Mapping family planning policy and programme best practices in the WHO Eastern Mediterranean Region: a step towards coordinated scale-up

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ترسيم أفضل السياسات والممارسات في برنامج تنظيم الأسرة في إقليم شرق المتوسط: خطوة نحو تنسيق الارتقاء

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الخلاصة: يُنظر إلى تنظيم الأسرة على أنه واحد من المكونات الأربعة الرئيسية في الأمومة المأمونة. ويستهدف المسح الذي قام به الباحثون ترسيم الروابط بين أفضل ممارسات البرنامج والسياسات المسندة بالبيِّنات في تنظيم الأسرة في البلدان الأعضاء في إقليم شرق المتوسط. وقد أعد الباحثون استبياناً يُنَفَّذ ذاتياً، وله بنية محددة لمسح المكونات المختلفة للعناصر السبعة الأساسية للبرامج الناجحة في تنظيم الأسرة. واستلم الباحثون الاستجابات من وزارة الصحة في 18 بلداً من مجموع البلدان الاثنين والعشرين. وقد أكّد سبعة عشر بلداً من البلدان الثماني عشرة التي أجابت (94٪)، (بما فيها سبعة من البلدان ذات الأولوية بالنسبة للمَرْمَيَيْن الرابع والخامس من المرامي الإنمائية للألفية)، تَوَافُر ما يزيد على 5 من أصل 7 عناصر رئيسية لنجاح برامج تنظيم الأسرة التي شملها المسح. وتَدلّ الممارسات الموثقة المتوافرة في تنظيم الأسرة على الحاجة إلى تنسيق وتعاون وثيقين بين أصحاب المصلحة في جهود الارتقاء بأفضل الممارسات هذه، ولاسيما في البلدان ذات الأولوية، من أجل تحسين صحة الأمهات والأطفال في الإقليم.

ABSTRACT Family planning is recognized as among the 4 core components of safe motherhood. This survey aimed to map evidence-based best policy and programme practices in family planning in the Member States of the WHO Eastern Mediterranean Region. A self-administered, structured questionnaire was developed to survey different components of 7 essential elements of successful family planning programmes. Responses were received from the ministry of health in 18 out of 22 Member States. A total of 17 out of 18 responding countries (94%) (including 7 priority countries for Millennium Development Goals 4 and 5) confirmed the availability of at least 5 out of the 7 surveyed essential elements of successful family planning programmes. Documented available best practices in family planning suggest a need for close coordination and collaboration among stakeholders in scaling up these best practices, especially in priority countries, to improve maternal and child health in the Region.

Cartographie des meilleures pratiques dans la mise en oeuvre des politiques et des programmes de planification familiale dans la Région de la Méditerranée orientale : une étape vers un élargissement coordonné

RÉSUMÉ La planification familiale est reconnue comme faisant partie des quatre éléments indispensables d'une maternité à moindre risque. La présente enquête visait à cartographier les meilleures pratiques reposant sur une base factuelle pour la mise en oeuvre des politiques et des programmes de planification familiale dans les États Membres de la Région OMS de la Méditerranée orientale. Un questionnaire structuré et destiné à être autoadministré a été élaboré afin d'évaluer les différentes composantes de sept éléments essentiels dans un programme de planification familiale efficace. Des réponses ont été reçues du ministère de la Santé de 18 États Membres sur 22. Au total, 17 pays sur 18 ayant répondu (94 %) (les sept pays prioritaires pour les objectifs 4 et 5 du Millénaire pour le développement compris) ont confirmé la disponibilité d'au moins 5 éléments essentiels étudiés sur les 7 requis pour un programme de planification familiale efficace. Les meilleures pratiques documentées et disponibles en matière de planification familiale suggèrent qu'une coordination et une collaboration étroites sont nécessaires entre les parties prenantes dans l'élargissement de la mise en oeuvre de ces meilleures pratiques, en particulier dans les pays prioritaires, afin d'améliorer la santé des mères et des enfants dans la Région.

