive and prepared to adopt new approaches and practices that built on recent reforms, particularly related to decentralization and primary health care.
- Decentralized training using trainers who are peers of the providers rather than specialists or academics was effective. A participatory and competency-based training methodology rather than theoretical and academic facilitated the process.

ducting participatory training. As the most important NGO working in FP/RH in Romania, SECS was an obvious partner for RFHI. It has continued key activities in partnership with RFHI, and also provides ongoing supervision at the district level and helps manage the national LMIS for contraceptive distribution. SECS and a number of other local NGOs have been able to pilot innovations on a small scale that were eventually used more widely. They have helped ensure the success of the program and now have the capacity to provide sustainable support for these activities.

- Access to modern contraceptives has been an important factor in the success of the program. By ensuring reliable availability of supplies, the national LMIS is a key component of the increased access to modern contraception in Romania.
- A robust monitoring and evaluation plan was included in the original strategic design of the RFHI, which has allowed program managers to identify quickly what was working and what adjustments needed to be made to the scale-up process. In particular, the use of Geographic Information Systems mapping technology has been very useful in managing, monitoring, and evaluating program scale up and allowing local managers to plan better their services.

WHAT WE LEARNED ALONG THE WAY

- **IEC/BCC takes a concentrated effort.** The still newly emerging decentralization process together with the lack of fluid communications among programs at all levels of the MOHF reduced the number of IEC/BCC activities, and at times caused them not to be synchronized with the availability of the new services. More focused and intensive BCC activities is also necessary.
- **It is important to ensure that providers have updated knowledge.** The FP program is focused on family health doctors who provide counseling and contraceptives to "healthy" clients. Many of the family health doctors are reporting difficulties when they refer clients with certain health conditions to the secondary level of care (Ob/Gyn and other medical specialists) for contraception consultations. This is due to the lack of updated contraceptive knowledge at the secondary level. The RFHI found that all levels of the health system and a broad array of providers (including pediatricians) should be provided updates on modern contraceptive technology and counseling so that the referral system is also effective.
- **A full range of contraceptive options is key.** The Romania method mix needs to be expanded to promote use of long-term and permanent contraceptive methods. Use of vasectomy is very rare and prevalence of female sterilization is only 2.8 percent (2004 RHS), due to misinformation held by both clients and providers and because few providers are trained to perform the procedures.
- **Integrating contraceptive logistics training into provider training is essential**, since the added burden of reporting must be clearly connected to the provision of services. It must also emphasize the benefits to providers of ensuring access to contraceptives: greater ability to meet the needs of their clients, increased job satisfaction in addition to the benefit to their clients.
- **Partnership with the private commercial sector needs to be integrated into the initial program strategy.** For RFHI, this was a missed opportunity, although the program did work with pharmaceutical distributors to lower their initial bid prices for the

- **Primary health care providers working in rural areas are isolated from their peers and need a forum for peer-to-peer interaction and support.** Such a forum would provide an opportunity to share experiences, learn from each other, and identify common challenges that can be addressed through advocacy for resources or policy change.

CONCLUSION

The impact of the Romanian Family Health Initiative has been significant. The integration of family planning into over 80 percent of the primary health care services nationally has dramatically increased access to contraceptives by 40 percent between 1999 and 2004. This has contributed to a significant reduction in the rate of abortion of over 260 percent in the same period, with a concomitant reduction in the rate of maternal mortality due to abortion of nearly 37 percent. Quality services are available in most rural communities now that family health doctors have the authority, the updated knowledge, and the supplies they need to provide quality, riety of information have improved, and clients are able to make well-informed choices about which method they want to use.

Romania's family planning program serves as a model for other countries in the region, offering innovative ideas and practical approaches that can be adapted by program managers and policymakers throughout Europe and Eurasia.

This family health clinic in Prundu Bargaului village now offers family planning services thanks to the RFHI.

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