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Improving access to quality family planning services in Nepal and Sri Lanka: insights from a South-South learning exchange

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ABSTRACT

Nepal and Sri Lanka ministries of health shared best practices and learnings, in a South-South learning exchange (SSLE) to improve access to quality and rights-based family planning services. The SSLE between the two countries followed a five-step methodology designed by the WHO, under the Family Planning Accelerator project. SSLE between the two countries started in January 2020 and is still continuing. Both countries started implementation of the learnings (step 4) at the time of preparing this manuscript (December 2021). An independent consultant from Sri Lanka carried out an evaluation, to inform future SSLEs. The evaluation included a desk review on SSLE and family planning in both countries and key informant interviews with Sri Lanka Ministries Health, WHO CO, external partners. A final evaluation of the outcomes/impact is planned in December 2022. The SSLE resulted in a systematic cross-country transfer of knowledge and implementation of the learnings. Sri Lanka implemented a web-based system for logistics management of family planning commodities and Nepal commenced implementing integrated family planning services in a decentralised environment using a lifecycle approach to improve postpartum family planning uptake. The success of this SSLE is attributed to the rigorous methodology, country-led designing of the learning agenda and process, extensive communication amongst the teams, a focus on outcomes, commitment and leadership by ministries of health in both countries. Learning and technical assistance needs of countries can be met by SSLE if national contexts, availability of resources are considered.

SUMMARY BOX

- ⇒ Countries facing common challenges and seeking to achieve common goals can make faster progress through shared learning and experiences.
- ⇒ Learning from peers is often far more convincing and powerful than learning from books (The World Bank 2020).
- ⇒ To the best of our knowledge, this is the first scientific paper to document the process and lessons learnt from conducting a South-South learning exchange (SSLE) in family planning using an online platform. The study demonstrates the importance of rigorous monitoring and using a standardised systematic approach like the one proposed in the WHO's five-step methodology. Like with other technical assistance initiatives SSLE success requires country-led preparation, extensive communication among the teams, a focus on outcomes plus commitment and leadership by ministries of health of both countries.
- ⇒ This study highlights the enablers of a successful SSLE. The lessons learnt during this process could be used to maximise the benefits in future SSLEs which can be used to scale up best practices in family planning in a sustainable manner.

INTRODUCTION

Learning through the systematic exchange of knowledge, skills and know-how of successful initiatives among countries is expected to result in effective and positive developmental outcomes in all spheres of human endeavour, including health.

In 2019, the WHO embarked on Family Planning Accelerator Project (2019–2022)[1] building on the achievements of the WHO Family Planning Umbrella Project (2015–2018).[2 3] Under the project, WHO supports partners and Ministries Health (MoH) to fast-track quality and rights-based family planning (FP) services within the broader frameworks of Sustainable Development Goals (SDG), Universal Health Coverage (UHC) and the WHO 13th Global Programme of Work (GPW).[4] South-South learning exchange (SSLE) is one of the four approaches applied under the FP Accelerator project to strengthen national FP programmes and enable countries to reach their SDG goals 3 and 5.

SSLE describes the process when two countries in South, engage in horizontal 'peer to peer' learning. It is based on the belief that

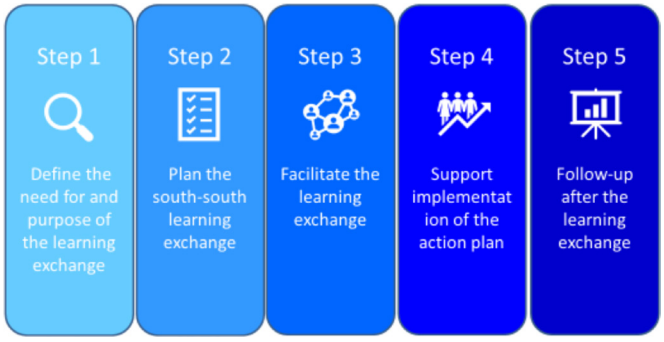

Figure 1 Five steps for conducting the South-South learning exchange.