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Introduction

The World Health Organization (WHO) has estimated that in 2008 about 58 300 women and 510 000 newborns died in the countries of the Eastern Mediterranean Region (EMR) due to complications related to pregnancy and childbirth [1]. In order to achieve the United Nations Millennium Development Goals (MDG) 4A (reduce by two-thirds the under-5 mortality rate) and 5A (reduce by three-quarters the maternal mortality ratio), between 1990 and 2015, policy-makers in EMR countries need to pursue the most effective, evidence-based strategies in health service delivery for improving maternal and child health outcomes [2].

Family planning (FP) is well recognized among 4 core components of safe motherhood, the other key health service strategies being: skilled attendance during pregnancy and childbirth; access to essential obstetric care; and postpartum care [3–5]. Promotion of FP to increase utilization of modern contraceptive methods, specifically in countries with high birth rates, has the potential to prevent up to 32% of all maternal deaths and almost 10% of childhood deaths, not to mention its indirect effects on promoting health through reducing poverty and hunger in overpopulated countries [6,7]. FP reduces mortality among women directly by avoiding the risk of death attributed to complications of childbearing and birth. However, it also indirectly reduces maternal mortality by shifting the risk associated with each pregnancy and birth away from high-risk maternal groups, e.g. among women who are too young (aged 15–19 years [2]), older women (aged over 35 years [2]), multiparous women and women with existing health problems. In addition, achieving spacing of consecutive births by 2 years has been estimated to reduce the chance of dying in infancy or before the age of 5 years by up to 50% in developing countries [3,8,9]. In terms of financial benefits, it has been well demonstrated that investing in sexual and reproductive health, in particular FP, is cost-efficient for countries due to the substantial savings on costs related to health and social services and emotional distress to women, their family and society at large [10,11].

Although progress has been made towards improving FP services in many countries of the EMR, the prevalence of use of modern contraceptives remains low. This is especially pertinent to 8 EMR countries where maternal mortality levels remain unacceptably high (Afghanistan, Djibouti, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen). These countries are classified as MDG priority countries due to poor performance in achieving targets of goals 4A and 5A. In particular, Afghanistan, Pakistan and Sudan contribute up to 80% of the total annual maternal deaths in the EMR, while contraceptive prevalence rates for use of modern methods in these 3 countries are 17.4%, 21.7% and 5.7% respectively [1].

Achieving success in FP programmes requires continued, coordinated and harmonized efforts from different national and international concerned stakeholders. Yet significant amount of time and resources could be saved by documenting, sharing, adopting and scaling up successful practices in FP services, that could be classified as best practices in the Region. In addition, documentation of best practices in FP would advise international donor and national efforts in evidence-based policy decision-making, programming and scaling-up. In the absence of any published literature on this subject in the Region we conducted this survey to identify and map evidence-based best policy and programme practices in FP in the countries of WHO EMR.

Methods

Setting

The survey was conducted in the 22 Member States of the WHO EMR: Afghanistan, Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen.

Survey instrument

A self-administered structured questionnaire was developed consisting of 77 questions that were grouped around 7 core categories widely recognized as essential components of successful FP programmes [12]. These were:

- integrated FP services and mix of service delivery points;
- staff training;
- polices, regulations and guidelines ensuring the quality of FP services;
- FP programmes targeted for special groups of population;
- FP commodity security;
- promotion of FP; and
- FP programme planning, monitoring and evaluation.

Process

The survey instrument was pretested in 4 EMR countries and finalized according to the feedback received. To standardize the survey process, the questionnaire was delivered to national FP programme managers through WHO representative offices and departments of international affairs at the ministries of health in each country. A supporting covering letter explained the purpose of the survey, type of the information being collected, description of who could answer the questions, where to return completed questionnaires and the voluntary nature of the survey. Reminder letters were sent to encourage responses from

countries. Completed questionnaires were returned to the WHO Regional Office for the Eastern Mediterranean and examined for completeness. This process took place between May and August 2009.

Analysis

Descriptive statistics were used to analyse the data.

