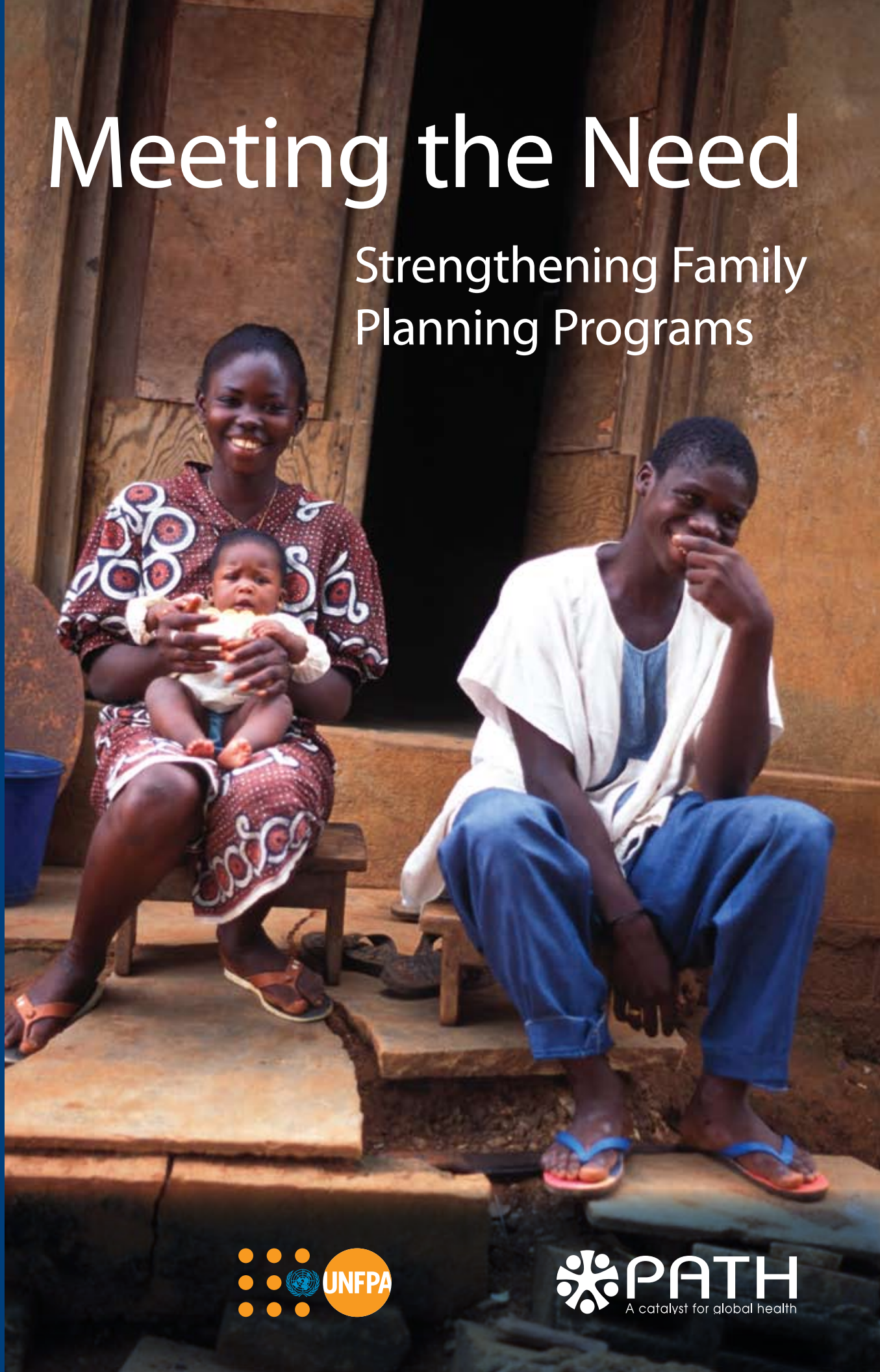
Meeting the Need

Strengthening Family Planning Programs



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Preface

Ensuring access to family planning information, services, and commodities is essential to protecting the health and well-being of women, families, and societies as a whole. Economic development, human rights, and global health all have deep but often overlooked roots in family planning. Yet recent trends, while effective in broadening the global health and development agenda, have diluted the attention and funding directed to family planning. The 1994 International Conference on Population and Development placed family planning within a broader context of women's reproductive health and rights and gender equity. Health sector reforms encouraged integrated services and let district-level officials set priorities that often overlooked family planning needs. New development frameworks, including the Millennium Development Goals set by world leaders in 2000, focused on meeting the needs of the world's poorest without specifying family planning as a priority.

Together these trends have diluted recognition of the integral role family planning plays in development. Family planning efforts can be reinvigorated by helping program managers and planners understand how energetic advocacy, improving access to and quality of care, encouraging people in need of family planning to seek services, and working towards financial sustainability can increase contraceptive prevalence. Helping donors and decision-makers understand how family planning is integral to economic and social development can ensure that the funding and political will are present to sustain services.

This report is designed as a general resource to help family planning program managers strengthen their programs and meet growing family planning needs. It does not attempt to present a detailed technical analysis of the issues and does not address the many regional and country variations and circumstances related to providing family planning services. Instead, it offers a broad overview of key programmatic considerations. Each subsection includes a list of practical specialized resources and hands-on tools (available online) that can support program managers desiring to bring about programmatic change. It should be emphasized that program managers need not try to simultaneously change all aspects of programming discussed in this report; in some cases focusing on one or two program components can bring about dramatic results. It is hoped that this report will inspire program managers to further investigate ways to strengthen family planning programs so that they may increase contraceptive prevalence and fulfill the reproductive rights of the women and men they serve.

Executive summary

Impressive global gains have been made in recent decades in improving contraceptive prevalence rates and decreasing fertility rates. At the same time, increasing numbers of men and women in developing countries want to adopt family planning and exercise their right to freely decide the number and spacing of their children. For program managers who are trying to meet this growing demand for family planning, the current environment is difficult. The international health and development field is trying to address new priorities, including the HIV/AIDS epidemic and pervasive poverty, in addition to established concerns like reproductive health, and it often overlooks the integral role that family planning plays in them. Health sector reforms have created new management challenges, including changes in funding mechanisms and the decentralization of service delivery to the district level. Integration of services, which has been the long-term goal of the family planning community, is not a simple task with a standardized solution; it requires careful management of a well-planned process. This is often beyond the capacity of new management centers and thus in some cases has resulted in weakening family planning services. In spite of these challenges, it is important now more than ever that family planning information and services be made more broadly available by integrating them systematically into general health services.

To meet these challenges, family planning program managers need to act on four fronts. First, they must advocate to increase understanding at the broader policy level of the linkages between poverty, development, and family planning. Second, they must ensure that family planning services are cost effective, accessible, and of good quality. Third, family planning program managers need to create demand for family planning. Finally, managers should work to improve financial sustainability of family planning programs.

Successful advocacy will clarify the connection between family planning and broader health and development goals. Ensuring that decision-makers understand the linkages between family planning and goals related to economic development, gender equity, HIV/AIDS prevention, and maternal and child health will support long-term family planning program impact and sustainability.

Effectively reshaping service delivery to ensure affordability, accessibility, and quality will help maximize the reach of family planning services. Integrating family planning with other health services can help meet the special needs of different populations and bring family planning services to new audiences, as can reaching out to the poor, adolescents, men, and other under-served groups. Improving contraceptive counseling and ensuring contraceptive supplies can make the goal of informed choice a reality. Finally, strengthening day-to-day service delivery can improve the quality of care that family planning clients receive.

Behavior change communication, including client education, community mobilization, and mass media, has the potential to change community norms as well as individual attitudes, thus building support for reproductive rights and overcoming social opposition to family planning. It can also increase knowledge and motivate potential clients to act. At the same time, compensating clients' out-of-pocket costs and waiving fees can remove the economic barriers that discourage individuals from seeking family planning services.

Carefully analyzing costs and revenues, and changing staffing patterns and service practices accordingly, can make programs more self-reliant. Partnering with the private sector—for example, through social marketing and social franchising—can increase the availability of affordable family planning services in the community and relieve pressure on the public health system.

PART 1

Outlining the challenge

- Priorities and development strategies
- Benefits of family planning
- Status of contraceptive prevalence

Family planning has lost focus amid recent shifts in international development strategies and priorities. Yet there are 201 million women in developing countries who need, but are not using, modern contraception: 137 million women at risk of unintended pregnancy are not using any method, and an additional 64 million are relying on a less effective traditional method (Singh et al. 2003). Many vulnerable groups, including the poor and adolescents, do not have ready access to good-quality family planning services. And the continually growing number of contraceptive users is straining the ability of family planning programs to meet their needs. Family planning managers must learn to understand the changing policy and funding environment if they are to obtain the policy attention and resources necessary to put their programs on a sound footing.

Priorities and development strategies

Changing global priorities and development strategies have greatly altered the family planning landscape, particularly in the last decade. Consensus reached at the 1994 International Conference on Population and Development (ICPD) in Cairo rejected a narrow focus on population issues in favor of a broad developmental approach based on realizing women's reproductive rights and gender equity, calling for family planning to be provided as an integral part of wide-ranging reproductive health care services (UN 1995). This call was reiterated five years later by the UN General Assembly (UN 1999) and again in the World Health Organization's 2004 reproductive health strategy

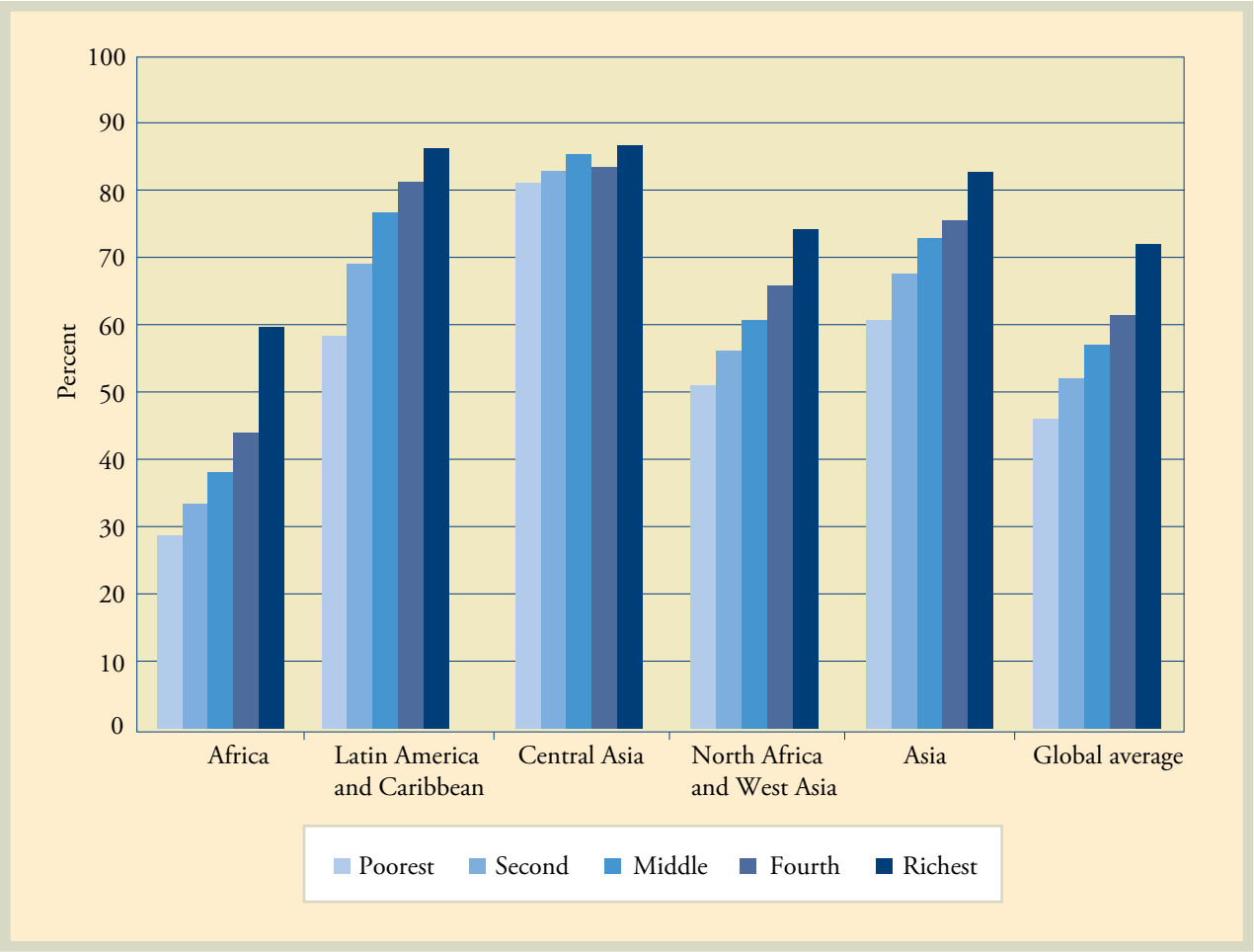
(WHO RHR 2004). This expanded agenda clearly has contributed to women's well-being, but family planning generally has had to share the spotlight and funding with a wider array of services—including important and long-standing but little-recognized problems such as female genital mutilation and gender-based violence (Gillespie 2004). Further, much-needed resources have been devoted to combating the HIV/AIDS pandemic, but its close linkages with family planning and other sexual and reproductive health concerns are often unrecognized, resulting in missed opportunities for improving health.

The drive for health sector reform has bolstered the ICPD's case for offering a wide range of reproductive health services. Reformers argue that integrated health services—along with decentralization, alternative financing schemes, allocating resources based on disease burden, and other innovations—can increase the efficiency, quality, equity, sustainability, and client responsiveness of health systems in the developing world. While it is clear that benefits of integration and other innovations is positive, sometimes these reforms may inadvertently undermine family planning. For example, integrated services often require family planning providers to divide their time over a wider range of services (Dmytraczenko et al. 2003, McIntyre 2005); decentralization lets district-level administrators determine what resources to allocate to family planning (Maceira 2005a, Merrick 2000); and burden of disease measures undervalue family planning because pregnancy is not an illness (Alvarez-Castillo 2005, Berer 2002). However, the potential benefits of health sector reform outweigh the disadvantages. For example, sector-wide approaches (SWAps) pool donor funding so that governments can coordinate a common approach to planning and spending across the entire health sector. While SWAps may reduce donor funding targeted to family planning, they eliminate the duplication of effort, fragmentation, and heavy administrative burdens that waste so many resources in a project-driven approach to health care, while strengthening local ownership and leadership—all of which can make health care more effective and efficient (CIDA 2003, Maceira 2005b).

At the same time, a growing focus on alleviating poverty has diverted attention and funding away from reproductive health and family planning. The World Bank and the International Monetary Fund introduced Poverty Reduction Strategy Papers (PRSPs) in 1999 as a condition for loans and debt relief, and donors and development partners are increasingly using them as a framework for development assistance. These multisectoral plans for economic growth touch on health issues but often do not explicitly recognize reproductive health and family planning as priorities or assign them budget allocations—another missed opportunity because development cannot take place without appropriate investment in family planning, particularly for poor people, who tend to have higher rates of unmet need (see Figure 1). Yet PRSPs hold enormous potential for reproductive health: they can heighten awareness of the importance of health outcomes for poverty reduction and economic growth, give the health sector a voice in the broader budget allocation process, and attract new funding to and streamline donor support for health (WHO 2005a).

FIGURE 1:

Proportion of contraceptive need met, by wealth quintile, 1996–2004



Notes: 1996 data for Bangladesh, Benin, Nepal, Tanzania, and Zambia and 1997–1998 data for Nicaragua are not included in this survey period. The global wealth quintile average is a simple average and does not account for differences in wealth quintile groups between countries.