countries facing common challenges and seeking to achieve common goals can make faster progress through shared learning and experiences. SSLEs are ideal opportunities for decision-makers and health professionals to collaborate and share knowledge, skills and successful initiatives on implementing and scaling up evidence-based good practices. It is based on the principles of national ownership, respect for sovereignty and equality among partners.[5] The Programme of Action of the International Conference on Population and Development refers to South-South cooperation (SSC) as an important development instrument and recommends 'more attention should be given to SSC'.[6] The United Nations Population Fund (UNFPA) describes SSC as a demand-driven, reciprocal and ownership-oriented development model for designing and implementing collaborative initiatives among developing countries. It states that to achieve a successful collaboration between two countries a series of activities are needed ranging from demand generation, matching, knowledge sharing, programme implementation, up to reporting.[7]

In the FP Accelerator project, SSLE is defined as 'an interactive exchange of knowledge and experience between two country teams to help one or both teams to work towards a (desired) change'.[8] SSLE may include the exchange of information, resources, technologies, technical assistance and knowledge sharing among the stakeholders in both governments, their private sector entities, universities, research institutions, non-governmental organisations and civil society organisations. Previous experiences report that learning from peers is often far more convincing and effective than learning from books.[9] Under the FP Accelerator project, WHO has developed a five-step process to engage the stakeholders and guide the process and ensure implementation of the knowledge learnt. The methodology focuses on preparation, planning, field visits to share/learn new knowledge, implementation of learnings on return, followed by evaluation and documentation of the findings. The methodology is not prescriptive; it gives countries the flexibility to apply the principles enunciated in the guide based on their context.[8]

This paper describes the experiences and lessons learnt, working strategies and methodologies in using the WHO five-step methodology to conduct SSLE between Nepal and Sri Lanka for use by the wider scientific community and to inform future SSLE. To the best of our knowledge, this is the first scientific paper to document the lessons learnt from conducting an SSLE in family planning.

EVALUATING THE LEARNING EXCHANGE

Both Nepal and Sri Lanka are low-income and middle-income countries[10] located in the South Asian Association for Regional Cooperation (SAARC) region. The population is similar in both countries and the total fertility rate are also similar (2.3 per women in Nepal, 2.2 per women in Sri Lanka).[11 12] The Nepal Demographic and Health Survey (NDHS 2016) reports contraceptive prevalence rate (CPR) as 53%, with 43% using a modern method.[11] The Sri Lanka DHS 2016 reports CPR as 65%, with 54% using a modern method.[12] The Human Development Index 2020 has ranked Nepal at 142 and Sri Lanka at 72.[13] Both countries are recovering from civil conflicts and some government functions including health are devolved to subnational governance structures. Nepal commenced delivering health services under the new system in 2017, while Sri Lanka's experience in delivering health services in a devolved system goes back to 1989.

Using a systematic approach, Nepal and Sri Lanka embarked on SSLE to expand and accelerate rights-based FP services using a health system strengthening approach. The conversation between the two countries was initiated in January 2020, using the WHO FP Accelerator project five-step methodology to conduct SSLE (figure 1). Despite COVID-19 pandemic and other challenges, the SSLE continued. Following multiple exchanges with and between countries, the two countries have moved on the fourth step and started implementation of the learnings since December 2021. Monitoring and evaluation is continuing, a final evaluation of the outcomes/impact following the exchange is planned in December 2022. During this time frame, three exchange meetings were held between the two countries and four in-country meetings were held to absorb the lessons learnt and prepare for the next exchange with the peer country.