Results

Responses were received from 18 out of 22 Member States of WHO EMR. Of the 18 countries who responded to the survey 17 (94%) confirmed the availability of at least 1 of the elements comprising 5 of the 7 essential components of successful FP programmes which we surveyed (Table 1).

Integrated FP services and mix of service delivery points

FP services were part of the basic health benefit package and were delivered at the primary health care level in 17 (94%) of the 18 respondent countries (Table 2). At primary health care level, contraceptives were provided to all women free of charge in over three-quarters of countries (78%). A range of different types of contraceptives were part of the essential drug list in 89% of countries. Counselling about FP was provided at antenatal care visits in 89% and postnatal care visits in 94%. While most countries provided actual FP methods postnatally (94%), few provided them as part of antenatal care (22%). FP counselling and methods were provided to parents as part of child care services in 61% of countries, vaccination services in 55% and sexually transmitted infection/HIV services in 55%.

Importantly, 7 of the MDG-priority countries in the region (Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen) reported the existence of many elements of best practices in terms of integrated FP services (Table 2) and other essential components of successful FP programmes, as reported in the following sections (Tables 3–8).

Staff training

FP was less commonly part of the pre-service training programmes in medical universities (78% of countries) than through technical schools for midwives, nurses and lady health visitors (94%) Table 3). However, FP was part of in-service continuing medical education for physicians in 94% and in-service training for midwives, nurses and lady health visitors in 83% of countries. FP training guidelines and materials were reportedly evidence-based in 83% countries and were updated regularly in 72%.

Polices, regulations and guidelines ensuring the quality of FP services

A competency-based national qualification system that certified health workers to provide FP counselling and services was in place in only one-third of respondent countries (Table 4). To ensure the safety of FP services, the national regulations required up-to-date minimum standards for health facilities in 89%, medical equipment in 89%, medical commodities in 100% and infection prevention measures in 94% of countries. The national guidelines and protocols for FP counselling and service provision were reportedly evidence-based in 89% and regularly updated in 72% of countries. An effective and functional quality assurance system to ensure the quality of FP services provided was reported to be in place in half of countries. A supportive supervision system was in place to support service providers and improve their performance at primary health care level in 83% of countries and at secondary care level in 50%.

FP programmes targeted to special groups of population

Less than half of responding countries had special FP programmes in place to meet the needs of certain vulnerable population groups: adolescents (39%), internally displaced populations or refugees in (50%), the poor (50%), periurban and slum populations (44%), males (22%) and persons with disabilities (22%) (Table 5).

FP commodity security

FP commodity security was reportedly ensured through: a well-functioning contraceptive logistics management information system (83%), data-based planning by the government (61%), effective supply chain management of all contraceptive commodities throughout the country (67%) and in certain geographic areas of the country (77%) (Table 6).

Table 1 Number of essential components of successful family planning practices present (defined as at least 1 element of the component present) in the family planning programme of 18 countries of the Eastern Mediterranean Region

Country	No. of essential components present (*n* = 7)
Afghanistan, Egypt, Iran (IR), Iraq, Jordan, Lebanon, Morocco, Pakistan, Qatar, Syrian Arab Republic, Yemen	7
Oman, Palestine, Saudi Arabia, Sudan	6
Bahrain, Somalia	5
United Arab Emirates	3
Djibouti, Kuwait, Libya, Tunisia	n/r

n/r = no response.

Table 2 Integrated family planning (FP) services and mix of service delivery points present in all 18 respondent countries and the 7 priority countries of the Eastern Mediterranean Region, 2009