Source: Adapted from UN Millennium Project 2006

The focus remained on poverty during the 2000 Millennium Summit, which brought world leaders together to produce a common framework for international development priorities and set the agenda for the United Nations in the twenty-first century. The Summit produced a series of eight Millennium Development Goals (MDGs), notably omitting the ICPD's goal of universal access to reproductive health information and care (Bernstein 2005, Crossette 2005). Yet family planning and reproductive health contribute, directly or indirectly, to achieving each of the MDGs (Singh et al. 2003), which are to:

- Eradicate extreme poverty and hunger.
- Achieve universal primary education.
- Promote gender equality and empower women.
- Reduce child mortality.
- Improve maternal health.
- Combat HIV/AIDS, malaria, and other illnesses.
- Ensure environmental sustainability.
- Develop a global partnership for development.

The Millennium Project's five-year progress report on the MDGs recognized this oversight, especially the links between population growth and poverty; population dynamics and climate change; reproductive rights and gender equality; and reproductive health and the well-being of mothers, infants, and those at risk of HIV/AIDS (UN Millennium Project 2005a). Indeed, some Millennium Project task forces have recommended adding indicators that explicitly address family planning and reproductive health (UN Millennium Project 2005b, Sinding 2005). Family planning and reproductive health advocates must continue to work at both the international and national levels to make reproductive health part of the MDG agenda and a policy and program priority (Basu 2005).

Five key goals for national family planning programs

International family planning agencies generally agree that there are five overarching goals linked to the success of national family planning programs. First, the programs must provide full access to a variety of contraceptive methods so that couples and individuals can obtain the method that best suits their needs. Second, programs must satisfy unmet need and intention to use a method so that those wanting to use a method can do so. Third, national family planning programs must strive to achieve desired fertility levels so that couples can have the number of children they desire. Fourth, countries should work to attain their desired replacement fertility levels for optimal population stability. Finally, national programs should work to satisfy the Millennium Development Goals and the Cairo Programme of Action in an effort ultimately to reduce poverty, improve health, and promote peace, human rights, gender equality, and environmental sustainability (Ross et al. 2005).

Benefits of family planning

Health

According to World Health Organization (WHO)s 2001 estimates, sexual and reproductive health problems account for 18 percent of the total global burden of disease and 32 percent of the burden among women of reproductive age (15 to 44 years old) worldwide (WHO 2001). Each year some 50 million women suffer illnesses related to pregnancy and childbirth, and over 529,000 die (WHO 2005a). By using family planning to prevent unwanted and high-risk pregnancies and to space births more widely, women can substantially reduce the risk of mortality and morbidity associated with complications of pregnancy and childbirth (Norton 2005, WHO 1994). Further, when family planning services are sufficient to meet the growing demand for contraception, abortion rates decline (Deschner and Cohen 2003). A recent analysis has calculated that the money spent on providing modern contraceptive services in the developing world—US$7.1 billion in 2003—prevents 187 million unintended pregnancies, 60 million unplanned births, 105 million induced abortions, 22 million spontaneous abortions, 215,000 pregnancy-related deaths each year, and the loss of 60 million disability-adjusted life years (DALYs*)—16 million among women and 44 million among infants and children (Singh et al. 2003). In other words, every $33,000 invested in family planning prevents one maternal death. A 1993 World Bank study found that in a typical African country with high mortality and fertility, the cost of averting a single unintended birth through family planning was $368 and the estimated savings to the government was $440 (Jamison et al. 1993). A study in Vietnam found that over time, every dollar invested in family planning would save about $8 in health, education, and other social services (VCPSI and Futures Group 1997). The health of infants and children also benefits from mothers' ability to space births more widely and to prevent high-risk pregnancies. Babies are more likely to be born prematurely, have low birth weight, be small for gestational age, die in infancy, and suffer from malnutrition when they are closely spaced (Norton 2005, Rutstein 2005, Zhu 2005). Low birth weight and infant mortality also are more likely when mothers are under 18 or over 35; children are more likely to have disabilities if their mothers are over 35. Short birth intervals also harm older siblings by reducing the duration of breastfeeding (Marston and Cleland 2004). The use of modern contraception in the developing world prevents 2.7 million infant deaths annually, meaning that every $2,600 invested in family planning prevents one infant death (Singh et al. 2003).

Family planning programs can prevent sexually transmitted infections (STIs), including HIV, by promoting male and female condoms for dual protection (Dehne and Snow 1999, WHO 2005b). They can also help fight the AIDS epidemic by preventing unwanted pregnancies among women infected with HIV and thus averting

*The DALY is a measure of life-years gained that combines the number of years of healthy life lost due to both premature morbidity and mortality, using a set of age and disability estimated weights.

mother-to-child transmission of the virus (Gillespie 2004, Stover et al. 2004). Finally, family planning services can provide a range of additional benefits (see Table 1).

Reproductive rights and gender equity

Universal human rights include the freedom to decide when and how many children to bear and the right to attain the highest possible standard of reproductive and sexual health. Family planning programs can help achieve both of these rights by enabling people to space and prevent births and to prevent HIV and other STIs (UNFPA 2005a).

Family planning also has the potential to advance gender equity (USAID IGWG and WHO 2005). It can increase women's educational, work, and life opportunities by preventing early pregnancies that force adolescent girls to drop out of school and by letting women have smaller, healthier families that make fewer demands on their time

TABLE 1:

Examples of medical benefits of sexual and reproductive health services

Contraceptive services	Maternal health services
Help space births, resulting in: • Lower rates of infant and child mortality. • Decreased risk of anemia for mothers. • More time to breastfeed, improving infant health and survival.	Prenatal care provides: • Education and counseling on healthy behaviors, diet, and nutrition. • Opportunity for prompt intervention in case of complications. • Opportunity for management of ongoing conditions such as hypertension, anemia, malaria, hepatitis, tuberculosis, and cardiovascular disease.
Prevent high-risk pregnancies among: • Very young adolescents. • Women in their late 30s and 40s. • Women who have had many births. • Women with pre-existing medical conditions.	Obstetric care reduces probability and severity of: • Hemorrhage. • Infection. • Obstetric fistula. • Urinary or fecal incontinence. • Pelvic inflammatory disease.
Prevent unsafe abortion resulting from unwanted pregnancies, thereby reducing: • Maternal deaths. • Ill health. • Infertility.	Postpartum visits help: • Reduce infection. • Increase breastfeeding. • Improve nutrition.
Prevent maternal and infant deaths and ill health resulting from unwanted births.	Care for complications of unsafe abortion reduces mortality and severity of subsequent ill health and promotes subsequent contraceptive use.
Facilitate screening for STIs and other health concerns.	

Source: Singh et al. 2003

and energy (UNFPA 2005a). Family planning programs, and complex societal changes in general, also may challenge traditional gender roles and dynamics and reshape social norms, for example, by endorsing women's right to refuse sex and encouraging couples to discuss and jointly decide on a contraceptive method (Jacobson 2000).

Economic benefits

Having fewer, healthier children can reduce the economic burden on poor families, allow them to invest more in each child's care and schooling, and thus help break the cycle of poverty (UNFPA 2005a, WHO 1994). Investing in family planning also opens a window of opportunity for faster economic growth in nations as a whole by reducing fertility and changing the population's age structure and dependency ratio. As the number of workers increases relative to the number of children they must support, savings and investment can increase. Countries that pursue sound economic and social policies can translate these economic gains into improved living standards and lower levels of poverty (Bloom et al. 2003, Merrick 2002). According to one recent analysis, opening this demographic window could lower poverty rates in developing countries by 14 percent between 2000 and 2015 (Mason and Lee 2004).

Investing in family planning also cuts the cost of social services as, for example, fewer children attend school and fewer, healthier pregnant women seek antenatal and delivery care. Depending on which social services are offered, each dollar spent on family planning may save governments up to US$31 in expenditures on health, education, food, housing, water, sewage, and the like (Singh et al. 2003). Slower population growth also places less stress on limited natural resources, including fresh water and arable land (Singh et al. 2003).

Status of contraceptive prevalence

Levels and trends

Contraceptive prevalence in the developing world has risen dramatically over the past four decades, from about 10 percent of women in 1965 to about 60 percent in 2000 (Ross and Stover 2004). In Asia and Latin America, contraceptive prevalence is now at 71 percent and 64 percent, respectively, indicating that much of the demand for contraception has been met. As Figure 2 illustrates on page 12, contraceptive use in Africa is low. Contraceptive prevalence has grown more slowly in Africa, where use of any method is 27 percent and most couples use family planning to space rather than limit births (UN DESA 2004).

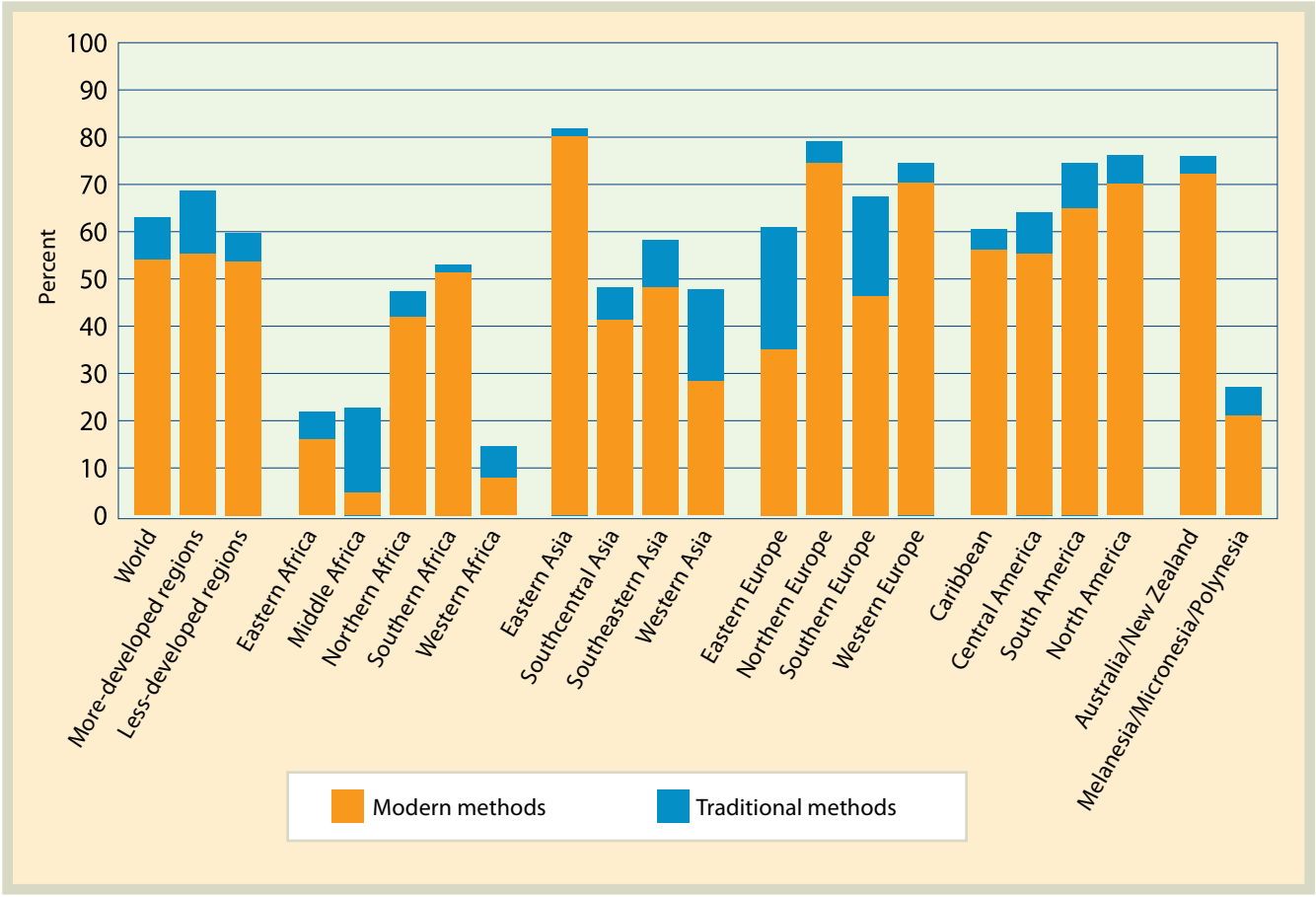
The global regional averages conceal wide variation between and within countries. For example, contraceptive prevalence in Latin America and the Caribbean ranges from a low of 28 percent in Haiti to a high of 77 percent in Brazil and Colombia (Ashford 2003). In Ethiopia and Nigeria (the latter is the world's ninth most populated country), use of any contraceptive method is 8 percent and 15 percent, respectively.

Within countries, contraceptive prevalence may be several times higher in urban than rural areas (Curtis and Neitzel 1996) and it also tends to be lower among the poor than the better-off (see section on "Reaching the poor," page 41).

Despite the increase in contraceptive prevalence over the past 40 years, many women remain unprotected against unintended pregnancies. An estimated 29 percent of women aged 15 to 49 in the developing world have an unmet need for modern contraception: that is, they are sexually active, can become pregnant, and do not wish to have a child ever or in the next two years—but they are not using a modern contraceptive method. Most (20 percent) are not using any form of contraception, while others (9 percent) are using traditional methods, such as periodic abstinence or withdrawal, that have relatively high failure rates (Singh et al. 2003). Levels of unmet need are highest in sub-Saharan Africa (63 percent) and are actually rising there because of growing interest in limiting family size (Singh et al. 2003).

FIGURE 2:

Percentage of married women of reproductive age currently using contraception, by region



Source: Adapted from UN DESA 2004

Determinants

People's decisions to adopt a contraceptive method are based, first and foremost, on whether they want another child. Interest in family planning has grown as desired family size has declined around the world—although it has dropped less in Africa than elsewhere (Ross and Stover 2004). Decisions also are deeply influenced by whether family, friends, and the larger community oppose or support family planning (Ashford 2003, UNFPA 2004). Once couples decide to postpone or prevent another birth, their ability to take action depends on the availability of services, which has multiple dimensions (Bertrand et al. 1995). Geographic accessibility refers to the physical location of services and the difficulties clients may face in getting there. Economic accessibility refers to the affordability of services, supplies, and transportation. Administrative accessibility refers to rules and regulations that may inhibit contraceptive use, such as limited clinic hours or inappropriate eligibility criteria based on age, parity, and spousal consent. Cognitive accessibility relates to clients' knowledge of what methods are available and where. Psychosocial accessibility refers to social and personal factors that may dissuade a potential client from seeking services, such as the social stigma attached to seeking services or the fear of a pelvic exam.

Quality of care also influences contraceptive decision-making. Good care can encourage potential family planning clients to seek out, adopt, and/or continue using contraception—and to spread the word to others (Bertrand et al. 1995). Quality of care depends on offering clients a full range of methods, giving them accurate and complete information, ensuring providers' technical competence, enhancing interpersonal relations between providers and clients, providing follow-up and continuity mechanisms, and offering an appropriate constellation of services (Bruce 1990).

Setting program objectives

Designing a program to increase contraceptive prevalence first requires a careful assessment of current levels of contraceptive prevalence and the full range of factors that determine those levels. Only with such an assessment in hand can managers develop effective interventions that respond to the situation on the ground and address both the supply of and demand for family planning services. For example, the family planning program in Malawi raised the prevalence of modern contraceptive use from 7 percent in 1992 to 26 percent in 2000 despite a myriad of obstacles—including a predominantly rural population, high levels of poverty, low literacy, shortages of health personnel, and cultural and religious barriers to contraceptive use (Solo et al. 2005). After assessing the barriers to contraceptive use, managers decided to increase the accessibility and quality of services by: offering family planning services on a daily basis at more sites; removing unnecessary requirements for age, parity, and spousal consent from policies and guidelines; training lower-level staff to provide methods like Depo-Provera and intrauterine device (IUD)s; establishing a community-based distribution program to serve rural areas; lowering or eliminating user fees; and introducing

an effective commodity procurement system. At the same time, managers sought to increase demand for family planning by having community-based distribution agents normalize the practice of family planning in rural areas and by flooding the country with informational and motivational messages.

Much of the information managers need to set priorities may already be available but, where gaps exist, managers may need to conduct their own assessments. Surveys, such as the Demographic and Health Surveys (DHS), can provide information on levels and trends in contraceptive prevalence by region, urban-rural residence, and women's characteristics, such as education and age. With this information, managers can pinpoint where rates are low and increases are limited, for example, in rural areas or among the poor, and focus efforts there. It is important to examine contraceptive continuation as well as adoption rates. Many contraceptive users start and stop methods because of some dissatisfaction with the method or with services, in a process that is frustrating for clients, wasteful for programs, and detrimental to contraceptive prevalence (Ross and Stover 2004). In many areas of Asia and Latin America, for example, where most demand for contraception is already being met, encouraging people to adopt a method is less important for contraceptive prevalence than helping them use that method correctly and continuously after the decision is made.

