STRATEGIES FOR ACCELERATING FAMILY PLANNING PROGRESS: ARE THERE LESSONS THAT NIGERIA CAN LEARN FROM MALAWI?*

A Draft Conference Paper

By

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* Views and opinions in this paper are the author's. They do not necessarily represent the views and opinions of the US Agency for International Development.

BACKGROUND

In the early 1980s, contraceptive prevalence rates for modern methods (mCPR) in both Malawi and Nigeria were about 1%, and total fertility rate (TFR) in Malawi was 7.6 compared to 5.9 in Nigeria. By 1990, the prevalence of modern contraceptive method (mCPR) in Nigeria was 3.5%, which was slightly higher than in Malawi. The total fertility rate in the country was 5.9, which was also lower than in Malawi (about 6.4). At that time, it was still illegal to use the term "family planning" in any official government document in Malawi (Chimbwete et al., 2005; African Institute for Development Policy, 2012). All family planning (FP) services provided to clients in Malawi before 1992 were provided only for the purposes of child spacing or "Kulera". About 1992, political and social changes in Malawi led to a dramatic change in the country's family planning service environment and opened up opportunities for FP service delivery.

For Nigeria, by early 1990s, family planning program had been in existence for more than 30 years, and the country had been home to innovative research programs in family planning service delivery models since the early 1970s. And, because of its population size, Nigeria was a priority country for several donor organizations for assistance in the area of population and family planning[1]. Thus, family planning programming environment in Nigeria was more auspicious than that of Malawi from the 1970s to early 1990s, and the country seemed to have a better prospect of FP programming success than Malawi. It therefore seems counter-intuitive that by 2003/04, mCPR in Malawi was already 28% compared to 8.3% in Nigeria[2], and by 2013/2015, mCPR in Malawi had increased to 58%, compared to 9.8% in Nigeria (Figure 1). In other words, Malawi's mCPR in 2015/16 was about six times that of Nigeria in 2013.

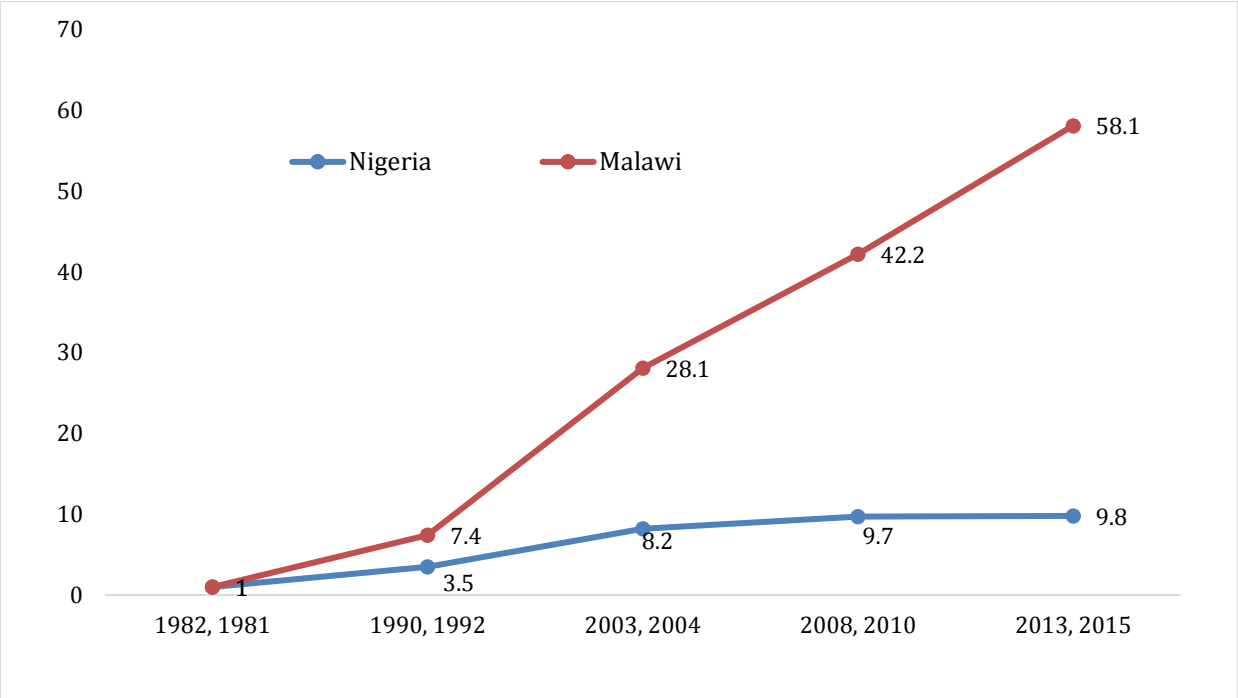
The questions that arise include: what factors are important in explaining the rapid increase in the uptake of modern contraceptive methods in Malawi compared to the slow pace of progress in mCPR