Item	All countries		Priority countries[a]						
	No.	%	Afg	Irq	Mor	Pak	Som	Sud	Yem
FP services are part of the basic health benefit package and are delivered at the primary health care level	17	94	✓	✓	✓	✓	✓	✓	✓
At primary health care level, contraceptives are provided to all women regardless of their ability to pay	14	78	✓	✓	✓	✓	✓	✓	✓
A mix of different types of contraceptives are part of the country's essential drug list	16	89	✓	✓	✓	✓	✓	✓	✓
FP counselling is provided:									
At antenatal care visits	4	22	✓	✓	✓	✓	✓	×	✓
At postnatal care visits	17	94	✓	✓	✓	✓	×	✓	✓
FP methods are provided:									
At antenatal care visits	4	22	×	×	×	✓	×	×	✓
At postnatal care visits	17	94	✓	✓	✓	✓	✓	✓	✓
FP counselling and methods for parents are provided during:									
Child health care services	11	61	✓	×	✓	✓	×	×	✓
Child vaccination services	10	55	✓	×	✓	n/r	×	×	✓
STI/HIV services	10	55	✓	✓	×	✓	✓	×	✓
FP counselling is provided by:									
General practitioner/ family doctor	16	89	×	✓	✓	✓	✓	✓	✓
Obstetrician/ gynaecologist	17	94	✓	✓	✓	✓	✓	✓	✓
Nurse	14	78	✓	✓	✓	✓	✓	×	✓
Midwife	14	78	✓	✓	✓	✓	✓	✓	✓
Community health worker	10	55	✓	×	n/r	✓	✓	×	✓
Lady health visitor	11	61	✓	×	✓	✓	×	✓	✓
FP methods are provided by:									
General practitioner/ family doctor	18	100	✓	✓	✓	✓	✓	✓	✓
Obstetrician/ gynaecologist	18	100	✓	✓	✓	✓	✓	✓	✓
Nurse	8	44	×	×	✓	✓	×	×	✓
Midwife	12	67	✓	×	✓	✓	×	✓	✓
Community health worker	8	44	✓	×	✓	✓	×	×	✓
Lady health visitor	9	50	✓	×	✓	✓	×	✓	✓

[a] *Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen: classified as priority countries due to poor performance in achieving targets of millennium development goals 4A and 5A.*

✓ *= available;* × *= not available; n/r = no response received from the country.*

STI = sexually transmitted infection; HIV = human immunodeficiency virus.

Promotion of FP

FP was actively promoted in according to the respondent EMR countries through: effective social marketing of FP methods (67%), via community education including wide distribution of quality education and information materials (77%) and through community mobilization efforts (61%). Public–private partnerships for FP were implemented more commonly via community education activities (77%), but also via community outreach services (44%) and service provision programmes (44%) countries (Table 7).

FP programme planning, monitoring and evaluation

Decisions on changes in FP programme were made based on evidence and the analysis of information obtained from health management information systems (61%), from FP programme evaluation (61%) and from special national and sub-national studies (77%) (Table 8). Evidence-based indicators were selected to monitor and evaluate FP programme 77% of countries. A similar proportion of countries (72%) regularly collected and analysed FP programme data using health management information systems.

Table 3 Staff training in family planning (FP) in all 18 respondent countries and the 7 priority countries of the Eastern Mediterranean Region, 2009

Item	All countries		Priority countries[a]						
	No.	%	Afg	Irq	Mor	Pak	Som	Sud	Yem
FP is part of the pre-service training programmes:									
In medical universities	14	78	✓	×	✓	✓	×	✓	✓
In technical schools for midwives, nurses and lady health visitors	17	94	✓	✓	✓	✓	✓	✓	✓
FP is part of in-service training programmes:									
For continuing medical education for physicians	17	94	✓	✓	✓	✓	✓	✓	✓
For midwives, nurses and lady health visitors	15	83	✓	✓	✓	✓	✓	✓	✓
Training guidelines and materials are:									
Evidence-based	15	83	✓	✓	✓	✓	×	✓	✓
Updated regularly	13	72	✓	✓	✓	✓	×	✓	✓

[a]*Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen: classified as priority countries due to poor performance in achieving targets of millennium development goals 4A and 5A.*
✓= available; ×= not available.