Managers also need information on: (1) the strengths and weaknesses of the service delivery system, which may affect access to and quality of family planning services; (2) the knowledge and attitudes of family planning clients and the larger community, which may affect clients' contraceptive decision-making; and (3) the policy environment, which may affect both of the above. Managers can look to the questionnaire developed for the Family Planning Program Effort Index, which measures program effort in the following areas: policy and stage-setting activities, services and service-related activities, evaluation and record keeping, and method availability and accessibility (Ross and Stover 2001). Comprehensive sources of data include:

- Situation analyses, which send research teams to selected service delivery points to inventory facilities, observe consultations, and interview clients, providers, and managers (Population Council 1998).
- Problem-solving methods developed for quality improvement initiatives, such as the COPE® (Client Oriented, Provider Efficient) methodology, which gives clinic staff some simple tools to assess service delivery, interview clients, and develop an action plan to address problems (EngenderHealth 2003a).
- Service Provision Assessment (SPA) surveys, which send data collection teams to a nationally representative sample of facilities to complete facility checklists, observe providers at work, and interview both providers and clients (MEASURE DHS 2005).

Managers should also look for any other family planning surveys and evaluations conducted in the country, perhaps as part of a behavior change communication campaign or operations research project. If little or no data of this kind are available, man-

agers can conduct a rapid assessment of the situation by talking to staff members with experience in administration, service provision, and daily operations; interviewing clients; observing service delivery; and inspecting supplies and equipment.

Managers should analyze all of the information they have gathered to determine which factors pose the greatest obstacle to contraceptive use and then devise interventions to address them. For example, if high costs discourage the poor from using contraception, managers might focus on better targeting government subsidies to the poor or adding family planning to the benefits offered by community-based health insurance schemes. Alternatively, if high rates of contraceptive discontinuation, fueled by misconceptions and fears regarding side effects, play an important role in restricting contraceptive prevalence, managers might focus on improving the quality of counseling.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PART 2

Increasing contraceptive prevalence

- Advocacy
- Reshaping service delivery
- Creating demand
- Sustainability

Advocacy

While family planning program managers have not always regarded advocacy as part of their responsibilities, they should reconsider given the importance of advocacy in keeping family planning on the national agenda as development strategies and priorities shift. Although managers may not be well-placed to lead advocacy efforts, their experience and credibility can reinforce the efforts of nongovernmental organizations (NGOs), civil society organizations, and other stakeholders that advocate for family planning.

One critical step is to engage early and actively in the process of developing PRSPs and SWAps, where critical decisions regarding national priorities and budget allocations are made (Merrick 2000, Quijada et al. 2004). Advocates must learn to understand the new funding environment so that they can work to include family planning goals, funding, and indicators in these multisectoral and multilateral plans (Merrick 2000). Ministries of Health also should take greater advantage of their role during the PRSP drafting process to lobby for health (WHO RHR 2004, WHO 2005a).

Successful advocacy will require redefining and repositioning family planning in response to the MDGs, increased funding for HIV/AIDS, and health sector reforms (Blanc and Tsui 2005, POLICY Project 2005, Quijada et al. 2004). Advocates must raise awareness of how family planning contributes to a range of MDGs, including poverty reduction, gender equality, and environmental sustainability as well as maternal

and child health (Singh et al. 2003). Demonstrating that family planning is a cost-effective way to reduce the country's disease burden is also essential where health sector reforms are being undertaken (Dmytraczenko et al. 2003). For example, a global cost-benefit analysis has concluded that spending US$3.9 billion on contraceptive services for the 201 million women in need of a modern contraceptive method in developing countries would prevent 52 million unintended pregnancies, 23 million unplanned births, 22 million induced abortions, 1.4 million infant deaths, and 142,000 pregnancy-related deaths as well as many cases of STIs and AIDS (Singh et al. 2003).

PROGRAM EXAMPLE:

The role of advocacy in Brazil

A highly effective advocacy community has worked at multiple levels of the health system in Brazil to ensure that the promises of the ICPD agenda and of health sector reform are realized. On the national level, women's organizations made certain that reproductive health, including family planning, became and remained a national priority by stimulating public debate on reproductive rights, creating coalitions, mobilizing public support, lobbying the legislature, and working with the Ministry of Health. Once health sector reforms began to decentralize and integrate services, advocates shifted their attention to the local level as well. They worked to make sure local officials directed funds to reproductive health and family planning, adhered to new service-delivery norms, and effectively integrated reproductive health into municipal-level primary health care services. Women's organizations also worked to improve service delivery by holding meetings and seminars to sensitize and train health professionals.

Sources: Corrêa et al. 1998, Langer et al. 2000, Merrick 2000

Advocates should highlight the role family planning plays in the response to HIV/AIDS, which is the greatest health threat currently facing developing countries. Family planning programs may be able to capitalize on funding for HIV prevention once they demonstrate how family planning can reduce both the sexual and mother-to-child transmission of the virus.

In countries where health systems have been decentralized as part of health sector reform, family planning advocates will need to broaden their efforts beyond the national level because district and local officials are responsible for allocating resources—and they may not consider family planning a top priority (Dmytraczenko et al. 2003, Merrick 2000). (See box, this page, for an example of successful advocacy efforts in Brazil.) In Indonesia, the National Family Planning Coordinating Board made a practice of promoting family planning to officials at every level of government, from the president, to provincial governors and district heads, to village chiefs (Shiffman 2004). In addition to directly petitioning local officials, reproductive health advocates can encourage community members and local civil society groups to participate in local decision-making and accountability mechanisms (Maceira 2005a).

Fortunately, service-delivery managers can draw on a wide range of resources to become effective advocates for family planning (see list of additional resources at the

end of this publication). Manuals outline a step-by-step process to build a broad base of support, craft effective messages, and develop a strategy to get the message out, while advocacy materials and informational websites make the case for the benefits of family planning. (See box, this page, for program tips on conducting effective advocacy campaigns.)

Reshaping service delivery

Integrated services

There is a strong political consensus in favor of integrated services—offering multiple health services at the same facility, often by the same provider. Service integration is borne of necessity in many parts of the world where people have access only to primary health care facilities. As the ICPD agenda suggests, integrated reproductive health care contributes to clients' well-being by addressing a wider range of their health needs and by offering them the convenience of receiving multiple services during a single visit (Berer 2003). As health sector reform suggests, integration can increase efficiency and effectiveness by minimizing duplication in administration and service delivery, by making greater use of existing infrastructure and personnel, and by delivering more services in fewer visits (MSH 1994). Integrated services also have the potential to raise contraceptive prevalence by attracting and offering family planning services to clients—such as men and adolescents—who are reluctant to visit family planning clinics (Dehne and Snow 1999).

However, integrated services may dilute the attention providers and managers pay to family planning and its funding (Berer 2003). Expanding the range of services offered also can overextend and demoralize providers, supervisors, and managers, all of whom are asked to master new knowledge and skills and to juggle more tasks

PROGRAM TIPS:

Conducting effective advocacy campaigns

1. Set realistic, achievable, measurable objectives that will help meet long-term goals.
2. Expand your base of support by networking and building coalitions.
3. Identify specific target audiences, including the decision-makers who can realize your objectives, such as legislators and government officials, as well as people in a position to influence those decision-makers, such as religious leaders and journalists.
4. Shape the content, language, format, timing, and source of all messages, materials, and activities to match specific target audiences.
5. Gather and present facts to substantiate your arguments and make them more persuasive.
6. Identify, gather information about, and be prepared to address the opposition.
7. Integrate advocacy into your work by staying in contact with members of the target audiences and building a position as a credible expert over time.

Sources: IPPF 2001, Sharma [no date], van Kampen [no date]

(McIntyre 2005). Unless staff are given adequate resources, training, and support, the quality of care may suffer. Integration also may meet resistance from the managers of vertical programs who are used to competing and fear the loss of power and resources under the new system (Hardee and Smith 2000). Thus before making the decision to integrate services, managers should answer a set of key questions on whether services should be integrated and, if so, how (see box, this page).

Deciding whether and how to integrate services

Before deciding to add new services, managers should assess the feasibility, costs, and effectiveness of the integration plan. Consider the following questions:

- *Will the clients be the same or different?* Integrating services is easier when clients are the same. When clients are different, you may need to change the facility's hours, make additional arrangements for privacy, or launch a promotional campaign to attract clients to the new services.
- *Will the current infrastructure be adequate?* If new services require adding expensive laboratories or other facilities, developing a referral system may be more cost-effective than fully integrating services.
- *Can current staff members supply the new services?* If so, will they need additional training? If not, how many and what kinds of new personnel will be needed? Integration is easier when new services tap workers' existing skills and expertise, for example, when family planning providers with strong counseling skills are asked to discuss HIV/STI prevention with clients.
- *Are new commodities needed?* If so, this may strain the logistics system.
- *How will the additional services affect the program's financial sustainability?* New services may increase costs and/or generate additional revenues.

Sources: Hardee and Smith 2000, MSH 1994, Mayhew et al. 2000

Preparing to integrate services

Managers can choose from several different approaches to integrating family planning services. They can select a reproductive health service that is directly relevant to family planning clients, such as STI prevention or screening for gender-based violence, and add it to a vertical family planning program. They can add family planning to other health services, such as postpartum care or voluntary HIV counseling and testing, where clients have a clear and immediate need for family planning. A more ambitious approach is to incorporate family planning into primary health care or wide-ranging reproductive health care. A less ambitious but still effective approach is to maintain independent family planning and other health programs but develop coordination and referral linkages among them. Careful planning is vital to choose an approach that will meet the needs of the target group and to estimate the human and financial resources that will be required to implement it (McIntyre 2005).

No matter what the approach, integrated services place new demands on every aspect of the service-delivery system, from staff training and supervision to logistics and records systems. (See box, page 21, for program tips on how to successfully integrate services.) The likelihood of success is greater when administration and

management activities are integrated along with service delivery, so that policies, planning, budgeting, providers' skills, and funding support the new model of service delivery (Berer 2003). For instance, it is essential to redefine work roles and draft new job descriptions for all personnel so that it is clear who is responsible for what (MSH 1994). Managers should beware of assigning providers and supervisors an unrealistic and unmanageable number of tasks. They should also try to preserve any special skills or expertise that staff members bring with them from vertical programs while at the same time offering additional training to deliver a wider array of services and/or make referrals for additional health needs (Mayhew et al. 2000, MSH 1994). Motivation may be as important as training. Managers should seek providers' support for the changes by explaining that integrated services will benefit clients, will be more stimulating and fulfilling for staff, and will save time in the long run by reducing the number of visits each client makes, even though each visit may be longer (Hardee and Smith 2000).

PROGRAM TIPS:

Successfully integrating services

1. Win over staff by demonstrating that integrated services are beneficial to clients and more stimulating and fulfilling to providers.
2. Simplify the workload. Providers need to be convinced that although each visit may take longer, they require fewer contacts with each client as services are integrated.
3. Reorganize case records so that all services are listed on one card, if possible.
4. Rearrange client flow to avoid missed opportunities for delivering services.
5. Assess outreach services and be realistic about how many services can be provided through outreach workers.
6. Integrate supervision so that all supervisors are competent to oversee the integrated services.
7. Promote coordination through the establishment of a district management team.
8. Promote community participation and communication between different health sectors.
9. Train health staff in all components of the integrated package of services.
10. Educate donors so that they think in an integrated manner rather than in terms of vertical programs.

Source: Walley 1997, cited in Hardee and Smith 2000

Managers seeking to integrate a vertical program also will need to integrate the support systems that accompany it. Support systems related to information, client flow, and logistics should be analyzed and adapted to ensure that key elements are retained in the new integrated system in an efficient and manageable manner. Logistics systems pose a special challenge for integration, not only because integrated supply systems are more complicated to operate, but also because integrating a successful contraceptive logistics system with a poorly functioning drug-distribution system can pull down the performance of both (FPLM and JSI 2000, MSH 1994). Managers should make sure that pre-existing logistics systems are operating at similar levels before attempting to integrate them.

The likelihood of success is greater when administration and management activities are integrated along with service delivery, so that policies, planning, budgeting, and funding support the new model of service delivery (Berer 2003). This means integrating budgeting so that funds are allocated appropriately and consistently. Equally important is assessing policy goals, strategies, technical guidelines, and service-delivery protocols to eliminate conflicts and to make sure that they cover all of the available services and offer clear guidance to health workers (Mayhew et al. 2000). Effective planning also assesses whether the existing infrastructure, including equipment, supplies, and space, can accommodate additional services so that any needed changes can be made.

Clearly, implementing integrated services places a heavy burden on managers, who will need increased training and support to face the challenges integration brings (Magwaza et al. 2002, MSH 1994, Mayhew et al. 2000). They need to become knowledgeable about service areas that are new to them; they need to learn how to address staff resistance to the changes integration brings; and they need to become capable of managing and trouble-shooting a more complex service-delivery system.

Integrate family planning into postabortion care

Family planning should be an integral part of postabortion care (PAC). In the short run, family planning can prevent the serious health consequences of becoming pregnant within six months of abortion, including maternal anemia, premature rupture of membranes, low birth weight, and preterm delivery (Conde-Agudelo et al. 2005). In the long run, it can prevent the need for repeat abortions. Health services often miss this opportunity, however, because family planning and postabortion care are provided by different providers, facilities, and institutions. Poorly planned services also can prevent effective integration. For example, an assessment in Kyrgystan found that while 86 percent of postabortion clients selected a family planning method, only 19 percent actually received one—either because doctors were misinformed about when women could start the method or because supplies were unavailable.

Ideally, integrated services should offer women a range of contraceptive methods, along with relevant information and counseling, during the same visit and at the same location as their postabortion treatment (Corbett and Turner 2003). This requires a private counseling space, contraceptive supplies, and providers trained on family planning and the special needs of PAC clients. If these conditions cannot be met, managers may decide instead to collaborate with family planning providers working in another part of the facility.

Contraceptive counselors working with postabortion clients should assess whether the pregnancy was intended (some PAC clients have miscarriages of a wanted pregnancy) and ask if the woman wants to become pregnant again or if she desires contraceptive counseling. If the pregnancy was unintended, the counselor should explore the reason for it in order to help the woman choose an appropriate contraceptive method (Herrick et al. 2004). Providers also need to know which methods are appropriate for

which women depending on their clinical condition and where in the community they can refer women for resupply and follow-up (Corbett and Turner 2003). After district health center staff in Senegal were trained in family planning as well as PAC, the proportion of PAC clients receiving family planning counseling increased from 38 percent to 70 percent, and 20 percent left the health facility with a modern method, compared with none before the intervention (Population Council 2004).

Screen family planning clients for gender-based violence

Reproductive health providers are well placed to identify women who have suffered domestic abuse and link them to support services (Bott et al. 2000, Garcia-Moreno et al. 2005). Managers must proceed carefully, however, because poorly designed and implemented services can make a bad situation even worse. For example, providers who share society's acceptance of domestic violence may blame the victims, while breaches in confidentiality may put a woman's safety at risk.

Family planning programs have developed simple but effective screening tools with which providers can identify abused women (Bott et al. 2000). While asking questions about abuse can be viewed as an intervention in its own right, because it signals that someone is interested, programs should not begin screening women until they can offer appropriate care and link abused women to support services, including psychological counseling, legal advice, and safety planning (Bott et al. 2000). In addition, family planning providers must be prepared to meet these women's special reproductive health needs, which may include access to emergency contraception, testing for HIV/STIs, and advice on choosing a contraceptive method that takes their vulnerability to violence into account. For example, a family planning visit may present a good opportunity to promote the female condom. As a woman-controlled protection method, it may empower women and help them manage or protect against sexual violence—although counseling must be supplemented with negotiation skills–building and institutional support.