The key stakeholders in Nepal team included Adventist Development and Relief Agency (team leader), Family Welfare Division-Department of Health Services (Chief FP and RH section and Chief Child health and immunisation section), DFID Nepal (Health advisor), Ipas (Deputy Chief of party), Knowledge Success, Nepal CRS Company (Managing Director), Nepal Health Sector Support Programme- Department for International Development (FP advisor), Province 5 (Provincial Health Directorate), UNFPA (NPO-FP & RH commodity security), USAID (Senior programme specialist-FP/RH), Visible Impact (President), WHO Nepal. Sri Lanka team key stakeholders are Family Health Bureau (FHB) (Director/Maternal and Child health and National Programme manager (NPM)-FP programme), Family

Planning Association of Sri Lanka (Executive Director and Advocacy Director), UNFPA (National Programme Associate) and WHO Sri Lanka (NPO). Catalytic funds from WHO facilitated the process on SSLE. As travel was not conducted due to COVID-19 pandemic, funds mainly supported online calls and monitoring the SSLE process. Domestic resources from the Ministry of Health in Sri Lanka supported implementation of the learnings, (development, piloting and scaling up of the new web based LMIS and for designing the new formats/data elements to update the existing Reproductive Health information system with PPFP information). In Nepal, MoH, UN societies including WHO civil society, academia, implementing partners supported/funded the strengthening and integrating PPFP into Reproductive, maternal, newborn, child and adolescent health (RMNCAH) services.

An evaluation of the SSLE process was carried out by an independent consultant from Sri Lanka. The evaluation was transparent, inclusive and conducted in a participatory manner. It had an important learning component and aimed to ensure a high degree of engagement and intense consultation and interaction with stakeholders throughout.

The evaluation was framed around the five steps of the WHO SSLE methodology (1) Step 1: Define the need for and purpose of the learning exchange, (2) Step 2: Plan the SSLE, (3) Step 3: Facilitate the learning exchange, (4) Step 4: Support implementation of the action plan and (5) Step 5: Follow-up after the learning exchange. (6) One additional question was included to ascertain the extent to which WHO was successful in its role as a knowledge broker at both regional and national levels. The findings from these six questions were analysed to draw the lessons from the implementation of the SSLE between Nepal and Sri Lanka.

The evaluation used mixed methods for data collection and analysis and drew on quantitative and qualitative data. First, a desk review to gain information on lessons learnt and challenges in conducting the SSLE was done, which included global, regional and country-level documents including existing policies, strategies and programme documents; notes for the record from SSLE meetings; PowerPoint presentations and documents shared between the two countries; WHO 13th GPW[4]; WHO Country Cooperation Strategies of Nepal and Sri Lanka[14 15]; latest Demographic and Health Surveys[11 12]; FP2020 Commitments update questionnaires,[16 17] and the 2016 Sri Lanka National Family Planning Review.[18] Second, the findings of the desk review were used to develop the key informant interview (KII) questionnaires. Five key informants were identified in consultation with MoH and WHO Country Office (WCO). Third, a series of face-to-face and telephone interviews were conducted with representatives from MoH, WCO, external partners and stakeholders in Sri Lanka. In-depth review and discussions focused on six questions to extract the results and lessons learnt from the implementation of the SSLE between Nepal and Sri Lanka. (1) how the SSLE process contributed to identifying gaps in the national family planning programmes in both countries (step 1); (2) how meticulous and comprehensive was the planning and execution of the SSLE to achieve the stated outcomes (step 2); (3) identifying facilitators and barriers to the learning exchange (step 3); (iv) extent to which the originally designed action plans were implemented (step 4); (v) extent to which follow-up measures were implemented (step 5) and (vi) the extent to which WHO Regional and Country Offices were successful in facilitating SSLE to improve access to quality FP in countries. Finally, a matrix was developed to guide the process and ensure the systematic collection and recording of data and information.