[1] Nigeria's family planning program dates back to 1958 introduced through the maternal and child services of the Lagos City Council (US Agency for International Development, 1970:74). In 1964, the Family Planning Council of Nigeria was inaugurated under the guidance of the National Council of Women Societies (Oyediran, 1969, US Agency for International Development, 1970). The country was the site for innovative family planning service delivery experiments, beginning with the 1969-72 Ishan experiment on hospital-based service delivery (Ross, 1986), the 1975-1980 Calabar rural maternal and child family health project, and the community-based delivery of health and family planning that began in 1981 at the Department of Community Medicine, University of Ibadan (Ross, 1986, UCH, 1986).

[2] Family planning program in Nigeria was suspended between 1994 and 1998 under the Abacha military regime. The effect of such interruption on long-term progress of the program is difficult to assess.

in Nigeria? In other words, what are the secrets of Malawi's FP program success that Nigeria can learn from?

Figure 1: Trends in mCPR in Nigeria and Malawi (1981-2015)



The objective of this paper is to investigate the factors that contributed to Malawi's stellar FP success, assess Malawi's strategies and identify lessons or practices that can be distilled and adapted to accelerate the pace of FP progress in Nigeria. We compare and contrast the trends and patters in key FP program indicators between the two countries. Special attention is paid to the use of modern contraceptive methods among married or in-union women of reproductive age (15-49) – the sub-sample for this study. We explore the factors that likely to have contributed to Malawi's stellar success in family planning between 1990 and 2015/16. The paper also assesses Malawi's programming strategies and distills lessons that can be adapted to accelerate FP progress in a country such as Nigeria. This approach is in line with peer-to-peer learning model currently being promoted by the international development community (Andrews and Manning, 2015).

DATA AND METHODS

The paper is based on the analysis of data from Demographic and Health Surveys (DHS) program. Malawi has participated in the DHS program since 1992 and implemented standard surveys in 1990, 2000, 2004, 2010 and 2015-16. Nigeria has also implemented about 6 standard DHS since 1990 (1990, 1999, 2003, 2008, 2013 and 2018), but data from the 2018 Nigeria DHS are not yet available and the 1999 DHS, which was implemented outside of regular DHS project, was excluded because of data problems. We used both bivariate analysis techniques as well as the multivariate logistics regression models to investigate mCPR patterns, trends and determinants in both countries. The determinants of contraceptive use examined include socioeconomic (educational attainment, place of residence, religion[3], and wealth quintiles in surveys conducted after 1999) and bio-demographic variables (age, number of children surviving, and fertility preference). Logistic regression models have the form:

$$\text{Log}_e \mathbf{p}/(1-\mathbf{p}) = b_0 + b_1x_1 + b_2x_2 \ldots. + b_kx_k$$

Where **p** is the probability that a married woman is using a modern method given the independent variables of x_1, x_2 …. X_k. For the logistic regression, currently married or in-union women between age 15 and 49 were selected. Those using modern methods were coded as 1 and 0 otherwise.

We also synthesized information from published and unpublished sources to elucidate on programming strategies and FP context in both countries. We distilled lessons from Malawi that can be adapted to accelerate FP progress in Nigeria. The next section of the paper is divided into three broad parts. The first part deals with mCPR patterns, trends in both Malawi and Nigeria. This part is based primarily on DHS data. The second part deals with broad contextual and programming environment for family planning and uses a mixture of DHS and information from other sources. The third part deals with strategies that Malawi adopted to accelerate progress in FP uptake.

FINDINGS

1. Patterns and trends

Trends in mCPR for the two countries are already presented (Figure 1). We also compare the levels and trends in the key FP determinants. Table 1 presents some of these differences in patterns,

[3] Interestingly, data on religion were not collected in the 1992 Malawi DHS.

including the annual percentage point change in the determinants. It shows that mCPR increased by an average annual percentage point of 2.2 in Malawi and by 0.3 in Nigeria – indicating that between 1990/92 and 2013/16 the annual percentage point increase in Malawi was on average seven times that of Nigeria (2.2/0.3).