Discussion

The major finding of this mapping survey is that all 18 respondent countries in the EMR have confirmed the existence of the majority of key elements of best policy and programme practices in FP. More than 90% of them had already taken actions and most of them have gained corresponding benefits through: integrating FP services into basic health benefit package at primary health care level and other vertical programmes; including a mix of different contraceptives into the national essential drug list; and by adopting evidence-based policies, guidelines, standards and practices for both health provider education and

Table 4 Polices, regulations and guidelines ensuring the quality of family planning (FP) services in all 18 respondent countries and the 7 priority countries of the Eastern Mediterranean Region, 2009

Item	All countries		Priority countries[a]						
	No.	%	Afg	Irq	Mor	Pak	Som	Sud	Yem
A competency-based national qualification system is in place that certifies health workers to provide quality FP counselling and services	6	33	✓	✓	×	n/r	×	×	✓
To ensure the safety of FP services, national regulations set up-to-date minimum standards for:									
Health facilities	16	89	✓	✓	✓	✓	×	✓	✓
Medical equipment	16	89	✓	✓	✓	✓	×	✓	✓
Medical commodities	18	100	✓	✓	✓	✓	✓	✓	✓
Infection prevention measures	17	94	✓	✓	✓	✓	✓	✓	✓
National guidelines and protocols for FP counselling and service provision are:									
Evidence-based	16	89	✓	✓	✓	✓	×	✓	✓
Regularly updated	13	72	✓	✓	✓	✓	×	×	✓
An effective and functional quality assurance system is in place to ensure the quality of provided FP services	9	50	✓	×	✓	✓	×	×	✓
Supportive supervision system is in place to support service providers and improve their performance at:									
Primary health care level	15	83	✓	✓	✓	✓	×	✓	✓
Secondary health care level	9	50	✓	✓	✓	✓	×	✓	✓

[a]*Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen: classified as priority countries due to poor performance in achieving targets of millennium development goals 4A and 5A.*
✓= available; ×= not available; n/r = no response received from the country.

Table 5 Special family planning (FP) programmes for vulnerable groups in all 18 respondent countries and the 7 priority countries of the Eastern Mediterranean Region, 2009

Item	All countries		Priority countries[a]						
	No.	%	Afg	Irq	Mor	Pak	Som	Sud	Yem
Special programmes are in place designed to meet the needs of vulnerable target groups:									
Adolescents	7	39	×	✓	×	n/r	×	×	✓
Internally displaced populations or refugees	9	50	✓	×	×	✓	×	✓	✓
Poor	9	50	✓	×	✓	✓	×	×	✓
Periurban and slum populations	8	44	✓	×	✓	✓	×	×	✓
Males	4	22	✓	×	×	n/r	×	×	✓
Persons with disabilities	4	22	✓	×	×	n/r	×	×	✓

[a]*Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen: classified as priority countries due to poor performance in achieving targets of millennium development goals 4A and 5A.*
✓= available; ×= not available; n/r = no response received from the country.

service provision. Reportedly, about 60% of responded countries had reliable contraceptive logistics and supply chain management systems and implemented community education and outreach activities for FP services, including services for internally displaced and refugee communities where applicable.

The results also indicated certain deficiencies in the availability of evidence-based FP programmes in 18 responded countries. For example, only one-third of respondent countries paid adequate attention to FP service quality assurance through national certification and accreditation systems. In addition, few countries reported having FP programmes specially designed to address the needs of vulnerable population groups as adolescents, persons with disabilities, men and periurban populations.

There were several limitations to this survey. First, although the survey instrument was sent to ministries of health through WHO representative offices, we cannot be sure who completed the questionnaires and whether they were qualified to respond to the questions. Secondly, regardless of who completed the questionnaires, the survey was based on self-reporting and the results may therefore reflect over- or under-reporting of services. Thirdly, responses came from only one source, the country's ministry of health, and we are not sure survey respondents had consulted other concerned organizations, such as universities, international and local partner organizations and professional associations. Another limitation of this survey was that it did not allow an evaluation of the geographical distribution of reported FP best practices, as well as their quality and sustainability.