Beyond building a referral network, training providers at all levels to offer sensitive and nonjudgmental counseling is the greatest challenge in integrating services for gender-based violence (Garcia-Moreno et al. 2005). Extensive training is needed to overcome the biases providers share with the larger community and to help them confront their own experiences of violence; to help providers understand how abused women make decisions and why it is so difficult for them to leave an abusive relationship; and to teach providers how to identify and counsel victims, assess their safety, document abuse for future legal action, and make appropriate referrals.

Integrate family planning with antenatal, postpartum, and newborn care

Prompt adoption of contraception after childbirth can help lengthen birth intervals, which benefits both mothers' and children's health. A good way to accomplish this is to integrate family planning into a continuum of services that extend from the beginning of a woman's pregnancy through delivery and infancy; antenatal visits offer

an excellent opportunity to discuss postpartum contraceptive methods. Combined services are a major convenience for mothers, and they also offer ample opportunity to counsel women on breastfeeding, the return to fertility, and appropriate contraceptive options (Winikoff et al. 1994). In Chile, for example, the Instituto Chileno de Medicina Reproductiva developed a program that trains health workers in breastfeeding and contraception and schedules joint visits for mother and child throughout the first year of a baby's life. During those visits, providers offer women contraceptive methods that do not interfere with lactation and then follow up later regarding their experience with the method (Winikoff et al. 1994).

It is also possible to integrate many basic antenatal services into family planning programs, although family planning providers usually do not see women when they are pregnant. For example, family planning providers could be trained to counsel pregnant women about complications and danger signs, help plan hospital transportation in advance, encourage breastfeeding, and provide iron supplements plus tetanus toxoid and malaria prophylaxis.

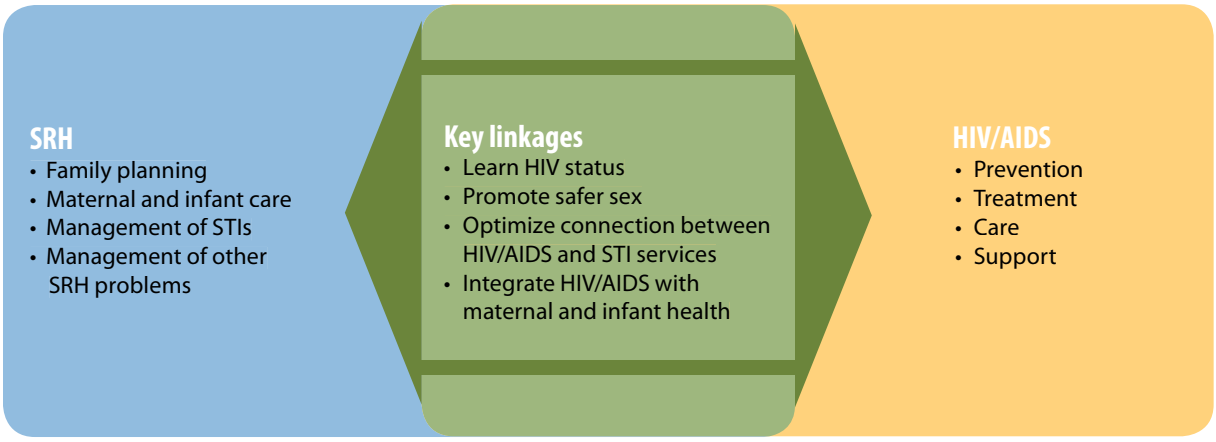
Integrate family planning with HIV/STI activities

International consultations have repeatedly emphasized the importance of linkages between reproductive health and HIV/AIDS prevention and care, which are illustrated in Figure 3 (UNFPA, UNAIDS, and FCI 2004; USAID 2003). Such linkages can increase the utilization of HIV/AIDS services, offer people living with HIV/AIDS better access to reproductive health services, reduce the stigma and discrimination associated with HIV/AIDS, improve coverage of underserved and marginalized populations, strengthen support for dual protection, improve the quality of care, and enhance program effectiveness and efficiency (WHO, UNFPA, UNAIDS, and IPPF 2005). Yet health programs have often failed to exploit the potential synergies between family planning, STI, and HIV/AIDS activities, all of which center on issues of safer sex (Dehne and Snow 1999, WHO RHR 2001). Indeed, these synergies present unique opportunities to promote condom use (with or without a backup method of contraception) as the key strategy for defense against both unplanned pregnancy and HIV/STIs.

The main arguments against adding HIV/STI services to family programs concern the incompatibility of clients and service-delivery requirements. Family planning clients in many countries often are married, monogamous women who believe they are at low risk for HIV/STIs. Yet where the prevalence of HIV is high, these women can be at risk of infection—and promoting safe sex behaviors across the general population is essential to slow the epidemic (Berer 2004, Fleischman Foreit et al. 2002, Boonstra 2004). While some family planning programs lack the clinical skills, laboratory facilities, drugs, and other resources to diagnose and treat HIV/STIs, their providers often have the strong counseling skills needed for prevention and voluntary counseling and testing activities (Boonstra 2004, Kane and Colton 2005). Indeed, family planning providers are especially well placed to open a dialogue with clients about the risks of

FIGURE 3:

Linkages between sexual and reproductive health (SRH) and HIV/AIDS prevention and care



Source: Adapted from WHO, UNFPA, UNAIDS, and IPPF 2005

unsafe sex. And at the same time, new simplified tests for diagnosing STIs can potentially be performed by family planning providers.

Of course, it is also possible to add family planning services to HIV/STI activities, as illustrated by the COPHIA program in Kenya (see box, page 26). A large proportion of HIV/STI clients, who are by definition sexually active, are in need of family planning to prevent unwanted births and, in the case of condoms, to prevent infection as well. At the same time, HIV/STI programs—which have trained counselors and the capacity to distribute condoms—generally meet service delivery requirements for family planning, although the usual concerns about overextending providers and systems remain.

In conclusion, depending on the setting and program resources, managers should consider integrating any or all of the following services with family planning:

- *HIV/STI prevention.* Family planning providers should routinely assess clients' risks for HIV/STIs as part of the contraceptive decision-making process, promote condoms for dual protection, and make it clear that other methods do not protect against infection (Askew and Berer 2003). HIV/STI prevention activities also can promote condoms for dual protection (Reynolds et al. 2003; WHO, UNFPA, UNAIDS, and IPPF 2005).
- *STI diagnosis and treatment.* Family planning providers can educate their clients about the symptoms of STIs and encourage them to seek care promptly if they think they are infected. They also can diagnose and treat common STIs (WHO 2003, WHO 2005b), although syndromic management of STIs has limitations in women (Fleischman Foreit et al. 2002). Simpler STI diagnostic tests will help to address this need.

- *Voluntary counseling and testing (VCT) for HIV infection.* Offering contraceptive counseling and methods as part of VCT makes good sense, since many clients will need family planning whether they are found to be infected with HIV or not. Likewise, family planning providers should offer all of their clients the opportunity, either directly or through referral, to learn their HIV status in settings where the prevalence of HIV is so high that family planning clients are at substantial risk of infection (Fuchs 2005; WHO, UNFPA, UNAIDS, and IPPF 2005).

- *Antiretroviral (ARV) therapy.* Anyone infected with HIV should have access to family planning to control their childbearing and, in the case of condoms, to prevent sexual transmission of the virus. Family planning is even more important for women taking ARVs because some ARVs have the potential to harm the fetus *in utero* (Poirier et al. 2003). Providers offering these services need accurate and up-to-date knowledge of the interactions between specific contraceptive methods, ARVs, and treatments for opportunistic infections (Fuchs 2005, Shelton and Peterson 2004, Shelton 2005). For example, drug interactions between certain ARVs and hormonal contraceptives may alter the effectiveness of both (WHO 2004).
- *Programs to prevent mother-to-child transmission (PMTCT).* Offering family planning information and services to women attending PMTCT clinics can help them avoid future pregnancies and thus reduce mother-to-child transmission of the virus (Stover et al. 2004, Sweat et al. 2004).

PROGRAM EXAMPLE:

Integrating community-based services in Kenya

The community health workers who provide home-based care to people living with HIV/AIDS in Kenya recognized that their clients needed family planning services. In response to their request for training and supplies, the Community-Based HIV/AIDS Care, Support, and Prevention Program (COPHIA) integrated family planning counseling into both basic and refresher training and added condoms to the kits distributed to families during home visits. Referral links to facilities offering family planning services also were strengthened. Community health workers now routinely stress the importance of condoms for dual protection and provide basic family planning counseling and referrals to clients and their families. Trainers from COPHIA also have begun supplementing the training received by community-based reproductive health agents with information on HIV/AIDS, so that they too can offer integrated services.

Source: Kane and Colton 2005

The program tips on linking HIV/AIDS and reproductive health services (see box, page 27) offer some practical guidance on how to achieve this kind of integration.

Screen all health care clients for unmet need for family planning

Although many hospitals and clinics in developing countries offer a wide range of health services, clients rarely take advantage of them. Clients frequently are not even aware of the other health services available at the facility they visit, while providers often stay narrowly focused on the health service that the client came for. By orienting health facility's staff to their clients' potential family planning issues and needs and creating linkages between family planning and other departments (sometimes called *inreach*), family planning providers can efficiently and effectively reach clients with information and services (Lynam et al. 1994). By routinely screening all health care clients for unmet needs for family planning, providers can extend family planning services to a broad range of people, including those who would never think about attending a family planning clinic. In Guatemala, for example, the Ministry of Health trained health center staff to ask every client a series of seven questions to discover whether they needed reproductive health care: Are you married or sexually active? Are you pregnant? Have you had a birth in the last two months? Do you have a child less than one year old? Do you want a pregnancy in the following year? Are you using a contraceptive method? Do you want a method? After training, 43 percent of all health center users received an appointment or referral for additional family planning services, compared with 19 percent before (Vernon and Foreit 1999). A Nigerian hospital has gone a step further, reorganizing its services so that women can access a range of reproductive health services in the same place (see box, page 28).

PROGRAM TIPS:

Linking HIV/AIDS and reproductive health services

1. Address the common root causes of HIV/AIDS and reproductive ill-health, including poverty and inequities in access to health services and information.
2. Focus on human rights, including the rights of women, people living with HIV/AIDS, and marginalized populations such as sex workers. Pursue gender-sensitive policies to establish gender equality and eliminate gender-based violence.
3. Promote a coordinated and coherent response to HIV/AIDS and other sexual and reproductive health priorities.
4. Involve women and men living with HIV/AIDS in designing, implementing, and evaluating policies and programs.
5. Foster participation by young people, key vulnerable populations, and the community at large.
6. Reduce stigma and discrimination.

Source: WHO, UNFPA, UNAIDS, and IPPF 2005

Security of contraceptive supplies

Unless contraceptives are available when clients want them, contraceptive prevalence will remain low. Hence an effective supply chain is essential to the success of family planning programs. Without an adequate and reliable supply of contraceptives,

family planning programs cannot guarantee access to services, providers cannot do their jobs, and frustrated clients are forced to leave the clinic without their preferred method or sometimes without any method at all. Having a diverse mix of affordable, quality-assured contraceptives on hand also ensures that family planning clients can have their choice of methods and thus supports continuing increases in contraceptive prevalence. Indeed, a recent analysis of logistics systems in 17 countries concluded that about one-fifth of the contraceptive prevalence rates in those countries could be attributed to the performance of the logistics systems (Karim 2005). Ensuring a reliable supply is becoming increasingly difficult, however, as demand for contraceptives increases. UNFPA has estimated that the number of contraceptive users will increase by 217 million from 2000 to 2015, in part because of growth in the number of people of reproductive age and in part because of rising contraceptive use (UNFPA 2001c). Over the same time period, the estimated cost of meeting those needs will rise from US$572 million to more than $1.2 billion (UNFPA 2001b), placing an increasing financial burden on developing-country governments, consumers, and donors (UNFPA 2001c).

PROGRAM EXAMPLE:

Offering integrated reproductive health care in Nigeria

While the Ahmadu Bello Hospital in Nigeria had always offered a variety of reproductive health services, until 2002 they were located in separate, compartmentalized programs. Clinics for family planning, STIs, and obstetrics and gynecology had different staffs and locations and even kept different hours. Making sure that women could get a full range of care meant bringing all of these services together into a new reproductive health center. A core group of doctors and nurses attended a six-week workshop on integrated reproductive health care and then worked to gain their colleagues' support for the new approach. Women now receive a full range of services so that, for example, women coming for postpartum and postabortion care also are counseled on family planning. A training program at the hospital is introducing the holistic approach to reproductive health care to hundreds of other doctors, nurses, and midwives throughout Nigeria each year.

Source: Shittu et al. 2002

Weak and inefficient supply systems already pose a problem for contraceptive security in many countries, even as health sector reforms create new challenges for these systems. Because reforms can prove disruptive for contraceptive logistics, early involvement of logistics experts, careful planning, and attention to the details of logistics system design and implementation are essential to successfully carrying out health sector reforms (Bates et al. 2000).

Integrated services naturally raise the possibility of integrated supply chains that handle a complete range of contraceptives and pharmaceuticals. While integrated supply systems have the potential to increase efficiency, they are complex, place additional demands on both personnel and the information system, and are potentially less reliable than supply systems that focus solely on contraceptives (FPLM and JSI

2000). To avoid compromising the availability of contraceptives, well-functioning vertical logistics systems should not be merged into a new, integrated system until that system has proven its capability. The integration of logistics systems is more likely to succeed when managers take an incremental approach rather than trying to integrate everything at once (Bates et al. 2000). Managers may choose to integrate some—but not all—products, functions, or levels of the distribution system. For example, they may exclude vaccines that require a cold chain from an integrated system; they may integrate transportation but not procurement; or they may integrate the distribution system at the service delivery but not the central level.

Decentralization raises two issues: some logistics functions operate more efficiently when they are centralized, and district and local officials rarely have the technical skills needed to take over the management of supply systems. Experience suggests that it is better to leave the logistics management information system, product selection, procurement, and quality assurance at the central level (Bates et al. 2000). In Mexico's decentralized system, for example, states and service delivery NGOs coordinate procurement to preserve discounts for bulk purchases of contraceptives (Finkle 2003). When decentralizing other logistics functions, the most important step is to offer substantial, competency-based training to district and local staff before decentralization takes place and to provide for periodic follow-up to ensure that they master essential skills (Bates et al. 2000). Other recommendations include modifying the supervisory structure, redesigning the information system, and requiring districts to stock contraceptives and other preventive products that they may not consider essential (Bates et al. 2000, Finkle 2003, Vogel et al. 2001).

Advocacy

Both the public and private sectors can benefit from advocacy for contraceptive security. If a problem is identified based on an analysis of logistics systems, program managers should raise awareness of the problem among government officials, legislators, NGOs, pharmaceutical firms, and consumers, based on a thorough analysis of local supply and demand for contraception (Sine and Sharma 2002). Then they should advocate for political commitment to contraceptive security. Only if reproductive health and contraceptive supplies are seen as a priority will they be included in aid mechanisms such as PRSPs and SWAps and be given adequate financial support by governments (UNFPA 2001a, UNFPA 2001c). In Romania, for example, NGOs and other advocates built high-level support for contraceptive security that culminated in a government-mandated budget allocation for contraceptive commodities (Sine and Sharma 2002). Also important is ensuring that national lists of essential medicines are consistent with the WHO list of essential medicines in their inclusion of contraceptives (WHO 2005c).

Market segmentation

Limited resources and competing health problems make it difficult for most developing country governments to make up any shortfall in funding by themselves.

Market segmentation and targeting, which identify and direct public resources to the poor and disadvantaged, are essential (Sharma and Dayaratna 2004). Other sources of contraceptive supplies, whether in the private or public sector, should be developed and promoted for clients who can afford to pay some or all of the costs of contraception (Finkle 2003, Sine and Sharma 2002). Family planning advocates can assist in this effort by working for changes in laws and regulations that impede private-sector efforts to sell contraceptive commodities, such as import duties on raw materials and contraceptives, price controls, and limits on contraceptive advertising (Quijada et al. 2004, Sharma and Dayaratna 2004, UNFPA 2001a, UNFPA 2001c). In Brazil, for example, advocates successfully campaigned for the elimination of tariffs and retail taxes that increased the price of condoms (Finkle 2003).