An inbuilt monitoring system was used throughout the SSLE process to track progress, understand the reasons for delay if any and for problem-solving. Monthly reports, teleconferences, postmeeting participant questionnaires were developed, and information was collected at the end/during the meetings. An additional monitoring and evaluation (M&E) approach, using the After-Action Review was conducted at the end of step three of the SSLE; following the exchange of knowledge and best practices, to understand the ideas generated, knowledge gained, what worked, what did not, why and what should be changed throughout the process. These six questions were analysed to extract the results and lessons learnt from the implementation of the SSLE between Nepal and Sri Lanka.

STEP 1: DEFINE THE NEED FOR AND PURPOSE OF THE LEARNING EXCHANGE

Both countries started the process with a needs assessment to identify the gaps in their FP programmes and the findings formed the basis for the learning exchange. According to the needs assessment in Nepal, the use of modern contraceptive methods has stagnated at around 43%, with the demand satisfied with modern methods at 56%.[11] Further analysis of NDHS 2016 data by the Nepal team showed that use of modern FP methods by postpartum mothers is low (22.6 %) and unmet need is high (31.5%,) when compared with all currently married women in Nepal (mCPR)—43% and unmet need—24%).[11] Nepal identified postpartum family planning (PPFP) as a missed opportunity for increasing the availability and utilisation of FP services. Integration of FP counselling throughout the life course of women and their partners was identified as the strategy to improve adequate birth spacing. The key learning need identified for the SSLE, by Nepal was 'to improve the organisation of clinical services to strengthen the integration of PPFP with a focus on provincial level ownership and to learn the practical "how-to" provide reproductive health services throughout the lifecycle'.

After a careful appraisal, it was felt that an exchange of knowledge between Nepal and a country in the region

with similar health systems and a well-defined PPFP programme would be the best option. Sri Lanka was identified as a suitable knowledge provider as it has a devolved health system since 1989, FP information and services are well integrated within m aternal and child health (MCH) and RH services and FP counselling services are provided at many levels, from the time a woman gets married, prepregnancy care, antenatal care, postpartum care, during child immunisation, well-woman clinics and sexual/adolescent care.

After Nepal and Sri Lanka agreed to the SSLE, Sri Lanka felt that instead of a mentor-mentee relationship, it would be beneficial for both countries to have a reciprocal learning exchange. In Sri Lanka, implants are inserted by medical officers who are transferred every 4 years which sometimes leads to a breakdown in service continuity. By task shifting, the insertion of implants to Public Health Nursing Sisters (PHNS), services could be continued when trained medical officers are transferred. In Nepal, task sharing on insertion of implants was a success story, hence the learning need expressed was—'how to do task-sharing of implant insertion from medical officer to PHNS'. However, when the learning need was presented to the Technical Advisory Committee (TAC) on Maternal Health and family planning at MoH, Sri Lanka, the TAC did not consider task sharing as a priority for the country due to inadequate numbers, maldistribution and high workload of PHNS. The perception of the TAC was that the number of medical officers is sufficient to continue the current practice of implant insertion rather than burdening PHNS with additional responsibility. Sri Lanka decided to explore another learning need.

The National FP Programme in Sri Lanka provides the desired mix of FP commodities to all public sector service delivery points in the country. The contraceptive supply chain includes a central warehouse located at the FHB. A review of the National FP Programme in 2016 highlighted issues regarding the Logistics Management Information System (LMIS), inventory control, storage and distributions and this underscored the need to improve reproductive health commodity security and to improve the LMIS.[18] Currently, 'CHANNEL', an inventory management software for stock monitoring at central stores is used. However, no information is being collected on district and divisional stock levels in real-time. Hence, Sri Lanka decided to learn from Nepal's experience to upgrade its paper-based LMIS to a web-based system and its learning need was on 'establishing a web-based e-logistics management information system (eLMIS) for contraceptives at the FHB to enable district and central levels commodity security'.