The Table also shows that mCPR among disadvantaged groups (those in the lowest quintile, with no education, etc.) increase faster than among the well-off groups in Malawi, but the reverse was true of Nigeria. For example, while rural mCPR increased almost tenfold in Malawi (58/6), it increased only fourfold in urban areas – or an average annual percentage point change of 2.2 in rural areas compared to 1.9 in urban areas. Similarly, mCPR in Malawi increased thirteen-fold among the women in the lowest quintile (53/4) but increased only 3.6 times among the richest between 1992 and 2016.

In Nigeria, the rate of increase in mCPR among the disadvantaged group was much slower: rural mCPR only tripled (from 1.9% to 5.7%) or an annual percentage point increase of 0.2 compared 0.3 in urban areas. Similarly, mCPR among the poorest quintile in Nigeria barely changed in 23 years – the average annual percentage point increase was less than 0.1 - but it increased thirteen-fold in Malawi in 23 years! The group with the largest and fastest increase in mCPR among the socioeconomic groups in Nigeria is the middle quintile – a five-fold increase from 1.7% to 9.1% in 23 years (Table 1) – which represents an annual percentage point increase of 0.3, compared to 2.2 in Malawi.

Consequently, mCPR disparities by socioeconomic categories in Malawi had been minimized by the time of its latest survey (2015/2016), but the disparities in mCPR across socioeconomic groups had widened in Nigeria by the time of its latest survey (2013). This pattern suggests that access to FP services was equitable in Malawi, and the poor were not disadvantaged. The situation was much different in Nigeria and the level of disparity in mCPR by socioeconomic groups seemed to have worsened over time.

Table 1 Changes between the first and the most recent DHS in mCPR and selected FP determinants in Malawi and Nigeria

Malawi				Nigeria			
Variable	1992 DHS	2015/16 DHS	Pct. point change/yr.	Variable	1990 DHS	2013 DHS	Pct. point change/yr.
	%	%			%	%	
MCPR	7.4	58.1	2.2%	MCPR	3.5	9.8	0.3%
Residence				Residence			
Urban	17.2	61.4	1.9%	Urban	9.6	16.9	0.3%
Rural	6.0	57.5	2.2%	Rural	1.9	5.7	0.2%
Education				Education			
None/Pry	6.4	58.1	2.2%	None/Pry	2.3	5.1	0.1%
Sec/higher	37.5	58.4	0.9%	Sec/higher	13.7	19.5	0.3%
Wealth Quintiles				Wealth Quintiles			
Poorest	3.9	53.2	2.1%	Poorest	0.5	0.9	0.0%
Middle	5.6	58.8	2.2%	Middle	1.7	9.1	0.3%
Richest	17.2	60.6	1.9%	Richest	12.2	23.4	0.5%
Age				Age			
15-24	3.4	37.5	1.5%	15-24	0.6	1.2	0.0%
25-34	9.5	64.2	2.3%	25-34	4.4	13.0	0.4%
35-49	7.5	55.9	2.1%	35-49	4.8	11.5	0.3%

Sources: Analysis of DHS data and statcompiler.com. Yearly percentage point change is obtained by dividing the difference in mCPR between the first and latest DHS by the time interval.

Table 2 presents the results of bivariate logistic regression models that assess the effects of each of the background determinants on the use of modern contraceptive methods in 1990 (Nigeria) and 1992 (Malawi) and compared the effects to the results in 2013 (Nigeria) and 2015/16 (Malawi). The results show that disparities across socioeconomic and bio-demographic variables improved much more rapidly in Malawi than in Nigeria. For example, women with secondary or higher education were 12 times as likely to use a modern method as women with no schooling in both countries in the early 1990s. However, while Malawi was able to practically eliminate the disparity by educational attainment, Nigeria's disparity by education got worse: the odds of a woman with secondary or

higher education using a contraceptive methods increased from a ratio of 12:1 in 1990 to 13:1 in 2013. Religious disparity seems to be the highest in 2015/16 column for Malawi in the table.

Table 2: Results of logistic regression models of the effects of various determinants of modern methods use among married women age 15-49 (Malawi 1992-2015/16 and Nigeria 1990-2013)