Build public sector capacity

Stock-outs of some contraceptives, oversupplies of others, and shipment delays are some of the common problems caused by weak supply systems. Strengthening these systems is essential to ensure continued access to family planning services. One key part of the solution is to build public-sector capacity in forecasting, procurement, supply management, distribution systems, and storage capacity at the national, district, and local levels (Hare et al. 2004, UNFPA 2001a). A well-designed and well-run supply system can make the most of limited resources by employing good procurement practices; ensuring that all supplies are in good condition; eliminating overstocks, spoilage, pilferage, and other kinds of waste; and making certain that each service-delivery point has sufficient stock to meet clients' needs (FPLM and JSI 2000). For example, strengthening procurement capacity in Bangladesh enabled the country to negotiate substantially lower prices for contraceptive commodities on the international market, leading to savings of over US$17 million on oral contraceptives alone (Sarley et al. 2005). (See box, page 31, for program tips on strengthening the supply chain.)

Building capacity requires managers to strengthen both people and systems so that there is adequate ability to detect, prevent, and manage potential stock-outs while also ensuring general system strength to monitor production-to-use flow. Investing in manuals, training courses, and regular supervision can ensure that skilled and experienced logistics officers staff every level of the health system. Designing and implementing a reliable logistics management information system is essential to regulate the flow of products and provide accurate and timely information to managers (FPLM and JSI 2000). To secure the funding for these costly improvements, managers must be able to convince the government or other donors that strengthening the logistics system is a cost-effective way to raise contraceptive prevalence that deserves priority. Jordan's new logistics system illustrates the impact that a comprehensive intervention can have on contraceptive prevalence (see box, page 32).

Quality of care

While improving the quality of care provided by family planning programs will have different effects depending upon the setting, its overall effect improves individ-

uals' personal well-being and ability to regulate their fertility (Bruce 1990). Improving quality of care can attract more clients to family planning services, increase their satisfaction, and even raise contraceptive continuation rates. Attention paid to quality is particularly important in light of the expanded responsibilities faced by health care providers when family planning is offered as part of an integrated package of services. Strengthening systems and improving providers' technical and interpersonal skills will go far toward ensuring that family planning programs offer quality services. The overarching components of quality of care are discussed below but, because quality of care is a cross-cutting issue, it is also referred to throughout this report.

Supervision

Supervisors play a critical role in improving the quality of care when they go beyond their role as inspector and take a more supportive approach. They can offer workers feedback on strengths and weaknesses, motivate them to improve their performance, provide needed coaching, assist with prioritizing a heavy workload, and help solve problems (Marquez and Kean 2002, Stinson et al. 2000). Despite its importance, supervision is frequently one of the weakest elements of family planning and reproductive health programs. Common problems include a focus on monitoring rather than problem-solving, weak technical and communication skills among supervisors, and infrequent and irregular supervisory visits due to lack of transportation and other resources (Marquez and Kean 2002).

Integrated services place additional strains on supervisory systems. Providers need even more support from supervisors to accomplish their expanded duties, but supervisors may not have any knowledge of or experience with new services added to a program (MSH 1994). To strengthen supervision systems, especially in inte-

PROGRAM TIPS:

Strengthening the supply chain

1. Instill a customer focus in the supply chain by concentrating on contraceptive availability at service delivery points, seeking to understand and respond to customers' needs, and collecting customer feedback.
2. Improve management and staff performance by providing leadership, training, supervision, clear expectations, and decent working conditions for supply chain staff.
3. Make sure the logistics management information system (LMIS) can produce complete, accurate, timely data and that the data is routinely reported to—and acted on—by staff members at every level.
4. Integrate forecasting into routine supply chain management, and make forecasts more accurate by using as many types of data as possible.
5. Make quality assurance an integral part of the procurement process.
6. Focus distribution activities on moving supplies quickly and efficiently to customers, not on storing contraceptives.
7. Keep abreast of developments in the field of logistics, and remain open to new ways of doing business.

Sources: FPLM and JSI 2000, Setty-Venugopal et al. 2002

grated service-delivery settings, managers can (Marquez and Kean 2002, MSH 1994, Stinson et al. 2000):

- Review and clarify supervision policies and procedures.
- Develop integrated supervisory guidelines.
- Create checklists, job aids, and other tools that cover all services offered and structure the supervisory encounter.
- Increase the frequency and/or duration of supervisory visits.
- Train supervisors on health workers' new technical skills.
- Train supervisors on coaching and facilitation skills.
- Focus supervision on clinical performance and problem resolution.

In Honduras, ASHONPLAFA used a mix of these interventions to strengthen its supervisory system (see box, page 33).

PROGRAM EXAMPLE:

Strengthening the logistics system in Jordan

Jordan introduced a new logistics system in 1997 after disruptions in contraceptive supplies threatened to undermine family planning services. With no written logistics manuals or formal inventory control systems, both stock-outs and overstocking were common. Over a two-year period, more than 550 service-delivery and supervisory staff received training in logistics, including midwives, nurses, doctors, and their supervisors as well as warehouse managers. A new computerized management information system was designed to collect and aggregate essential data on contraceptives dispensed and stock on hand; it produces regular, accurate reports for all management levels.

Ongoing monitoring and supervision ensure that the system runs smoothly. A senior logistics officer holds monthly discussions with each directorate to help resolve problems, visits service-delivery points to review how the system is functioning and motivate staff, and offers refresher and on-the-job training. Before the new system was introduced, 85 percent of health centers experienced a stock-out over a six-month period; afterwards that figure dropped to just 10 percent. Losses from expiration and damage also dropped sharply. More reliable contraceptive supplies have contributed to rising contraceptive use in Jordan.

Source: Rao 2000

Training

Continuing training is essential to reinforce and upgrade family planning workers' knowledge and skills throughout their careers. Health sector reforms can spark additional demands for training, as decentralization places new management and technical responsibilities on district staff, while integration requires providers, supervisors, and managers to master new service areas.

Formal workshops, like the ones used to improve counseling in rural China (see box, page 34) are the most common approach to training. However, alternative approaches may be less expensive, less disruptive, and just as effective. On-the-job training pairs new or untrained staff members with experienced coworkers, who tailor their instruction to the setting. Supervisors can update providers on new information or coach them on skills they have yet to master. Distance education uses print materials, audio tapes, radio and television broadcasts,

and computer software to bring a standardized curriculum to scattered trainees. Regardless of the training approach used, providing continuous feedback and support after trainees return to work is essential to helping them transfer their new skills to the job and ensuring uptake of new practices.

Pre-service training

Ensuring that the medical information and training on family planning offered in academia is current and complete can improve the long-term quality of related services. Sexual and reproductive health is significantly underrepresented in basic curricula for medical and other health professionals (Haslegrave and Olatunbosun 2003). Managers can collaborate with educational bodies to advocate for including or upgrading family planning information and skills in medical, nursing, and midwifery curricula as well as in continuing medical education and professional development programs.

Improving providers' skills

While necessary, training is not solely sufficient to improve providers' skills and bring about lasting changes in their performance on the job. Performance improvement systematically considers and addresses all of the factors that influence workers' performance, which include environmental factors as well as a worker's personal qualities (Lande 2002). For example, regular, clear, constructive feedback is critical to improving providers' skills. By pointing out weaknesses and making suggestions for improvement, supervisors can motivate providers to improve their skills (Rudy et al. 2003). Helpful feedback can come also from on-site managers and colleagues, who are especially well placed to understand the challenges a provider faces. Formal self-assessment systems, which ask providers to assess their own performance against a list of clear standards, also can help providers improve their skills.

PROGRAM EXAMPLE:

Strengthening supervision in Honduras

Cost-cutting measures at ASHONPLAFA, the largest private provider of sexual and reproductive health care in Honduras, undermined the supervisory system by reducing resources while expanding supervisors' responsibilities. Managers used a combination of old and new approaches to strengthen the supervisory system. They developed a manual and standardized procedures and protocols to guide field visits. They designed a performance planning and evaluation system in which supervisors and supervisees evaluate and negotiate performance goals every two months. And they adopted distance learning to supplement annual supervisors' workshops and help reinforce supervisors' skills. One result has been greater dialogue between supervisors and providers, which has helped providers reach performance goals. Strong, consistent support from supervisors has enabled providers to offer better quality of care to their reproductive health clients.

Source: Children's Vaccine Program 2003

Well-designed job aids, such as checklists, can help providers apply their skills on the job by reminding them of key information. For example, referring to medical eligibility requirements for specific contraceptive methods prior to offering contraceptive

counseling can help prevent false contraindications that can severely and needlessly limit a woman's choice of contraceptive method (FHI 2002, FHI 2004, Shelton et al. 1992). In addition, these tools can help providers make decisions, such as determining whether a non-menstruating woman is pregnant, and provide guidance through a complex process (for example, the many steps in counseling a family planning client). Health education materials, including service delivery guidelines, should be updated and accurate.

Motivating providers to offer good care

Providers who feel their work is meaningful and who are committed to doing their best can make the difference in the actual quality of care a client receives. Motivation may be especially important when providers face the additional demands imposed by integrating services—and it maybe especially challenging when providers are getting paid poorly or irregularly. Some sources of motivation are intrinsic, such as the satisfaction of a job well done or the pleasure of helping others. However, managers can help motivate providers to offer good care by recognizing and rewarding their performance, supporting costs or leave time to pursue continuing education, and providing career advancement opportunities such as increasing supervisory responsibilities. While managers may be limited by a program's rules and resources, they should consider taking the following actions (Rudy et al. 2003, Setty 2004, Stinson et al. 2000):

- Praise good performance, especially in the presence of other health workers.
- Establish formal recognition programs, such as an "Employee of the Month."
- Feature exceptional providers in the organizational newsletter.
- Give financial bonuses or raises.
- Empower providers by giving them the authority to make decisions about everyday issues.
- Clearly tie providers' performance to the facility's certification or accreditation.

PROGRAM EXAMPLE:

Counseling training in China

In 1991, the State Family Planning Commission (SFPC) of China launched a five-year project to upgrade the knowledge and skills of family planning workers in rural areas. Based on surveys of villagers and providers, project staff developed a standardized curriculum that relies on adult learning principles and participatory training methods, such as role plays and skills practice, to train providers in interpersonal communication and counseling skills. It also introduces new concepts, such as informed choice.

Regular monitoring and evaluation were built into the project, and results led to a second wave of training that offered more in-depth information on contraceptive methods and more skills practice. Providers and clients agree that their relationship has benefited from the training, as has the quality of care. Providers learn more about clients' individual needs and tailor their counseling accordingly. Clients learn more about the range of methods available and play a more active role in choosing a method.

Source: SFPC, UNFPA, and PATH 1995

Information systems

Health management information systems let managers know how well people and systems are performing, help them identify and solve problems, and form the basis for sound decision-making (MSH 1991). Information systems sometimes seem to be more of a burden than a help to service delivery. They may collect more data than is needed; the data may be incomplete, inaccurate, or out of date; and little of the data may be analyzed and disseminated. Integration may pose the additional challenge of merging multiple, incompatible information systems (INFORM 2005), while decentralization may require inexperienced district-level staff to take on responsibility for data analysis.

To strengthen information systems, reproductive health managers can (INFORM 2005, MSH 1991):

- Work to develop a data culture, in which staff members at every level appreciate the importance of accurately collecting and analyzing data and consistently apply data to decision-making.
- Simplify the system by tracking only essential indicators.
- Redesign forms to make data collection quicker and easier.
- Create simple summary sheets to reduce errors in tabulating data.
- Train staff in the technical skills needed to control data quality, analyze data, create graphs, and interpret the results.

Program monitoring

By selecting indicators that reflect the quality of services rather than their quantity or cost, managers can monitor the quality of care. For example, they can focus on the proportion of family planning clients who received an appropriate method rather than the absolute number served. Process indicators, which measure how well program activities are being carried out, are especially important for monitoring quality of care because they can pinpoint service delivery problems (Kols and Sherman 1998). Quality indicators should incorporate clients' as well as providers' perspectives. They should also meet general standards for sound health indicators (see box, page 36).

From among the hundreds of indicators available to assess the quality of family planning services, managers must choose a small number that are important to program objectives. For example, one practical, low-cost approach to assessing the quality of clinic-based family planning services, the Quick Investigation of Quality, includes 25 indicators that assess providers' performance, client attitudes and behavior, and the facility (Bertrand and Sullivan 2000).

Quality improvement

Service-delivery managers can improve the quality of care at their facilities by adopting a systematic, data-based approach to resolving problems, such as quality assurance or clinical audits. These approaches set standards for service delivery, measure

Characteristics of an appropriate monitoring indicator

- *Action-oriented*: It helps managers decide what to do. For example, the frequency of contraceptive stock-outs can help managers decide whether the logistics system needs strengthening.
- *Relevant*: It reflects progress toward a program goal, objective, or target. For example, assessing whether facilities have received a supervisory visit in the past three months can help measure a program's progress in offering frontline workers regular feedback and support.
- *Easily generated and measured*: It draws on data from normal service and surveillance activities. For example, the number of clients adopting each method on a monthly or annual basis can be derived from regular service statistics.
- *Valid, consistent, reliable, representative, and sensitive to change*: It accurately measures the issue of interest. For example, assessing whether providers mention HIV/AIDS during family planning consultations can help measure the success of efforts to integrate services.
- *Understandable*: Its meaning and importance can be understood without special explanation. For example, the percentage of a target audience exposed to behavior change activities and materials clearly communicates the reach of a behavior change communication campaign.

Source: INFORM 2005

the current quality of care against those standards, identify and analyze problems, and then take action to improve quality. Audits typically focus on a narrow service issue, prompted by client complaints, high complication rates, or other evidence of a problem. In contrast, quality assurance systems develop guidelines, procedures, and performance standards for an entire service-delivery program, including both clinical and management areas; regular monitoring identifies problems that need to be resolved (DiPrete Brown et al. 2000).

Whether an audit or quality assurance approach is used, making real improvements depends on collecting data and closely analyzing service-delivery activities to develop an in-depth understanding of a problem and its root causes. Based on these facts, staff teams can then devise ways to solve a problem and improve the quality of care.

Informed choice and contraceptive counseling

To support people's right to make an informed choice of contraceptive methods, family planning programs must offer clients ready access to a range of methods, complete and accurate information about those methods, and help in weighing the options. While this is an intrinsic component of quality of care, it merits special mention here because its importance is often overlooked. Effectively counseling family planning clients calls for a combination of technical knowledge and good interpersonal communication skills (Murphy and Steele 2000), but those alone are not sufficient. In many settings, informed choice is constrained by lack of understanding of the concept of informed choice as well as by social norms that limit women's and adolescents' ability to assert their rights (EngenderHealth 2003b, Upadhyay 2001). Therefore, it is also essential that providers understand the concept

of sexual and reproductive rights, their role in helping clients exercise these rights, and the power imbalances inherent in the client-provider relationship and the cultural setting that may deter clients from asserting their rights. Clients must understand that they have the right to ask questions, get answers, and make their own decisions—and be willing and able to do so (EngenderHealth 2003b). Achieving this calls for a mix of interventions directed to both providers and clients. (See box, this page, for program tips on improving client-provider interaction.)

Strengthen providers' skills

As described in the previous section on quality of care, pre-service education and periodic in-service training can impart the technical knowledge base and communication skills that providers need to practice good client-provider interaction. Continuing education is essential both to reinforce those skills and to update providers' technical knowledge over the course of their careers, since evidence regarding contraceptive technology is constantly changing, as illustrated by recent findings on hormonal contraceptive methods (see box, page 38). Managers can heighten the effectiveness of this training by developing curricula that emphasize interpersonal communication skills as well as technical knowledge, teaching providers how to tailor the interaction to the individual client, and taking an integrated approach to sexual and reproductive health counseling (Rudy et al. 2003).