The learning needs identified by both countries were in accordance with the national policies and plans. Family planning programme is a priority programme for the Government of Nepal as reflected in the National FP Strategy 2011, Family Planning Costed Implementation Plan (2015–2020), FP2020 commitment 2015, Safe Motherhood and Newborn Health Roadmap 2018/2019 Action Plan, National Health Policy 2019, Social Health Insurance Package 2017, and the Basic Health Services Package. In Sri Lanka, the proposed learning need, transforming a paper-based logistic management system (LMS) to an eLMIS is aligned with the National Health Policy Sri Lanka (2016–2025), National Health Strategic Master Plans for Sri Lanka (2016–2025), National Strategic Plan Maternal and Newborn Health (2017–2025).

STEP 2: PLAN THE SSLE

The Ministries of Health of both countries led the discussions during the planning for SSLE. Key stakeholders involved in the SSLE from the beginning of the process, in Nepal, composed of MoH including provincial Health officials, academia, professional societies, WHO-Nepal, United Nations Population Fund (UNFPA), United States Agency for International Development (USAID), Department for International Development (DFID) and various partners (Ipas, Marie Stopes, etc.). In Sri Lanka, the country team composed of representatives of the FHB of Ministry of Health (MCH national programme focal point), UNFPA, Family Planning Association of Sri Lanka, Sri Lanka College of Obstetricians and Gynaecologists and WHO Sri Lanka. The roles and responsibilities of the partners within the teams were defined.

Leadership by the MOH of both countries from the beginning ensured the SSLE is aligned with national plans and policies. This made plans more realistic and achievable and ensured the longer-term sustainability of the strategies and tools shared. The Director Maternal and child health (MCH) and the National program manager for family planning (NPM/FP) in Sri Lanka have championed FP over the years, and both participated in the SSLE. The Sri Lankan team identified the need for human and financial resources at the planning stage of the SSLE to develop the eLMIS.

The two teams reviewed the objectives and developed a monitoring system with intermediate outcomes, monthly reports and after-action reports every quarter to track the progress of the learning exchange. Nepal identified two intermediate outcomes: (1) to gain and disseminate knowledge on best practices on the organisation of clinical services for PPFP/PAFP and (2) to develop guidelines and tools for integration of the PPFP/PAFP into RMNCH service with a focus on counselling training tool, training healthcare workers and identifying how to capture the disaggregated data for PPFP. Sri Lanka identified two intermediate outcomes: (1) to gain knowledge on how to implement e-LMIS and (2) to train staff on using e-LMIS and pilot test the process in one district.

Although study tours were planned as the mode of learning exchange, due to the COVID-19 pandemic

related travel restrictions, virtual exchange was used for learning exchanges.

STEP 3: FACILITATE THE LEARNING EXCHANGE

The learning exchanges were facilitated by WHO and Knowledge success. Before the learning exchange, concept notes, a list of questions and an agenda were shared with all participants. Both teams were aware of the learning needs of each other. PowerPoint presentations were made by the two teams describing the service delivery system for FP in their countries and responding to queries posed by the other team. Nepal shared information on the e-LMIS, while Sri Lanka provided an account of PPFP services, experience in the provision of FP information and counselling and the role of policymakers and programme managers in delivering these services. Any queries arising from the presentations were clarified during the learning exchange sessions.

During the exchange sessions, the Sri Lanka team identified gaps in its existing Reproductive Health Management Information System (e-RHMIS). In Sri Lanka data on FP new acceptors and the specific method of contraception, uptake was collected, however, information on specific time points when the women accept FP that is, by 1st or 3rd or 6th or 12th month post partum was not being collected. Realising the missing link, the Sri Lanka team took immediate steps to introduce specific data elements into the e-RHMIS to capture FP acceptance at different time points in the postpartum period.

Six virtual intercountry learning exchanges sessions took place followed by six in-country workshops in both the countries among the stakeholders to analyse the new information/knowledge gained and prepare an implementation plan to address the country needs.