The benefits of existing evidence-based practices do not always materialize into scaled-up national level programmes in the EMR. For example, in our survey the 4 largest contributor countries to maternal and under-5-year-old mortality in EMR— Pakistan, Afghanistan, Sudan and Yemen—reported meeting a high percentage of the 77 best practices surveyed (84%, 94%, 65% and 96% respectively). However,

Table 6 Commodity security in family planning (FP) services in all 18 respondent countries and the 7 priority countries of the Eastern Mediterranean Region, 2009

Item	All countries		Priority countries[a]						
	No.	%	Afg	Irq	Mor	Pak	Som	Sud	Yem
FP commodity security is ensured through:									
Well-functioning contraceptive logistics management information system	15	83	✓	✓	✓	✓	✓	×	✓
Data-based planning by the government	11	61	✓	×	✓	✓	×	×	✓
Effective supply chain management of all contraceptive commodities throughout the country	12	67	✓	×	✓	✓	×	×	✓
Effective supply chain management of all contraceptive commodities in certain parts of the country	14	77	n/r	✓	n/r	n/r	×	×	n/r

[a]*Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen: classified as priority countries due to poor performance in achieving targets of millennium development goals 4A and 5A.*
✓= available; ×= not available; n/r = no response received from the country.

Table 7 **Promotion of family planning (FP) services in all 18 respondent countries and the 7 priority countries of the Eastern Mediterranean Region, 2009**

Item	All countries		Priority countries[a]						
	No.	%	Afg	Irq	Mor	Pak	Som	Sud	Yem
FP is actively promoted through:									
Effective social marketing of FP methods	12	67	✓	✓	✓	✓	×	✓	✓
Community education, including wide distribution of quality education and information materials	14	78	✓	✓	✓	✓	×	×	✓
Community mobilization efforts	11	61	✓	×	✓	✓	✓	×	✓
Public-private partnership is ensured in:									
Community education activities	14	78	✓	✓	✓	✓	×	✓	✓
Community outreach services	8	44	✓	✓	n/r	✓	×	×	✓
Service provision programmes	8	44	✓	×	n/r	✓	×	✓	✓

[a]Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen: classified as priority countries due to poor performance in achieving targets of millennium development goals 4A and 5A.
✓= available; ×= not available; n/r = no response received from the country.

the contraceptive prevalence for use of modern methods in these countries is reported to be low (16%, 22%, 6% and 13% respectively) [1]. This calls into question the scale and quality of implementation of acknowledged best practices in these countries. For instance, FP services may be included in basic health benefit packages at primary health care level and integrated into other vertical programmes such as child care or sexually transmitted infections/HIV prevention, but not actually accessible to clients due to different reasons, such as deficiency in availability of qualified and/or motivated personnel, lack of contraceptive commodities or insufficient empowerment and social support to women. Similarly, although respondent countries widely acknowledged the existence of successful practices in FP programmes, according to 2008 estimates, on average only 31.1% of married women in EMR were using modern contraceptive methods to avoid unwanted pregnancy, which corresponds to a regional average total fertility rate as high as 4.2 children per woman of reproductive age (15 to 49 years) [13].

The results of our survey add to the scarce published literature on the availability of best FP policies and programmes in the EMR. Some countries, such as Egypt, Jordan, Kuwait, Islamic Republic of Iran, Libya, Palestine and Tunisia, are champions both in implementing successful FP programmes and in achieving favourable indicators for contraceptive prevalence and maternal and under-5 child mortality rates. However, such achievements will be difficult to observe in the MDG-priority countries unless existing constraints in terms of political commitment and bottlenecks in health service systems are addressed simultaneously. In their global assessment of the health system and policy environment for maternal, newborn and children health, the Countdown working group on

Table 8 **Programme monitoring and evaluation and planning of family planning (FP) services in all 18 respondent countries and the 7 priority countries of the Eastern Mediterranean Region, 2009**