Training alone cannot assure the quality of counseling, especially given the new demands made on providers when services are integrated. Integrated services call on providers to make a complete assessment of a client's health status and address any other needs they identify, for example, diagnosing and treating a family planning client's STI (EngenderHealth 2003c). A broader

PROGRAM TIPS:

Improving client-provider interaction

1. Teach providers to respect clients' ability to choose for themselves and to engage clients in decision-making.
2. Address clients' concerns about side effects by counseling them on what to expect before they start a method and responding to their concerns if side effects develop.
3. Encourage clients to play an active role in consultations by developing mass media campaigns, print materials, and client education that legitimate clients' rights and encourage them to ask questions of the provider.
4. Disseminate and reinforce policies, guidelines, job descriptions, and protocols that promote good communication practices by providers.
5. Focus supervision on client-provider interaction, and encourage coworkers, clients, and the community to give providers feedback on their performance.
6. Make counseling training more effective by refining curricula, adopting proven training methods, and supporting trainees' efforts to apply new skills on the job.
7. Provide the space, supplies, and time that providers need to counsel clients effectively.
8. Recognize and reward providers who do an excellent job of counseling clients.

Source: Rudy et al. 2003

performance improvement approach, which assesses and addresses the institutional context as well as a provider's personal qualities, will be more effective in improving the quality of counseling (Lande 2002, Rudy et al. 2003). For example, job aids and reference materials can help providers carry out the wider range of responsibilities that accompanies integrated services. Family Health International has developed checklists to help providers determine whether a client is pregnant or meets the medical eligibility criteria for a specific method (FHI 2002). Supervisors can periodically check providers' performance by observing consultations and offer providers feedback about how to improve their counseling. The balanced counseling strategy adopted in Peru and Guatemala (see box, page 39) relies on a combination of job aids and supervision for its impact.

Recent findings on hormonal contraception

Bone density. Depot medroxyprogesterone acetate (DMPA) reduces bone mineral density (BMD) in adults and slows its acquisition in adolescents, but premenopausal women regain BMD after they stop using the method. WHO has concluded that DMPA's advantages generally outweigh the risks of fracture, even among adolescents and older women (WHO and HRP 2005a). Oral contraceptives, implants, and the levonorgestrel-releasing IUD do not affect bone mineral density.

Cancer. Combined oral contraceptives (OCs), especially older higher-dose formulations, reduce the risk of ovarian and endometrial cancer but slightly increase the risk of cervical, breast, and liver cancer. WHO has concluded that the health benefits of combined OCs clearly exceed the risks for most healthy women (WHO and HRP 2005b).

HIV/AIDS. No conclusive evidence exists that hormonal contraceptive use increases the risk of HIV acquisition, transmission, or disease progression. Current knowledge does not indicate a need to change existing recommendations (including those of the WHO) that women at risk of HIV infection or those who are HIV-infected may safely use hormonal contraception (WHO and HRP 2005c). WHO recommends that there be no restrictions on OCs and injectables for women at high risk of acquiring HIV. Like other people at risk of STIs, however, these women are urged to use barrier methods of protection to guard against infection.

Encourage client participation

In many countries, clients tend to take little part in family planning or reproductive health consultations. Providers should be trained to offer clients more opportunities to speak out and to prompt them to ask questions, express concerns, and disclose information. (See box, page 40, on how providers can support informed choice.) Print materials in clinics can reinforce this message. For example, the International Planned Parenthood Foundation has created a poster on the "Rights of the Client" that encourages clients to claim their rights to information, confidentiality, and privacy (Newman 1997). WHO has developed a decision-making flipchart that prompts clients to raise questions and concerns (WHO and JHU CCP 2005), and other programs have developed leaflets listing sample questions for family planning clients (Rudy et al. 2003, Upadhyay 2001).

It is equally important for family planning programs to take action outside the clinic (Rudy et al. 2003,

Upadhyay 2001). Mass media campaigns can model active client behaviors and disseminate messages about clients' rights. Group talks can reinforce messages about clients' rights and responsibilities and also teach helpful skills, such as writing down a list of questions for the provider before going to the clinic. If successful, these kinds of behavior change communication can make clients feel that speaking out and taking control of family planning decisions are expected and desirable behaviors.

PROGRAM EXAMPLE:

Using job aids to reinforce counseling skills in Peru and Guatemala

The balanced counseling strategy developed in Peru and refined in Guatemala uses a combination of training, job aids, and an algorithm to improve the quality of family planning counseling and promote informed choice. A poster outlines the new counseling model and gives providers step-by-step guidance on how to proceed. Providers use a set of small cards, one for each contraceptive method available, to help clients narrow the options and choose a method. Individual method pamphlets then prompt providers to give complete and accurate information about the benefits, disadvantages, contraindications, and usage instructions for the chosen method.

When the strategy was first tested in Peru, researchers found that quality of care improved, but only if providers actually used the job aids—which many failed to do. The solution, implemented in Guatemala, was to reinforce training by making a series of follow-up visits to providers and instructing supervisors to monitor providers' use of the job aids during their regular field visits.

Source: León et al. 2003

Offer a wide range of methods

Ensuring that clients can freely exercise their personal preferences in selecting a contraceptive method requires ready access to a variety of safe, effective, and affordable methods (EngenderHealth 2003b). Most countries offer a limited range of contraceptive methods, and some are much more widely available than others (Ross and Stover 2004). When the method mix is skewed towards a single method, as is the case in many countries, clients' choices may be limited.

Introducing additional methods can attract new users because each one meets the needs and preferences of a different group of potential clients (Ross et al. 2002). With more methods to choose from, clients also may be more satisfied with and more likely to continue using their method. Where resources are limited, however, public-sector programs may not be able to offer some expensive methods or may have to limit those methods to individuals who have experienced problems with other methods or have restrictions on medical eligibility for most methods. Since the latest, newest method often is not the best overall, this shouldn't be a problem.

Often, expanding contraceptive choice does not require introducing a new method, but rather increasing access to existing methods (WHO 2002). This may require addressing problems with the quality of care—such as limitations on when, where, and by whom certain methods are offered; stock-outs of supplies; and pro-

vider bias—that effectively limit access to some methods. This approach has succeeded in increasing contraceptive choice for family planning clients in some areas of Brazil (see box, page 41). Alternatively, managers may strengthen referral mechanisms: although family planning programs operate mainly at the primary health care level, some methods, such as female sterilization, and some complicated cases require a higher level of care. Managers also should consider promoting underused methods, such as non-scalpel vasectomy and contraceptive implants.

How providers can support informed choice

- Treat clients with respect and friendliness, and create an atmosphere of trust that allows sharing between provider and client.
- Distinguish between different client types, for example, new clients, returning clients with a problem, and clients at high risk for STIs.
- Tailor counseling to address the individual client's needs, situation, and personal preferences.
- Assess the client's HIV/STI risks as part of the process of choosing a method.
- Discuss the potential side effects of methods.
- Avoid overloading the client with too much information.
- Encourage clients to explain their needs and priorities, express concerns, and ask questions.
- Give the client her/his preferred method unless it is inappropriate for medical reasons or the client is requesting it for the wrong reason.

Sources: Rudy et al. 2003, Murphy and Steele 2000

Link emergency contraception with regular use of family planning

Women who seek emergency contraception (EC) have a demonstrated need for some regular method of contraception; indeed many are current or recent users of contraception and their situation may make them more interested in discussing it. Therefore providers should always offer clients a regular method in addition to EC, give them instructions on when to start it, and offer them condoms or another barrier method to use temporarily (Huezo and Carignan 1997). If an EC client does not want contraceptive counseling at the time, the provider should make a follow-up appointment with a family planning provider in the community and offer her condoms to use in the meantime.

Providers may need additional training to integrate EC and contraceptive counseling. Family planning counseling for EC clients should reflect and respond to the reason why the woman had unprotected sex (ICEC 2003). If the woman was forced to have unprotected sex, she will need counseling and support services to help her protect herself from violence in addition to contraceptive counseling. If the woman had a problem with her regular method, such a missed injection or condom breakage, she will need to decide whether that method is still the best one for her and, if so, how she can prevent the problem from recurring. If the woman had no regular contraceptive method, she will need to be told about the options so that she can make an informed choice. Providers should also assess the woman's continuing vulnerability to STIs and

HIV during the counseling process. While providers should offer EC clients a full range of methods, they should recognize that for some women, the stressful conditions surrounding EC use may not be an appropriate time to choose a permanent method.

Overcoming barriers to reach under-served groups

Reaching the poor

There are large health disparities between rich and poor in most developing countries (Carr 2004). Inequities in publicly funded health systems contribute to the problem: the poor receive less than their fair share of government health spending even though their needs are the greatest and their ability to pay for services the least (World Bank 2003). Poor people are also less likely than others to use basic health services, such as family planning and maternity care—in part because the poor have less access to services, because the services offered to them are of inferior quality, and because the cost of services poses a greater burden for them (Carr 2004, UNFPA 2004).

One way to prompt health systems to reach the poor is to formulate objectives that focus on the poor. For example, managers might call for an increase in the contraceptive prevalence rate among people living below the poverty line as well as in the population as a whole. However, managers must be careful that targeting the poor does not lead to incentives that infringe on their right to informed and voluntary choice. Expanding the ways programs assess their success may also promote change. For example, managers can use new measures to calculate what proportion of a program's benefits go to the poor (Waters 2004).

PROGRAM EXAMPLE:

Expanding contraceptive options in Brazil

Strengthening a program's capacity to offer quality services can effectively expand contraceptive choice by increasing access to existing methods. The Santa Barbara project in Brazil found a consistent pattern of constraints on clients' access to contraceptive methods and other reproductive health care, ranging from the difficulty of getting an appointment to long waits and lack of supplies. Offering clients more contraceptive choices required wide-ranging service improvements. The project increased the amount of time providers spend on family planning, changed the way appointments are scheduled, trained providers to discuss a wider array of contraceptive options with clients, arranged for regular and sufficient supplies of contraceptives, and increased the availability of male methods.

Sources: Diaz et al. 2002, WHO 2002

Programs have tested various approaches to targeting resources and services to the poor. Possibilities include improving the quality of services that poor clients receive by investing in facilities that serve poor communities, increasing poor clients' access to services by shifting from clinic- to community-based services, and contracting with NGOs to serve populations that have been identified as poor. Health-financing schemes that shift government subsidies for health towards the poor can also make a

difference. These include insurance schemes, prepayment plans, and fee schedules that use exemptions, waivers, and sliding payment scales to charge the wealthy but not the poor (Carr 2004, Waters 2004) (see section on "Lowering Economic Barriers," page 50). Still another possibility is to empower poor clients and communities to demand better services and influence management of service delivery, although the effectiveness of this strategy is not clear (World Bank 2003).

Serving adolescents

Adolescents have a real need for reproductive health and family planning information and services (UNFPA 2003; WHO, UNFPA, and UNICEF 1999). Sexually active adolescents tend to have multiple short-term relationships, to use contraceptives inconsistently, and to be ill-informed about how to protect themselves against pregnancy and STIs, including HIV/AIDS. Poverty and gender norms also make adolescent girls vulnerable to the sexual overtures of older men in some countries. Once pregnant, teenagers are more likely than adult women to suffer complications during pregnancy and childbirth and to resort to unsafe abortion.

However, many societies disapprove of premarital sex and consider reproductive health care for young people inappropriate. As a result, parents, educators, and health care providers often are unwilling to give young people the information and services they need. Laws and policies also may restrict adolescents' access to services, for example, by limiting family planning services to married adolescents (Senderowitz 1999). Even when counseling and services are available, young people may be reluctant to visit clinics because of a lack of privacy and confidentiality, inconvenient locations and hours, high costs, limited contraceptive choices and supplies, and, perhaps most importantly, negative and judgmental provider attitudes (Senderowitz 1999, Moya 2002).

Continuing, broad-based advocacy is needed to give adolescents ready access to reproductive health counseling and affordable family planning options. Advocates must promote the rights of young people to reproductive health and family planning information and services, campaign for changes in policies and regulations, and lobby for funding for reproductive health and family planning programming for adolescents (FOCUS on Young Adults 2001).

Program managers also need to devise new approaches to reach young people with messages promoting abstinence, the delay of sexual debut, and partner reduction as well as family planning information and services (UNFPA 2003; WHO, UNFPA, and UNICEF 1999). In an effort to attract young clients, many programs have modified their clinics to be "youth-friendly" (see box, page 44, for program tips on how to design youth-friendly services). Other programs take information and services to places where young people learn, work, and socialize. Successful strategies include teaching about reproductive health in the schools; distributing condoms through social marketing programs; using the mass media, especially entertainment formats, to disseminate messages; setting up telephone hotlines to provide anonymous counseling; training

peer educators to talk to young people in the community or workplace; and offering reproductive health care at multipurpose youth centers (FOCUS on Young Adults 2001, Senderowitz 1999).

When designing family planning and reproductive health programs for young people, managers must remember that their circumstances and needs vary. For example, some are single, while others are newly married; some attend school, while others have jobs or live on the street. Strategies to reach them must vary accordingly. Messages promoting abstinence and the delay of sexual debut are appropriate for young people who have not yet engaged in sex, while messages about partner reduction and contraception are more important for those who are sexually active. Unmarried adolescents may be the most in need of family planning, and messages focusing on pregnancy prevention may be more effective for some, especially young girls, than messages on preventing HIV/STIs.

Whatever approach is used, managers should involve young people in the design and implementation of services to make sure that they are appropriate and attractive to adolescents. They should also address issues of special importance to young people, including puberty and dating, the skills needed to say no or to negotiate sex and condom use, and gender norms that limit girls' control over sex and shape boys' notions about masculinity. Programs for adolescents also are more effective when they employ multiple approaches, for example, combining mass media, community mobilization, and personal counseling (FOCUS on Young Adults 2001, FHI 2000). The Youth.now project in Jamaica illustrates this kind of multifaceted approach to increasing adolescents access to reproductive health services (see box, page 45).

Bringing reproductive health care to refugees

While refugees have the same right to family planning services as other people, their special situation may shape their need and desire for services. Demand for family planning among refugees depends in part on levels of contraceptive use in their home country, as current users may want to continue using their method. Present circumstances are also important: refugees may want to defer childbearing until their lives are less uncertain. High rates of sexual violence may increase women's need for EC and postabortion family planning services and also for post-exposure prophylaxis for HIV in settings with high HIV prevalence rates (WHO and UNHCR 2005). Over the past decade, relief agencies have greatly improved the reproductive health and family planning services offered to refugees, but many gaps remain (Ramchandran and Gardner 2005). For example, refugees living in camps are far more likely to receive appropriate services than displaced families who are dispersed throughout the community.

Reproductive health managers in refugee settings face unique challenges, beginning with a lack of information about the needs of the population. Because refugee situations and populations are enormously variable, a thorough needs assessment is essential. It should investigate refugees' knowledge and attitudes regarding contracep-

PROGRAM TIPS:

Designing youth-friendly services

Providers

1. Train staff to treat adolescent clients with respect, to honor their privacy and confidentiality, and to understand their concerns and special reproductive health needs.
2. Encourage counselors to spend as much time as necessary with each client to address all of his/her concerns.
3. Make peer counselors available.

Facilities

1. Set aside separate space or special times for young clients.
2. Offer services at hours that are convenient for young adults, such as late afternoons, evenings, and weekends.
3. Place clinics in convenient locations.
4. Ensure privacy in counseling spaces.
5. Create a youthful, informal environment that appeals to young people.
6. Stock waiting rooms with audiovisual and print materials of interest to young people.

Program design

1. Involve young people in designing and running services.
2. Welcome drop-in clients.
3. Minimize crowding and time spent in waiting areas.
4. Offer free or low-cost services that young people can afford.
5. Welcome boys and young men, and recruit male staff to serve them.
6. Offer as many sexual and reproductive health services as possible, and minimize referrals.
7. Widely publicize the availability of special programs for young people.
8. Whenever possible, provide contraception to young women without requiring a pelvic exam and blood tests.

Sources: Moya 2002, Senderowitz 1999

tion, contraceptive prevalence in the country of origin, and the in-country availability of contraceptive supplies (WHO, UNFPA, and UNHCR 1999).

Shortages of skilled staff and supplies are common. Managers should first recruit experienced providers from among the refugee population and then train other refugees as needed on contraceptive methods and counseling (WHO, UNFPA, and UNHCR 1999). A limited assortment of contraceptive methods can be made available to refu-

gees from the start of a complex emergency (Krause et al. 2000; WHO, UNFPA, and UNHCR 1999). During the initial phase of a complex emergency, managers can order reproductive health supply kits from UNFPA. As the situation stabilizes, the range of methods should be expanded and integrated with other reproductive health care. To assure a consistent supply of contraceptive commodities, managers will also need to build a functional logistics system, with forecasting initially based on data from the country of origin (Dixon 1999; WHO, UNFPA, and UNICEF 1999). Other challenges include short-term and sporadic funding, the difficulty of maintaining confidentiality and privacy in a densely populated camp, and conflicts between family planning protocols in the country of origin and the host country (Krause et al. 2000).