	Malawi			**Nigeria**		
	1992	2015/16	Change in OR	1990	2013	Change in OR
Education						
No Schooling	1.0	1.00	-	1.00	1.00	-
Primary	1.77***	1.24***	-0.53	4.47***	8.97***	+4.50
Sec/higher	12.08***	1.21***	-10.87	12.46***	13.79***	+1.33
Religion						
Moslem/other	--	1.00	--	1.00	1.00	-
Protestant	--	2.01***	--	5.31***	3.98***	-1.33
Catholic	--	2.18***	--	3.93***	5.37***	+1.44
Place of residence						
Rural	1.00	1.00	-	1.00	1.00	-
Urban	3.24***	1.18***	-2.06	5.46***	3.36***	-2.10
Age						
15-24	1.00	1.00	-	1.00	1.00	-
25-34	1.85***	1.65***	-0.20	1.70**	2.49***	+0.79
35-49	2.03***	1.46***	-0.57	2.58***	2.99***	-0.41
No. of living children						
0-3	2.01***	1.70***	-0.31	2.39***	1.69***	-0.70
4-6	2.50***	1.31***	-1.19	3.60***	1.05	-2.55
7+	1.00	1.00	-	1.00	1.00	-
Ideal family size	NS					
0-4	1.37	1.37***	0.00	7.61***	7.37***	-0.24
5-7	1.29	1.28**	-0.01	4.31***	4.41***	+0.10
8+	1.00	1.00	-	1.00	1.00	-
Wealth quintile						
1	--	1.00	--	--	1.00	--
2	--	1.22***	--	--	4.50***	--
3	--	1.25***	--	--	11.71***	--
4	--	1.30***	--	--	19.66***	--
5	--	1.14***	--	--	35.52***	--
No of women						

Notes: OR = odds ratios; * = significance at 5%; ** = significance at 1%; *** = significance at 0.1%.
In columns 4 and 7, a negative sign indicates a reduction in odds ratios (gap), while a positive sign indicates that the disparity or gaps (measured by odds ratios) widened (i.e. worsened).

Similarly, while Malawi largely closed the rural-urban gap in modern contraceptive use between 1992 and 2015/16, women in urban Nigeria were still three times as likely to use a modern method as women in rural areas in 2013 (Table 2). The same story could be told with regards to age disparities, as well as disparities by fertility preferences. Perhaps the most egregious disparity is the one across wealth quintiles: Malawi had very small differences in contraceptive use across household wealth quintiles in 2015 while Nigeria's rich-poor gaps are really huge, ranging from 4:1 between the first and second quintiles to 36:1 between the poorest and the richest quintiles. Additional analyses of recent trends (not shown here) indicate that the prevalence of modern method use among the poorest quintiles has been declining since 2003 while it keeps increasing among women in the richer quintiles. Thus, while Malawi made huge progress in eliminating or minimizing the disparities in modern method use across socioeconomic and bio-demographic categories between 1992 and 2015/16, Nigeria was able to reduce the disparity in a small way among some groups, but the disparity got worse in several groups (Table 2, columns 4 and 7).

2. Contextual and programmatic factors

At least two conclusions can be made from the preceding results: Malawi's mCPR increased at a much faster pace overall and across socioeconomic categories in Malawi and in Nigeria between the periods under study; and that while Malawi managed to close (minimize) the disparities across socioeconomic categories through faster increase in mCPR among the disadvantaged, Nigeria disparities in across socioeconomic categories worsened (widened) over time.

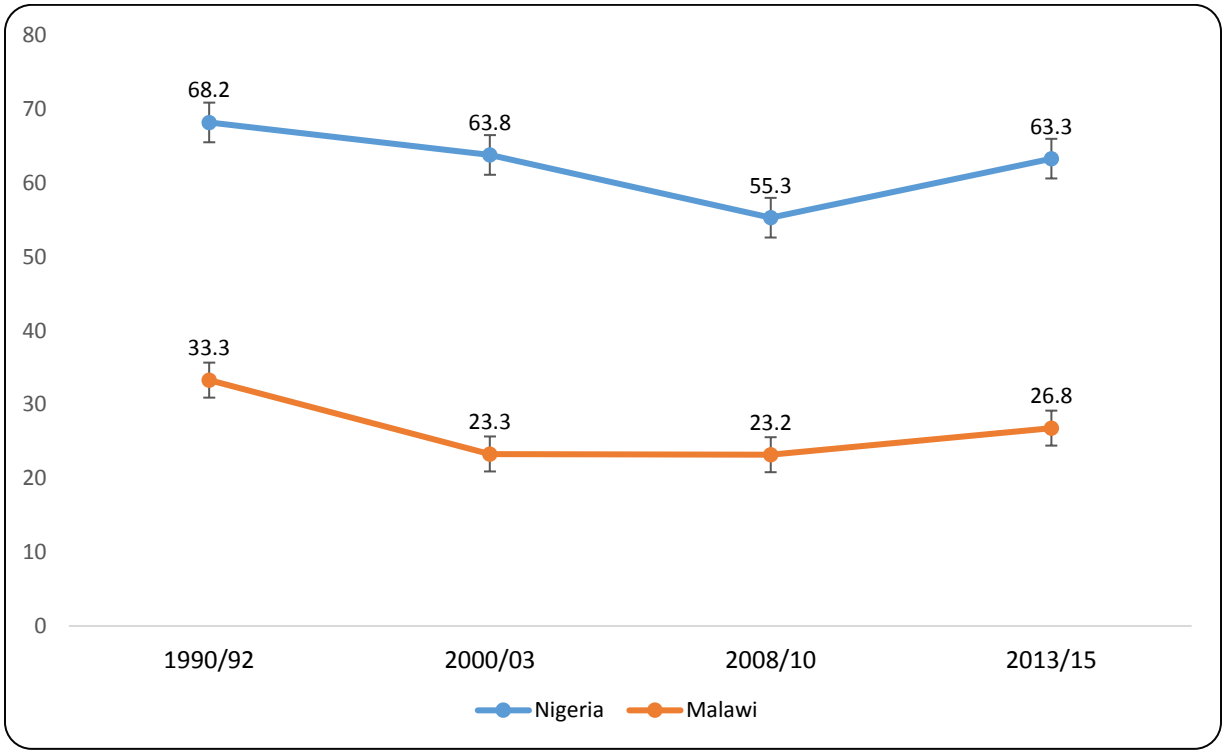
A faster acceleration of mCPR suggests that demand for family planning grew and that the family planning service environment (supply side) responded appropriately to meet the demand. Minimizing disparities across socioeconomic categories suggests that services were intentionally pro-poor. In the next section, we provide indicators and discussions of the demand and supply side factors and we also discuss the contextual factors that were favorable in Malawi.