Item	All countries		Priority countries[a]						
	No.	%	Afg	Irq	Mor	Pak	Som	Sud	Yem
Evidence-based indicators are selected to monitor and evaluate FP programme	14	78	✓	✓	✓	✓	×	✓	✓
Health management information system regularly collects and analyses FP programme data	13	72	✓	✓	✓	✓	×	✓	✓
Decisions on changes in FP programme are made based on the evidence and analysis of information obtained from:									
Health management information system	11	61	✓	✓	✓	n/r	×	×	✓
FP programme evaluation	13	72	✓	✓	✓	✓	×	×	✓
Special national and subnational studies	14	77	✓	✓	✓	✓	×	✓	✓

[a]Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen: classified as priority countries due to poor performance in achieving targets of millennium development goals 4A and 5A.
✓= available; ×= not available; n/r = no response received from the country.

policy and health systems suggested that the prerequisites for successful implementation and eventual scale-up of evidence-based practices are: strong national leadership and effective governance; adequate and sustainable financial resources; integration of desired services; and availability of qualified workforce [14].

In order to promote the diffusion of successful FP programmes during the past decade WHO and its partners have focused on identifying, documenting and categorizing successful policy and programme practices in FP. Recently 10 essential components of successful FP practices have been crystallized and shared widely [12]. In addition, the Implementing Best Practices consortium was established in 2003, sponsored by WHO, the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID) and represented by more than 23 international agencies, to advance documentation and diffusion of knowledge about best practices to improve reproductive health outcomes [15]. Further, a special operations research methodology called "A guide for fostering change to scale up effective health services" was developed and promoted by WHO and USAID to facilitate the process of scaling-up successful reproductive health practices in countries [16].

It is important to mention that successful experience from countries where relevant operations research activities have been applied to increase contraceptive uptake and/or reduce maternal mortality have reported certain common factors that enabled success. These include: i) effective leadership and stewardship capacity of top national health authorities for coordination, collaborative planning and monitoring implementation of interventions; ii) a comprehensive approach in covering a range of key contributing factors, such as: policies, regulations and guidelines; health systems; health education and accreditation; health information and commodity security; iii) transparency and wide stakeholder involvement both from public and private sector; iv) continuous technical support and motivation of health organizations and personnel; and v) local capacity-building, close monitoring and supportive supervision [17–22]. Increasing the use of modern FP methods has a wide range of potential benefits including: improved maternal and child health; enhanced empowerment of women by reducing the burden of excessive childbearing; reduction of poverty; contribution to environmental sustainability; and significant monetary savings in reduced costs of health care, social welfare and environmental sustainability [23].

Additional research is needed to further elucidate the scale and quality of the existing best FP practices identified in individual countries of the WHO EMR. Countries lagging in achieving MDG goals 4A and 5A should invest both in scaling-up identified FP best practices, as well as adapting to the local context practices that have proved successful elsewhere in the Region. Priority should be given to scaling-up: integration of quality and acceptable FP counselling and methods into primary and community health care services; training and deployment of a sufficient skilled workforce; ensuring FP commodity security; and introducing performance motivation packages for qualified FP service providers.

In conclusion, the results of the study enable us to recommend that identified best policy and programme practices in family planning should: advise planning and implementation of FP programmes in the Region; and facilitate closer collaboration and coordination of efforts of stakeholders concerned to increase the prevalence of modern contraceptive use in order to improve maternal and child health in the countries of the WHO EMR.

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Family planning: a global handbook for providers (2011 update)

Family planning: a global handbook for providers (2011 update) is an essential resource for health-care professionals providing contraceptive methods. The handbook is the successor to *The essentials of contraceptive technology,* first published in 1997 by the Center for Communication Programs at Johns Hopkins Bloomberg School of Public Health. Experts from around the world have contributed to the development of the handbook, and many major international organizations and professional organizations working in family planning have endorsed and adopted this guidance. It is one of WHO's "Family Planning Cornerstones", a companion to the *Medical eligibility criteria for contraceptive use,* the *Selected practice recommendations for contraceptive use* and the *Decision-making tool for family planning clients and providers.*

This publication is also available in Arabic and French. Further information about this and other WHO publications is available at: http://www.who.int/publications/en/