Engaging men

Reproductive health and family planning programs historically have focused on female clients and designed services accordingly. The result is that men, who are generally hesitant to seek medical care of any kind, feel particularly uncomfortable and unwelcome at family planning and reproductive health facilities. Barriers include inconvenient hours and locations, lack of male staff, limited availability of male methods, bias against male methods, and providers' unfavorable attitudes towards men (Wells 1997).

However, involving men—who control social and economic power in most communities and families—is essential to women's sexual and reproductive health and to the larger goal of gender equity (UNFPA 2005b). For example, involving men can expand the range of contraceptive options available to a couple, increase contraceptive adoption and continuation, and help prevent HIV/STIs (Wells 1997). One approach views men as clients and seeks to make reproductive health care more accessible and attractive to men. Thus family planning programs may try to attract male clients by establishing separate male-only clinics or by taking information and supplies to the places where men gather, including the workplace, bars, and sporting events (Cohen and Burger 2003). This is the approach employed in Guinea (see box, page 46). A second

PROGRAM EXAMPLE:

Reaching out to young people in Jamaica

The Youth.now project is employing a variety of approaches to increase adolescents' access to reproductive health information and services in Jamaica, where most 15- to 19-year-olds report being sexually active but shun traditional reproductive health clinics. Advocates are working to change a policy that prohibits providers from supplying contraceptive services to young people under age 16. A media campaign promotes abstinence for younger adolescents, condoms for older adolescents, and a telephone hotline for youth-friendly information. A training program on youth-friendly services includes janitors and caretakers as well as doctors and nurses because they all act as gatekeepers at reproductive health clinics. Various outreach activities target street boys, schoolchildren, and the wider community, while other programs combine family planning services with fitness facilities or skills training and tutoring.

Source: Brown 2003

approach views men as partners and encourages men and women to discuss and make joint decisions regarding contraception and other reproductive health issues (UNFPA 2005b). An important benefit of this approach is engaging men to support the use of female methods. A third approach views men as agents of positive change and seeks to transform gender relations by questioning men's attitudes and values regarding gender (UNFPA 2005b). (See box, page 47, for program tips that incorporate all three approaches.)

In addition to these approaches, family planning programs can offer information and services to men that enable them to play more supportive roles to their wives during pregnancy. For instance, programs can teach men about nutritional needs during pregnancy, identifying risky labor, and arranging transportation if needed. In addition, family planning programs can help men develop their understanding of broader family health interventions such as children's immunization needs.

No matter what approach is used, program managers should recognize and take steps to ensure that involving men in family planning will not have a negative impact on women. Programs that add services for men must take care that new activities do not take away services for women, erode women's autonomy, or unintentionally reinforce inequitable gender norms and values. Indeed, reproductive health programming for men should explicitly recognize gender imbalances in power and work to change them. (UNFPA 2004, UNFPA 2005b).

PROGRAM EXAMPLE:

Involving men in reproductive health in Guinea

A male involvement project in Guinea not only created new reproductive health services for men at two health centers operated by the Ministry of Health, but also worked in the community to stimulate demand for those services. The first step was training doctors, counselors, health educators, support staff, and auxiliary personnel at the health centers on men's reproductive health needs. The staff then consulted with clients to create a comfortable and supportive environment at new Men's Sections established at the health centers. To create demand for the new services, the project trained 120 peer educators about general reproductive health issues and male involvement and conducted formal behavior change communication campaigns involving home visits by peer educators, lectures by local imams at mosques, radio and television broadcasts, and a day of speeches and special activities. Together these efforts have increased the number of men and couples coming to the clinics for consultations, decreased repeat STI infections among women, and changed attitudes in the community.

Source: Bernal Verbel et al. 2003

Creating demand

Behavior change communication

Many people are unaware of the health and economic benefits of family planning and so they do not seek information or services. Others who desire to postpone or

PROGRAM TIPS:

Promoting male involvement

Providers

1. Train providers on men's physiology and sexuality, male methods, and counseling skills needed to work with male clients and couples.
2. Build an organizational culture that integrates a gender perspective and is committed to working with men.

Facilities

1. Set aside a separate space or special times for men's services.
2. Rearrange clinic hours to accommodate men as well as women.
3. Decorate the waiting and service areas in a way that appeals to men as well as women.
4. Designate a male restroom.
5. Stock waiting rooms with reading materials that interest men.

Program design

1. Involve men in designing and implementing services.
2. Offer men a range of integrated health services, including family planning, HIV/STI services, cancer screening, and sexual health counseling.
3. Encourage women to invite their partners to counseling sessions.
4. Encourage couple communication and joint decision-making.
5. Design behavior change communication for men that seeks to change gender norms and shows men playing a positive role in their family's well-being.

Sources: AVSC International and IPPF/WHR 1999, Cohen and Burger 2003, Mehta 2002, Wells 1997

avoid another birth do not seek out family planning services because they do not know what methods are available or where to get them. Others are discouraged because they think—rightly or wrongly—that their partner, family, community, or religion is opposed to family planning. In addition, some may be concerned about the potential health effects of contraceptive methods or myths associated with their use (see Table 2 for an overview of some myths about male and female condoms).

One of the most effective ways to overcome these barriers, create or increase demand for family planning, and reinforce positive values, norms and actions is behavior change communication (BCC). BCC is a multifaceted strategy for encouraging individuals and communities to adopt new health behaviors. Effective BCC recognizes that behavior change is a process and that individuals proceed through a series of stages before adopting a new belief or practice. Individuals must first learn about a practice,

decide that they approve of it, and intend to adopt it before they will take action and change their behavior (Murphy 2005, Piotrow et al. 1997). To spur the process of behavior change, well-designed BCC campaigns can encourage critical reflection on sensitive areas, stimulate open dialogue on taboo subjects, encourage sharing experiences as a way to diffuse learning and solutions, increase ownership of issues, heighten awareness and knowledge, and prompt discussion. In a reproductive health context, BCC has potential to result in:

- Greater awareness of reproductive rights, including the right to freely decide on the number and spacing of children and the right to contraceptive information and services.
- Increased knowledge of contraceptive methods, including which methods are available, their safety, and their effectiveness.
- Improved knowledge of where contraceptive methods can be obtained.
- More favorable attitudes and societal norms regarding family planning.
- Discussion of family planning with partners, family, and friends.
- Increase in contraceptive communication and decision-making by couples.
- Growth in joint decision-making by couples on family planning.
- Greater willingness to consult a family planning provider or buy condoms.
- A reduction in the number of children that couples say they want.
- Improved health-seeking behavior, resulting in increased contraceptive use and intentions to use contraception in the future.

An array of factors influence the outcome of a BCC intervention. Individuals must believe that the behavior change is desirable; community support for new norms or behaviors must be galvanized; individuals must have the skills and confidence needed to change their behavior; and program policies and infrastructure must facilitate the desired behavior change. The effectiveness of BCC depends on local ownership and the close participation of beneficiaries to ensure that key issues are uncovered and addressed, an approach illustrated by the HEART program in Zambia (see box, page 50). Sometimes the appropriate response to a problem is disseminating correct information, for example, when misconceptions about the safety and side effects of specific methods are scaring women away from family planning. In other cases, a more effective response is to demonstrate social support for family planning, for example, by showcasing respected leaders who endorse contraception. Modeling and thus magnifying desired behaviors that are emerging within the community is a good way to propagate and teach new skills; for example, BCC that focuses on skills-building might involve activities demonstrating how women can raise the issue of condom use with their partners.

Also critical is selecting communication channels that can deliver the messages to the intended audience. BCC campaigns have successfully employed a wide variety of media, materials, and approaches, some of which are listed in the box on page 51.

TABLE 2:

Responding to myths, perceptions, dislikes, and fears about male and female condoms

Client's concern	What to say
Condoms are only for sex workers and promiscuous people.	All kinds of people use condoms now, including married couples, because they are a simple way to protect against pregnancy and disease. HIV and STIs are becoming so common that everyone is at risk.
Using a condom means I don't love or trust my partner.	If you are truly concerned about your partner, you will help protect his or her health by using condoms.
I know my partner doesn't have HIV or other diseases.	Most people do not show any signs when they have HIV. They may not even know themselves. Anyone can have it and pass it on to others.
If I use condoms, people will think I have HIV/AIDS.	Most people who use condoms don't have HIV or AIDS—and it's because they use condoms to protect themselves.
I can't afford condoms.	Condoms don't cost any more than other everyday items, like toiletries and beer. You can even get them for free from the clinic.
I feel too embarrassed to buy condoms.	Sales clerks are used to handling condoms and don't think twice about it. Go with a friend the first time if it makes you feel more comfortable. You also can sometimes get condoms from vending machines.

Source: Adapted from UNFPA , WHO, and PATH 2005

Each channel has different strengths and weaknesses. For example, mass media can reach large numbers of people and repeat messages frequently, but a personal endorsement by a respected leader or a face-to-face encounter with a peer educator or other informed individual is more likely to prompt people to take action (O'Sullivan et al. 2003, Murphy 2005). The most effective strategy is to employ multiple communication channels and approaches to extend the reach of a campaign and reinforce key messages. The accumulation of repeated messages from multiple sources—preferably from within rather than outside the community—can stimulate discussion among an ever-widening circle of people, create the confidence that contraceptive use is becoming a social norm, and eventually change social values and individual behavior. (See box, page 52, for program tips to help managers maximize the impact of BCC.)

BCC must be an ongoing effort, otherwise the interest it prompts will soon dwindle. To sustain and extend the impact of BCC efforts, programs must produce follow-up

materials and activities that do not simply reinforce old messages but also introduce new themes that will lead people further through the behavior change process (Piotrow et al. 1997). For example, a first wave of BCC activities designed to raise awareness of a certain contraceptive method might be followed by activities that promote community support for the method and prompt individuals to ask a provider about it. Effective, large-scale communications activities can be costly, and programs need to be prepared to invest considerable time and resources to ensure success.

PROGRAM EXAMPLE:

Using behavior change communication to fight HIV/AIDS in Zambia

The HEART (Helping Each other Act Responsibly Together) program uses behavior change communication to shape community and societal norms about HIV/AIDS prevention in Zambia. To make sure that young people find the project's messages compelling, HEART relies on feedback from dozens of young people who serve on a youth advisory group. HEART's third phase tailored different messages to boys and girls in the audience and to those who were and were not sexually active. Focus groups and in-depth interviews tested the appeal and comprehensibility of the message concepts before production of television spots.

The television spots urged boys to delay their sexual debut, discouraged girls from forming relationships with "sugar daddies" and accepting gifts for sex, dispelled the myth that it is possible to tell who has HIV/AIDS just by looking at him or her, promoted consistent and correct condom use, and featured a local condom brand. The spots reached most young people in urban areas and increased the likelihood that they would choose to abstain or use condoms. To extend the messages to rural areas, HEART developed radio messages echoing the television spots in five regional languages.

Source: JHU CCP 2004

Lowering economic barriers

Compensation and incentives

Cost is one reason that the poor may delay or avoid seeking services. Costs include not only official charges for contraceptive services and supplies, but also access costs (such as transportation, lodging, and food) and opportunity costs (the cost of being away from home or work), and sometimes even under-the-table fees demanded by providers (Bitran and Giedion 2003). Ensuring access to inexpensive, long-lasting, and effective contraceptive methods can go far toward lowering client costs. Safely minimizing the number of medical examinations and tests required to make contraception available also helps minimize costs and maximize convenience for clients.

To further offset costs, family planning programs may offer to compensate people for out-of-pocket expenses, for example, by offering them free transportation to a facility where they can have an IUD inserted or reimbursing them for wages lost (Upadhyay 2001). Compensation can lower economic barriers to access, broaden individual choice, and raise demand for family planning. However, the practice raises ethical questions, especially given that incentives, which could range from food to housing preferences, were

once commonly used to meet government targets and quotas for long-term and permanent contraceptive methods. Incentives of this kind clearly interfere with informed choice, and they were explicitly rejected along with demographic targets by the ICPD Programme of Action.

Managers and providers should be sensitive to the fine line between compensating expenses and subtly encouraging a client to undergo a procedure they might not otherwise choose. This sensitivity should extend to incentives applied to health workers and health facilities. Health sector reforms often introduce incentives—such as education, career opportunities, and flexibility in working schedules—to motivate health workers to improve their performance. They may also reward facilities or districts for positive outcomes in an effort to raise the quality of care. Managers must take care that any such incentives do not interfere with clients' free choice, for example, by promoting a specific contraceptive method.

Communication media, materials, and approaches for behavior change

- Client education materials, such as leaflets and flip charts.
- Interpersonal interaction, such as individual counseling, peer education, and telephone hotlines.
- Community mobilization activities, such as group talks and live dramas.
- Mass media, such as radio, television, newspapers, popular music, and billboards.
- Traditional or folk media, such as puppet shows, proverbs, and poetry.
- Special events, such as sports games, concerts, parades, and fairs.

Some Latin American countries have experimented with a broader approach to compensation and incentives that does not raise these kinds of ethical issues. Conditional cash transfer programs make direct payments to families if they use preventive health and other services (Palmer et al. 2004). For example, Mexico's Health, Nutrition, and Education program, which is known by the Spanish acronym PROGRESA, makes monthly cash payments to poor households if family members get regular medical check-ups, including antenatal care for pregnant women and growth monitoring for young children, and if children attend school. PROGRESA, which serves about one-fifth of Mexico's population, has succeeded in reducing poverty levels, improving health indicators, and increasing school enrollment (Coady et al. 2005).

User fees

Health sector reforms have led some family planning programs to introduce fees for services (Dmytraczenko et al. 2003). When reinvested in the health system, the additional revenue generated by fees has the potential to improve the quality of care and broaden access to services, to reduce dependence on donors, and to increase a program's financial sustainability. Fees charged to middle-income clients also can subsidize services for the poor (Janowitz et al. 1999, Langer et al. 2000). In prac-

tice, however, user fees have an inconsistent track record: they may raise less revenue than expected, strain the administrative capacity of the health system, and undermine efforts to rationalize the use of services and encourage providers to offer good care (Nolan and Turbat 1995).

Introducing or raising fees also frequently decreases demand for services (Palmer et al. 2004). Clients' ability and willingness to pay fees for family planning depends on many factors, including economic conditions, how high fees are set, whether clients see an associated improvement in the quality of services, and even the type of contraceptive for which the fee is charged (Janowitz et al. 1999, Lande and Geller 1991). When deciding how much to charge, managers should consider both the actual cost of providing the service and clients' ability to pay. Many programs weigh proposed fees against the cost of other common household expenses, such as bus fare or soft drinks. Managers' greatest concern should be that charging fees will be an economic barrier to services for the poor—especially for women who have less control over household resources than do men (Langer et al. 2000, Maceira 2005b, Janowitz et al. 1999). When faced with fees for family planning, the poor have few choices: to cover the cost, they may cut back on other essentials, such as food; they may switch from modern to less effective traditional methods; or they may stop using contraception. Concern about the negative impact of even modest user fees on access to services by poor and vulnerable groups has led the UN Millennium Project to recommend eliminating user fees for basic health care and education (UN Millennium Project 2005a.)

PROGRAM TIPS:

Maximizing the impact of behavior change communication

1. Analyze potential audiences. If they are at different stages in the process of behavior change, segment them and develop different approaches for each.
2. Identify and address barriers to behavior change.
3. Use engaging and participatory approaches to communication.
4. Design precise and clear messages that promote increased understanding of and reflection on the behavior that needs to change.
5. Select a mix of communication channels, media, and approaches that can cost-effectively reach the intended audience.
6. Consider using entertainment formats, such as soap operas and popular songs, to attract larger audiences and model desired attitudes and behaviors.
7. Pretest all messages and materials with members of the intended audience and revise accordingly.
8. Ensure the quality and appropriateness of messages and materials.