Demand for family planning

One great factor that helped Malawi is that there seems to be a broad-based demand for family planning, but demand for family planning seems much weaker in Nigeria. A proxy indicator of demand for family planning is the proportion of married women of reproductive age who are not

using a method and do not intend to use a method in future. We looked at the DHS data for this indicator in Nigeria and Malawi. The results are presented in Figure 2 and we found that the proportion of married or in-union women of reproductive age (MWRA) who were not using a method and did not intend to use a method in future remains over 60 percent from 1990 to 2013 in Nigeria – decreasing slightly from 63% to 55% in 2008 and bouncing back up to 63% in 2013. By contrast, a vast majority of MWRA currently not using a method intended to use one in future. The proportion not using and not intending to use in Malawi decreased from 33% in 1992 to 23% between 2000 and 2010 before increasing slightly to 27% in 2015/16 – the proportion in Nigeria is more than double that. Thus, not only is the proportion of MWRA who are not using a modern FP method high in Nigeria (about 90%), 63% of those are not planning to adopt a method in future – meaning a very low demand for FP in Nigeria and a robust demand in Malawi.

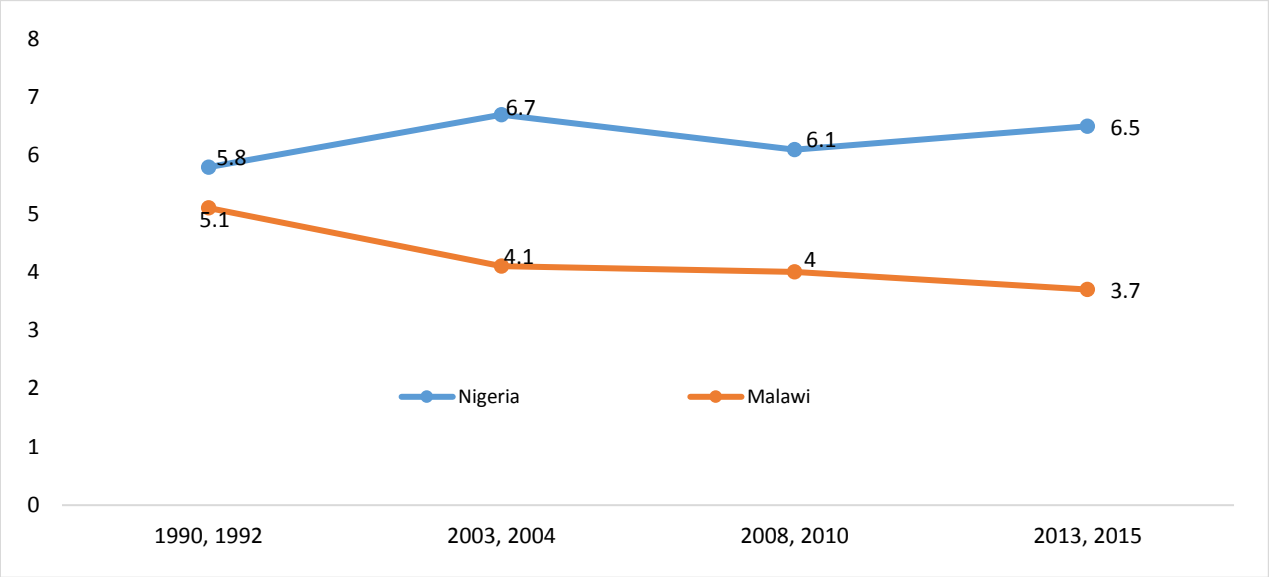
Figure 2 Trends in the Proportion of MWRA not using and not intending to use Modern Methods: Nigeria 1990-2013 and Malawi 1992-2015/16