STEP 4: SUPPORT IMPLEMENTATION OF THE ACTION PLAN

Following the virtual exchange of knowledge/information and the practical 'how-to', the Sri Lanka team designed the roadmap for transforming the paper based LMIS into an electronic format. Following discussions with the technical team working on District Health Information Software 2, the Sri Lankan team included a dedicated page on the reporting system of the contraceptive commodities at different levels. This reporting system was piloted in the nine districts of the Northern and East provinces and then scaled up to all 28 health districts. The Officers in Charge of Regional Medical Supplies Divisions (MSD) were trained on the new formats and web-based platform. The FP Unit of FHB initiated the process of introducing e- returns on stock balances for FP commodities for regions and divisions and introduced a What's app group with regional MSDs to provide prompt support, and feedback for technical glitches and to enhance follow-up.

Following the SSLE, Nepal developed an advocacy tool for PPFP. The tool elaborates on missed opportunities and benefits from PPFP and recommends strengthening PPFP services in health systems building blocks model for policy-makers to community health volunteers. Policy dialogue with policymakers and programme managers was conducted in two of the provinces using the advocacy tools. Following this, the MoHP Nepal has allocated a separate budget for all seven provinces to initiate and strengthen PPFP in 20 referral hospitals. PPFP service strengthening is included in national, provincial, and local level work plans including referral hospitals, maternity hospitals, and comprehensive obstetric and neonatal care sites. Review and planning meetings have been organised with responsible programme managers at Provinces and Hospitals to strengthen the PPFP services. The Provincial and Hospital level focal points have developed action and committed for their implementation. Further, questions on PPFP uptake have been proposed in the DHS 2021 and NHFS survey which will continue generating data/evidence and help identify deficiencies in the system.

STEP 5: FOLLOW-UP AFTER THE LEARNING EXCHANGE

Sri Lanka has completed the piloting of e-LMIS and has scaled it up to the district level. The country is now planning to extend the system down to 354 Medical Officer of Health areas at the divisional level, which is the lowest unit in the Sri Lanka health system. Each Medical Officer of Health areas is headed by a Medical Officer responsible for a defined population, which on average is around 40 000–80 000. The use of mobile phone technology is being explored to improve real-time stock monitoring and resupply planning and to address selective stockouts of contraceptives at the district level proactively. Further, Sri Lanka has taken action to introduce additional data elements into the e-RHMIS to address the gaps identified during the SSLE. New formats and new data elements will facilitate the collection of information on PPFP acceptance at delivery, 6 weeks postpartum, 3, 6 and 12 months after delivery.

Nepal commenced implementing integrated family planning services in a decentralised environment using a lifecycle approach to improve PPFP uptake. A total of 47 participants including policy-makers, programme managers and service providers at provincial and district levels were oriented on the PPFP services at the community level. Ninety-eight participants including programme managers, obstetricians/gynaecologists, nursing officers, public health officers participated in workshops to review and develop action plans for strengthening PPFP services at referral hospitals. Nepal is also revising the ANC and PNC guidelines to include FP counselling in a life cycle continuum of care approach. In a long run, the recently endorsed Safe Motherhood and Newborn Health roadmap in Nepal has proposed that community nurse practitioners carry out home visits following delivery and discuss PPFP. Based on the learning, the Nepal team is expanding facility and community-based PPFP initiatives.

Box 1 Lessons learnt during each of the five steps of the South-South learning exchange (SSLE) process

Lessons learnt

1. Learning objectives of SSLE must be clear and specific
The learning objectives set by the two countries were specific and arrived at after much thought and consultation with key stakeholders and technical working group in the country. The objectives were in line with country plans and needs. This is reflected in the ease with which learnings were implemented. Nepal identified integrating postpartum family planning (PPFP) in Maternal, newborn and child health (MNCH) services to strengthen PPFP and Sri Lanka identified a web based e-Logistics Management Information System (eLMIS) to upgrade its paper based LMIS. The eLMIS will provide timely reports on family planning (FP) commodity availability and use. This will help to moderate the capacity to manage stock out situations and facilitate planning and implementation of procurement and supply processes