Another proxy indicator of demand for family planning is ideal or desired family size. Figure 3 shows that the mean ideal family size in Malawi decreased from 5.1 in 1992 to 3.7 in 2015/16, whereas it

increased in Nigeria from 5.8 in 1990 to 6.5 in 22013. Thus while the gap in mean ideal family size between the two countries was 0.7 in the early 1990s, the gap had widened to almost 3 (a fourfold increase) in 23 years. When women want large numbers of children, their demand for (or motivation to use) family planning is weak. Even if they use a method, it will be only temporarily for spacing in the peak childbearing years.

Fig. 3: Trends in Mean Ideal Family Size in Nigeria and Malawi (1990-2015)



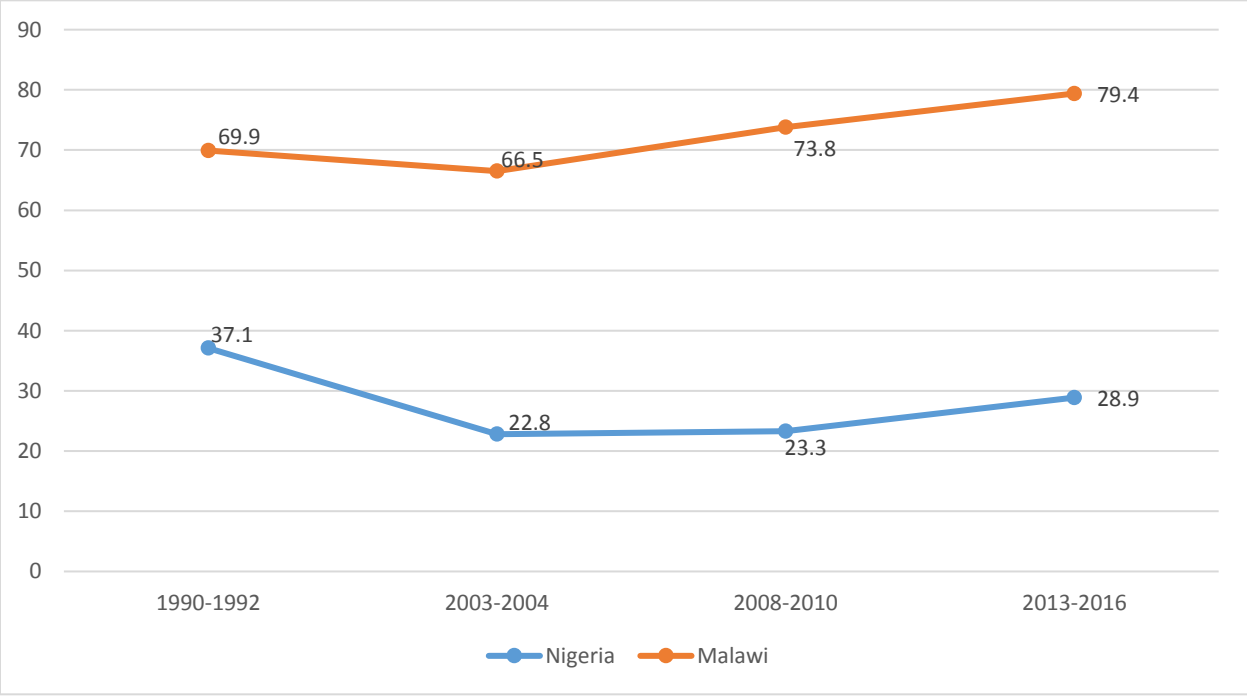
Demand generation: What led to the emergence of a broad-based demand for modern family planning methods, especially for injectables, in Malawi? There would be many reasons for that, some contextual, some programmatic. First, let us address the contextual factors: one important factor seems to be fact that in years when the term "FP" was proscribed in Malawi, FP was introduced as a key intervention for maternal and child health (MCH). This seems to be a blessing in disguise. FP was introduced for spacing or birth pregnancies for the health benefits of mothers and their children. The President of Malawi who allowed this programming linkage and integration was a medical doctor. When family planning programs officially started in Malawi in the early 1980s and 90s, it was in the context of MCH. Injectable contraceptives were the mainstay of Malawi's FP program, and they were administered by trained medical doctors and clinicians in health facilities – the same way that children received immunization. And they could be administered to interested mothers when they brought their children to immunization. Thus, from the outset, Malawi's FP

program had very weak links to birth control or population limitation. This is much different from the experience in Nigeria.

Supply Factors

Another big difference between Nigeria and Malawi is in the way demand for family planning methods are met. DHS data show that while the public sector is the main source of modern contraceptive methods in Malawi, it is a minor source of methods for married women in Nigeria. In 1992, about 70% of married women using a modern method in Malawi obtained their methods from public facilities. By 2015/16, that percentage had increased to 79%. MCPR increased from 7% to 58% within that same period. In Nigeria, the proportion of the same population receiving their methods from public sector decreased from 37% in 1990 to about 23% in 2003-2008, and increased slightly to 29% in 2013 – which was more than 20% decrease from its level in 1990. This over the past six years, the proportion of married women age 15-49 receiving their methods from public facilities in Malawi was 2.7 times more than that in Nigeria. Women in Nigeria rely mostly on the private sector.

Figure 4 Trends in the percentage of current users of modern methods who obtained their methods from the public sector in Malawi and Nigeria



Political commitment

Beginning from President Muluzi in the early 1990s, Malawi's family planning enjoyed support from the leadership of the country. The height of the political support came during the Presidency of H.E. Joyce Banda (2012-2014) – she herself was a women's rights activist and former Minister for Gender, Children's Affairs and Community Services. She committed to an mCPR goal of 60% to be driven with a renewed focus on young adults age 15-24 and she increased budget allocation to the health sector to 22% of total GOM budget. It decreased to between 9 and 10% after 2014 when President Banda left office. She successfully created a line for FP in the federal budget of Malawi; she signed and adopted a new population policy for Malawi, increased the age for marriage to 18 years and elevated the Reproductive health Unit to a full directorate.

3. Strategies that Accelerated FP Progress in Malawi

Now, let us focus on the programmatic elements. A number of strategies were put in place to accelerate FP program in Malawi in the 1990s (Table 3). Program managers recognized in the early 1990s that once restrictions in access were removed, there would be a surge in the number of women who wanted access to family planning methods.

i. FP program managers knew that there were in insufficient numbers of service delivery points in the country. There were two main strategies for dealing with those: first, Banja La Msogolo (BLM), a Marie Stopes affiliate, provided extensive outreach services through its 29 facilities. Second, there was an expansion and provision of incentives (e.g. bicycles) to Community-Based Distribution Agents to provide services in rural areas of Malawi.

ii. To avoid the problems of stock-out at health facilities, the strategy adopted was to expand the logistic system for commodity distribution through the Contraceptive Distribution Logistics Management System.

iii. There were also staffing shortages for family planning. Therefore, in-service and pre-service training programs were expanded to produce continuous streams of FP service providers.

iv. At the policy level, all major existing obstacles in the way of women being able to access FP services were removed. For example, age and parity restrictions were removed through the adoption of the Child Spacing and Contraceptive Guidelines in 1992. The Guidelines also removed the need for husband's consent for FP services and it expanded FP service provision to five days per week.

v. To remove cost barriers, FP services and commodities were provided free of charge.

vi. To remove knowledge barriers, there were extensive multiple channels of communication about FP and in multiple languages – they included radio jingles, posters, dramas, health talks, etc. Population education was also introduced in schools in the country.

Table 3: FP Programmatic Challenges in Malawi and Strategies for Dealing with them in the 1990s

Problem	Strategies for Dealing with it
1. Insufficient number of Service Delivery Points	• Banja La Msogolo (BLM) provided extensive outreach services through its 29 facilities • Expansion of and provision of incentives (e.g. bicycles) to Community-Based Distribution Agents
2. Lack of commodities at facilities	• Expansion of contraceptive commodity distribution through Contraceptive Distribution Logistics Management Info System
3. Staffing shortages	• Expansion of in-service and pre-service training of FP providers
4. Restrictive policies for accessing services	• Adoption of the 1992 Child Spacing and Contraceptive Guidelines - it removed restrictions on age and parity, and husband's consent for FP service • Expansion of FP service provision to 5 days per week
5. Knowledge barriers	• Extensive multiple channels of communication about FP and in multiple languages: radio jingles, posters, dramas, health talks, etc. Population education in schools.
6. Cost and poverty barriers	• FP services and commodities were provided free