2. Involving the government and stakeholders from the beginning of the process is crucial for implementation of the learnings
An important prerequisite for the successful implementation of the action plan is, commitment, and leadership in both countries. Early consultation and discussion with the Technical Advisory Committee/ stakeholders was beneficial not only for obtaining their guidance, but it ensured the fullest support of the MoH for the process and created an enabling environment for implementing the learnedlearnt knowledge. Sri Lanka mobilised domestic resources to finance the development, piloting and scaling up of the new web based LMIS and for designing the new formats/data elements to collect PPFP information. Strengthening PPFP was being discussed in Nepal for some time, SSLE provided the impetus and served as a catalyst to put in place a programme that the country was already working on. Implementation of action plan was planned in a conscious effort to avoid duplication with other programmes, and to provide complementary support to ongoing activities.

Champions for change

In Sri Lanka, the director maternal and child health (MCH), the National programme manager for family planning (NPM-FP) are experienced programme managers in FP. Both the FP Unit and the M&E unit are under the supervision of director MCH. Having the support of the Director was instrumental not only in establishing the eLMIS, but also for mobilising resources to finance the development of the eLMIS including the piloting of new formats for the e-Reproductive Health Management Information System. Having in-house experts in FP programme management, HMIS and information technology within the Family Health Bureau itself, contributed to incorporating the new developments seamlessly. In Nepal, provincial managers participation in the SSLE ensured ownership of the process both at the highest levels of the MoH, as well as provincial levels to enable implementation of integration of PPFP in the MNCH services.

3 The SSLE process constantly evolves, hence flexibility and adaptability is a must
The flexibility of the SSLE process allowing Sri Lanka to change the objectives of SSLE from task sharing to eLMIS, was helpful in responding to the evolving country needs. Similarly, though study tours and face-to-face meetings were planned as mode of SSLE, due to COVID-19 pandemic the modality of exchange moved to virtual meetings. This flexibility and adaptability by the teams and the facilitator to a new way of working were remarkable and was a key factor in the success.

Continued

Box 1 Continued

4. Reciprocal learning is an effective way to conduct SSLE as it keeps the mentoring country motivated
Instead of a mentor and mentee approach, the mentor country suggested for mutual learning, hence both countries were on an equal footing as seekers and providers of knowledge, they were respectful of each other and achieved their goals.

5. SSLE can be conducted using virtual platform
This SSLE was conducted using virtual platforms via Zoom and TEAMS. Virtual sessions enabled provincial managers to participate. As implementers, they provided the perspective from the field making plans more realistic and achievable. The virtual modality had its advantages in terms of increased participation and disadvantages in terms of the quality of the experience. The success of leveraging digital platforms to extend the reach and ease of exchange of knowledge and best practices during COVID-19 is an example which cannot only be scaled up in SSLE, but also be used to support other programmes.

6. SSLE is a time-consuming process for both countries
The teams must invest time in preparing documents, PowerPoint Presentations, handouts, videos, etc, for a meaningful knowledge exchange to take place. Multiple sessions are required both in and across countries during the process for learnings to be implemented.

7. Inbuilt monitoring system is critical
To monitor progress and keep the SSLE on track, an monitoring and evaluation (M&E) system must be in built from the start and followed up throughout. Monthly reports, meetings, postmeeting participant questionnaires and after-action review are useful tools to keep the stakeholders motivated and committed.

8. WHO is well placed to support and facilitate SSLE
Having a strong facilitator is necessary to keep the discussion on track and to meet the aim of learning exchange. This is especially important during a virtual learning exchange since time is of the essence. There were instances during the Nepal-Sri Lanka learning exchanges where the facilitator intervened when the discussion was losing focus. WHO's convening power, global reach, country presence, technical expertise and impartiality has facilitated and strengthened collaboration between the countries.