Compiled from Solo et al. (2005) report, and USAID (1992)

Between 2000 and 2004, the rate of increase in mCPR slowed drastically it increased by just two percentage points (from 26.1% in 2000 to 28% in 2004). These DHS results led to some self-reflections among family planning program managers within USAID/Malawi as well as among other partners in the country. One of the results of that self-reflection was the realization that much of the progress of the 1990s was achieved by meeting pent-up demand for FP. However, after the low-hanging fruits were reaped, there was a need to expand access to people in rural areas. Since Depo-Provera (a clinic-based method) was the mainstay of Malawi's FP method mix, and clinics were not easily accessible to rural residents, a logical strategy was to allow Health Surveillance Assistants (HSAs) to dispense Depo-Provera in rural areas. For that to happen, Malawi Medical Association

had to agree to allow non-medical staff to administer Depo injections. That required a major policy change, and USAID's Health Policy Project (HPP) was brought in to assist.

- The Health Policy Project successfully negotiated that policy change in 2008, and HSAs began administering Depo. This strategy was a major reason for the jump in mCPR in observed in the 2010 Malawi DHS – a 50% increase from 28% to 42%.
- From 2011, there was a deliberate strategy to expand access to implants. Therefore, mobile clinics were used to provide services in rural areas. Right now, the strategy is shifting to meeting the needs of adolescents and young adults also.

Altogether, the Malawi FP program is very intentional in its approach. It put a lot of emphasis or removing barriers and expanding access, and providing rural women with services that are convenient and mainly free.

What lessons can Nigeria learn from Malawi?

Nigeria needs to put more emphasis on demand generation activities for FP. The fact that the mean desired family size is above six children suggest that there will be low demand for family planning. Drivers of such desire for large family size are probably contextual factors and may be beyond what could be addressed through family planning interventions alone. However, the drivers of the desire for large families need to be understood and addressed.

Second, there should be a devotion to programming efforts that are aimed at removing barriers in access to family planning methods by people who need them. This emphasis on removing barriers should be intentional and evidence-based. Analysis in this paper shows that women who are poor, reside in rural, or are not educated barely use modern family planning methods in Nigeria. Malawi's approach ensures that such women are not left behind. There is high level of poverty in Nigeria. Perhaps the predominance of private sector provision of family planning methods in the country is contributing to the high disparity in method use across the socioeconomic categories. Further evidence also suggests that there is increasing reliance on traditional methods in many parts of Nigeria. Reasons for this trend needs to be understood and addressed. For example, in some states in southern Nigeria, the proportion of married women of reproductive age relying on traditional

methods now exceeds the proportion relying on modern methods. If there are unfounded fears of side effects, they need to be addressed.

Third, a strong political commitment to family planning as an essential component of maternal and child health intervention is needed. The political advantage offered through sheer population numbers should be minimized. Education of children and provision of jobs for all adults are essential. However, one thing that stood out about Malawi's family planning program is the willingness of the program managers to take service to the people where they are. Malawi is more than 80% rural and many women or reproductive age are poor. With the dependency on clinic-based method, the program has expanded service provision through health surveillance assistants, used community-based distribution of injectables, used mobile clinic, and provided free or heavily subsidized commodities. Since there was demand, every expansion of access to services has led to increases in uptake of family planning. Nigeria can learn from this approach.

SUMMARY AND CONCLUSION

Overall, the results in the paper showed stack differences between both countries in mCPR patterns and trends, equity patterns, source of methods, and indicators of demand for FP. This is partly because Malawi adopted multiple, evolving and culturally-acceptable communication channels to generate demand and expand access; it progressively modified strategies, policies, methods and partnerships to meet client needs; FP enjoyed high political commitment levels; its mCPR growth is broad-based and equitable; and staffing/capacity weaknesses in its service environment are addressed using a combination of task-shifting, training, salary top-up for various cadre of health care staff, etc.

It is perhaps serendipitous that the introduction of FP into Malawi as a maternal and child health intervention program, including the mother could bring a child to the clinic for vaccination and also receive injectable contraceptives herself helped its widespread acceptance with no obvious link to fertility. By contrast, population numbers and the issues of fertility have been hijacked by ethno-religious interests in Nigeria as sections of the country seek to leverage their population numbers for cornering more resource allocation and political power. Changing this form of programming environment and generating high demand for FP will require thoughtful strategies and creativity in

programming. Malawi has shown that it can be done. The onus is on FP program managers in Nigeria to study Malawi's FP programming strategies and adapt its lessons to improve its mCPR.

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