Both countries were determined to provide and receive knowledge and learn from each other. The virtual modality allowed the engagement of more people including provincial managers from both countries in the SSLE. The virtual modality was perceived as a barrier when it came to learning about the practical aspects of the eLMIS as they could not be demonstrated adequately. KIs said that a hands-on experience would have made it clearer. Several KIs said that the time allocated was not adequate for the question-and-answer sessions during the exchange meetings. A Sri Lankan KI said that due to the virtual learning it was not clear how much the other team understood and absorbed. Participants from both countries found that

sometimes they were unable to give their full attention to the SSLE as they were often distracted by official matters needing their urgent attention. Participants from both countries felt that additional learning materials would have been useful. KIs from Sri Lanka felt that photo stories/videos would have been beneficial and complementary to the online sessions.

WHO HAS A NICHE IN BROKERING, CURATION AND DISSEMINATION OF KNOWLEDGE ON FP

From the desk review and KII, WHO used its convening power to bring together governments, civil society, academia, professional organisations, and other international organisations. WHO Headquarters, the Regional Office and Country Offices provided quality assurance to the SSLE. Moreover, the WHO country presence and Regional Office has been a strong facilitating factor in this knowledge exchange, specifically helping the countries to identify good practices and selecting the most appropriate knowledge provider country teams WHO also had extensive technical know-how on FP, a strong portfolio of good practices, availability of the five-step guide on SSLE and networking ability.

The SSLE has also contributed to WHO country offices objectives as articulated in the respective WHO CCS documents. The WHO Sri Lanka CCS strategic priorities clearly define the importance of learning exchange via the stated deliverable—'Best practices and lessons learnt from Sri Lanka in public health documented, published and shared in regional and global forums.'

Important lessons can be drawn from successful and unsuccessful experiences of SSLE, and they must be systematically documented and disseminated. Knowledge-management platforms and tools both internal and external to WHO need to be strengthened and used to capture and disseminate SSLE practices via public-facing platforms, including the WHO website, the HRP YouTube channel and the implementing best practices (IBP) initiative. A summary of the lessons learnt from the SSLE is presented in box 1.

INTERPERSONAL PEER AND PROFESSIONAL RELATIONSHIPS BETWEEN COUNTRIES

During the KIIs, participants reflected how the learning exchange created opportunities and gave them new ideas of how to approach the specific challenge in their country, they learnt about other countries FP programme. Majority of respondents (from postmeeting survey) expressed that the standardised process for learning exchange helped in generating new ideas as well as to create networks/interpersonal peer and professional relationships between countries. The in-built accountability, monitoring system with after-action review and focus on outcomes kept stakeholders motivated and committed towards achieving the outcomes.

KIIs reported-

'It was interesting and an eye opener for Nepal to hear from Sri Lanka on how counselling and FP services are integrated at various entry points within existing MCH and RH services, within the community/clinic and at the institutional level to enable frequent and timely counselling of couples to avoid any missed opportunities'.

'Participants feel confident in applying the knowledge gained.'

'Discussion with the national technical working group helped to ensure the learning objective is in line with country needs and priorities'.

'SSLE brought policy-makers and stakeholders involved in strengthening family planning programmes to share their knowledge about the effectiveness and applicability of interventions and information on what worked and did not work in their contexts'.

'Early engagement of the stakeholders enhanced learnings, fostered motivation and created an environment of 'team-working'

CONCLUSION

This study confirms the importance of following a standardised method like the WHO's five-step methodology for conducting a successful SSLE with a focus on monitoring progress and outcomes, in-built flexibility and intensive communication and collaboration. The SSLE has made a positive contribution to improving the knowledge and capacity of national and subnational FP programme managers on technical and programmatic issues and contributed to strengthening the health systems of both countries to better elaborate, implement and deliver quality FP programmes.

It is anticipated that WHO's five-step approach to SSLE and the lessons learnt during this process could be used to scale up best practices in FP in a sustainable manner and fast-track quality and rights-based FP services within the broader framework of SDGs, UHC and the WHO 13th GPW.

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