Sources: O'Sullivan et al. 2003, Piotrow et al. 1997

Health insurance

Health insurance programs can reduce clients' out-of-pocket costs for health care while also generating revenue for the health system (Ekman 2004, Palmer et al. 2004). Social insurance is national in scope, collects mandatory premiums from employers

and employees via payroll deductions, and generally covers only those people working in the formal sector. In contrast, community-based health insurance (also known as micro-insurance or prepayment schemes) is locally based and operated, purely voluntary, and open to every household in a community. Both types of insurance enable people to spread payments for health care over time in a predictable manner, protect families from catastrophic health costs, and spread risks across a pool of members so that the healthy subsidize the expenses of the sick (Bennett and Gilson 2001, Maceira 2005b).

Most social insurance schemes largely exclude the poor because they do not work in the formal sector. However, several countries, including Thailand, Colombia, and Costa Rica, have extended national health insurance coverage to include those employed in the informal sector and the poor in an effort to reduce the financial burden of health care (Ekman 2004, Palmer et al. 2004).

There has been far more activity in the development of community-based health insurance schemes, which may be organized and run by community organizations such as women's committees, service delivery organizations such as hospitals, or the government. These schemes may be more equitable because they include people working in the informal sector, charge low premiums (as little as US$1 or $2 a year per person), and may even accept contributions in kind or in labor (Hope 2003). However, the small size of most schemes (the number of beneficiaries is frequently less than 500 and rarely more than 10,000) limits their impact, raises administrative costs, reduces managerial capacity, and makes the schemes vulnerable to financial insolvency (Carrin et al. 2005). Affordable premiums also limit the amount of money the schemes can raise, so that most are subsidized by the government or donors, limit the benefits package, or leave members with substantial out-of-pocket costs (Carrin et al. 2005, Hope 2003, Maceira 2005b).

In Rwanda, community-based health insurance schemes have proliferated since 1998 when the Ministry of Health initiated a few pilot projects: by 2004, more than 200 schemes were serving fully one-fifth of the population (Diop and Butera 2005). In return for an annual premium of US$7.60, an entire family is eligible for a broad mix of preventive and curative services, including some services at the district hospital. While each scheme operates as a partnership between the community and the local health center, it is also a part of a district-level federation that offers technical support and pools risks across a broader population. The schemes have increased the use of reproductive health services and encouraged members to seek care when sick. Recent efforts to increase poor peoples' access to the schemes include micro-financing to help pay the annual premium and subsidies for poor and vulnerable groups, including orphans, widows, and people living with HIV/AIDS.

Waivers and exemptions

To protect the poor, while still generating additional revenue, programs may establish some kind of waiver or exemption system that reduces or eliminates user fees and

insurance premiums for the poor. Programs that charge user fees have tried many different approaches to identify which individuals should be eligible for waivers, including means-testing, community-based identification by local leaders, and using data from national surveys (Maceira 2005b). In Ecuador, an NGO called CEMOPLAF has tried a simpler approach: charging less for reproductive services at clinics located in poor areas without trying to assess the ability of individuals to pay (Sine and Sharma 2002). Community-based health insurance schemes usually set a flat rate for all members, so that poor people are less likely than others to join the plans (Carrin et al. 2005, Ekman 2004). An exception is the Gonosasthya Kendra Scheme in Bangladesh, which has four different premium levels; members in the lowest socioeconomic group pay one-tenth as much as members in the highest group—but the scheme is still not affordable for all (Carrin et al. 2005).

It has proven difficult to design and implement a fair and effective waiver system that adequately covers the poor without leaking subsidies to those who can afford to pay (Nolan and Turbat 1995). The box on page 55 outlines what a fair and effective waiver system should look like. Frequently, however, providers grant exemptions from user fees on an informal and subjective basis, while poor clients may not even request waivers—either because of the stigma attached to them or because they do not know waivers exist (Bitran and Giedion 2003, Janowitz et al. 1999, Lande and Geller 1991). In Bangladesh, for example, staff did not provide fee waivers openly and systematically for fear it would raise concerns about fairness and make it difficult to enforce posted prices for the majority of clients. As a result, clients often interpreted waivers as personal favors. If the money raised from user fees goes directly to the health facility—for example, paying for additional equipment or staff bonuses in an effort to improve the quality of care—providers also will face a conflict of interest in granting waivers (Maceira 2005b). For all these reasons, it may be better to design a system that determines who is eligible for waivers and exemptions before people come to a facility for services.

Sustainability

Self-reliance

Lowering costs

Making family planning services financially sustainable over the long term is an increasing challenge, given the growing number of users and competition for scarce resources by other health and development programs. One route to sustainability is increasing the cost-efficiency of services. Managers should learn to use cost-revenue analysis tools to understand how staffing patterns, the service mix, service practices, and procurement contribute to the cost of delivering services. Based on the results of the cost-revenue analysis, managers can then devise strategies to reduce costs and/or increase revenues. (See box, page 56, for program tips that outline a variety of changes that can potentially increase the cost-efficiency of services.) When making changes,

however managers must be careful not to erode the quality of care or reduce access to services.

Raising quality

Improving the quality of care can contribute to sustainability both by attracting more clients and by increasing revenues. Clients naturally migrate to programs that have a reputation for offering good services. A larger clientele permits programs to spread fixed costs over more clients, thus reducing the cost per client served. There is also less waste in busy facilities, since staff and equipment never stand idle. A reputation for good care also can help programs raise additional revenue via user fees, since clients are generally willing to pay more for services that they believe are of good quality. The combination of good quality services plus a large and enthusiastic clientele is more likely to attract donor support as well (Kols and Sherman 1998).

Private sector partnerships

Engaging the private sector can increase the availability of much needed family planning services and supplies. For example, collaborating with private employers may allow family planning programs to deliver services to men in the workplace. Involving the private sector also has the potential to shift clients who can afford to pay from the public to the private sector, freeing up public resources to serve the poor. Many clients seek out private providers and commercial commodities in the belief that the private sector offers better quality of care. However, careful implementation and regular monitoring are vital to ensure that private-sector initiatives provide good quality care and adhere to national guidelines, do not drain resources or personnel from the public sector, and do not skew the method mix towards more profitable services (Doherty 2005).

Waiving user fees: characteristics of a fair and effective system

- Careful design and implementation.
- Adequate financing, including compensation for any revenue that providers lose from granting waivers.
- Clear definitions to distinguish who is poor from who is not.
- Written guidelines, formal eligibility criteria, and training to help staff understand how the waiver system works and determine who is eligible.
- Periodic readjustment of fee levels and income-eligibility levels to reflect inflation and other economic changes.
- Advertising to make the poor aware of the waiver system and encourage them to request waivers.

Source: Bitran and Giedion 2003

Social marketing

One common approach, social marketing, uses commercial marketing techniques to sell commodities like condoms and OCs at relatively low prices through local retail outlets. Subsidized social marketing programs run by NGOs are better able to reach

PROGRAM TIPS:

Increasing the cost-efficiency of services

1. Attract more clients to clinics so that staff, equipment, and facilities operate at full capacity and overhead is less.
2. Increase the amount of time providers spend with clients, for example, by eliminating non-essential tasks.
3. Switch to less expensive service-delivery strategies, for example, by shifting from time-intensive community-based services to clinic-based services.
4. Eliminate unnecessary tests, procedures, and return visits.
5. Reduce waste, for example, by more accurately forecasting demand for commodities or simplifying records systems so that they do not collect unnecessary data.
6. Organize work more efficiently, for example, by delegating tasks to lower-level providers or giving frontline staff the authority to make everyday decisions.

Sources: FPLM and JSI 2000, Janowitz et al. 1999, Mitchell et al. 1999, Setty 2004

low-income groups, but programs operated by manufacturers can serve middle-income customers and are more sustainable (Armand 2003, Sharma and Dayaratna 2004).

Successful social marketing programs will (PSI 2003):

- Brand, attractively package, and aggressively promote products.
- Develop BCC campaigns to encourage people to adopt positive health practices, including contraceptive use.
- Set prices at a level that is affordable for lower-income consumers.
- Employ sales teams to solicit outlets to carry their products.
- Increase access and sales by distributing products through non-traditional outlets, such as market kiosks, bars, liquor stores, nightclubs, hotels, and filling stations.

Social franchising

Social franchising networks expand the availability of good-quality reproductive health care by recruiting, training, and equipping doctors and nurses in private practice to offer standardized services under a brand name (Smith 2002). Some networks also subsidize the cost of services for the poor. The Green Star network in Pakistan offers a good example of how social franchising can increase access to services in under-served communities (see box, page 57).

Successful social franchising programs will (LaVake 2003, McBride and Ahmed 2001):

- Outline the roles and responsibilities of the franchisor and franchisee in a formal business contract.
- Carefully screen applicants and only accept those who are committed to the franchise concept and are likely to succeed.
- Assure the quality of services by setting strict service standards, training franchisees, and making frequent site visits to support and monitor providers.

- Promote, position, and market the branded service through the use of logos, signs, mass media advertising, and community-based activities involving franchisees.
- Use centralized purchasing and other techniques to minimize costs.
- Use non-economic incentives—such as recognition ceremonies—to motivate providers, in addition to the economic rewards of being a member of the network.

Pharmacies

Pharmacies are well placed to offer family planning information, supplies, and referrals. Many people prefer pharmacies to clinics because their locations and hours are more convenient, there is no waiting and no consultation fee, and the staff are more accessible (Beitz 2004, WHO and FIP 1997). However, only some drugstore workers are trained pharmacists, and even they may lack much knowledge of reproductive health.

To encourage pharmacies to offer customers accurate and up-to-date information on family planning, programs should (Kobilke 2002, Beitz 2004):

- Get the support of professional pharmacy associations.
- Train counter workers as well as pharmacists on technical and counseling skills.
- Supply educational materials for pharmacy workers and customers.
- Build a referral network for customers who need clinical services.
- If needed, campaign for changes in national policies on what services pharmacists are allowed to provide.
- Use a logo to identify pharmacies that offer upgraded family planning services.

PROGRAM EXAMPLE:

Social franchising in Pakistan

The Green Star franchise network in Pakistan recruits physicians in poor areas to add family planning services to their existing medical practices. The physicians agree to follow strict protocols in return for training, support, materials, and the right to operate under the Green Star name. The network also includes pharmacists and "lady health visitors," who deliver health care to the poorest and most underserved urban neighborhoods. To ensure that providers meet advertised standards of quality, all must attend and pass a training course, which ranges in length from half a day for pharmacists to 40 hours for women physicians learning how to insert IUDs.

Multimedia advertising campaigns, promotions, and public relations activities have made the Green Star brand a well-known symbol of good-quality family planning at affordable prices. Since its launch in 1995, the Green Star network has added family planning services to more than 11,000 private sector outlets in 40 urban areas in Pakistan. Together they serve an estimated 7.5 million family planning clients annually, 74 percent of whom are from low-income groups. Green Star's efforts contributed to an increase in contraceptive prevalence in Pakistan from 17 percent in 1997 to 23 percent in 2000.

Source: McBride and Ahmed 2001

PART 3

Conclusion

Reproductive health and family planning managers need to be aware of broad shifts in their nation's development priorities and policies and the international pressures that are driving them. They also need to understand the challenges and opportunities presented by decentralization, integration, and other health sector reforms. With this knowledge, they can take action to improve the quality, availability, and cost-effectiveness of family planning services, which, in turn, will lead more couples in need of family planning to use a modern contraceptive method.

It is important for managers to play an active role in the advocacy community so that they can participate in the policy development process. Effective family planning advocacy must speak to and adopt the language of policy priorities such as poverty reduction, HIV/AIDS, and health sector reform. In decentralized systems, advocacy needs to be conducted on the district as well as the national level.

While the integration of health services has the potential to dilute family planning efforts, it also creates exciting opportunities. Managers should carefully consider whether and how integrating family planning with other health services can extend contraceptive counseling to new audiences. For example, integrating family planning with HIV/STI activities is a good way to reach the men and adolescents who rarely visit family planning clinics. Before proceeding, however, it is essential to assess the additional burdens integrated services will place on staff and on service-delivery systems and to carefully weigh the feasibility of the integration plan.

Realizing the goal of informed choice is both an ethical and a practical way to make sure that clients get a safe, appropriate method that they will want to continue using. To help reach that goal, managers should increase the efficiency of the supply system so that clients have a wide range of contraceptive options. They also should strengthen providers' counseling skills and encourage clients to participate more actively to improve contraceptive decision-making.

Improving the quality of care can attract more clients to family planning services. Managers need to critically examine and strengthen all of the elements that support good quality care, including supervision, in-service training, job aids and feedback systems that reinforce providers' skills, health management information systems, monitoring, and quality assurance activities. Access to services is also important. Managers should examine whether current service-delivery arrangements exclude certain vulnerable groups, including the poor, refugees, and adolescents. If so, they need to devise creative new approaches to bring services to these hard-to-reach groups.

Managers in charge of family planning services also can act to create more demand for their services by using behavior change communication to raise awareness, increase knowledge, change attitudes, and motivate people to seek services. Also important is removing the economic barriers that discourage potential clients from seeking services.

Finally, managers need to work towards financial sustainability so that their programs can meet the growing need for family planning services and become less dependent on uncertain donor and government funding. Cost-revenue analysis can help them make changes—for example, in staffing patterns or service practices—that increase the cost-efficiency of service delivery, and building partnerships with the private sector can reduce demand on public services.

Acronyms

AIDS	acquired immune deficiency syndrome
ARV	antiretrovirals
BCC	behavior change communication
BMD	bone mineral density
DALY	disability-adjusted life year
DHS	Demographic and Health Surveys
DMPA	depot medroxyprogesterone acetate
EC	emergency contraception
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IUD	intrauterine device
LMIS	logistics management information system
MDG	Millennium Development Goal
NGO	nongovernmental organization
OC	oral contraceptive
PAC	postabortion care
PMTCT	prevention of mother-to-child transmission
PRSP	Poverty Reduction Strategy Paper
SPA	Service Provision Assessment
SRH	sexual and reproductive health
STI	sexually transmitted infection
SWAp	sector-wide approach
UNFPA	United Nations Population Fund
VCT	voluntary counseling and testing
WHO	World Health Organization

References

Alvarez-Castillo F. Priority setting in the context of health sector reforms: implications for sexual and reproductive health services [policy brief]. Johannesburg: The Initiative for Sexual & Reproductive Rights in Health Reforms, Women's Health Project, School of Public Health, University of the Witwatersrand; 2005. Available at: www.wits.ac.za/whp/rightsandreforms/policy.htm.

Armand F. *Social Marketing Models for Product-Based Reproductive Health Programs: A Comparative Analysis*. Washington, DC: USAID/Commercial Market Strategies Project; 2003. Available at: www.psp-one.com/content/resource/detail/971/.

Ashford L. Unmet need for family planning [policy brief]. Washington, DC: MEASURE Communication, Population Reference Bureau; 2003. Available at: www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=8212.

Askew I, Berer M. The contribution of sexual and reproductive health services to the fight against HIV/AIDS: a review. *Reproductive Health Matters*. 2003;11(22):51–73.

AVSC International and International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR). *Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms—Report*. New York: AVSC International and IPPF/WHR; 1999. Available at: www.ippfwhr.org/publications/publication_detail_e.asp?PubID=19.

Basu AM. The Millennium Development Goals minus reproductive health: an unfortunate, but not disastrous omission. *Studies in Family Planning*. 2005:36(2):132–134.

Bates J, Chandani Y, Crowley K, Durgavich J, Rao S. *Implications of Health Sector Reform for Contraceptive Logistics: A Preliminary Assessment for Sub-Saharan Africa*. Arlington, VA: Family Planning Logistics Management/John Snow, Inc.; 2000. Available at: http://portalprd1.jsi.com/pls/portal/docs/page/DEL_CONTENT_PGG/DEL_PUBLICATION_PG1/DEL_POLICY_PAPER_PG1/HSR_synthesispaper2000.pdf.

Beitz J. Increasing access to reproductive health services through pharmacists. *Outlook*. 2004;21(2):1–8. Available at: www.path.org/publications/pub.php?id=931.

Bennett S, Gilson L. *Health Financing: Designing and Implementing Pro-Poor Policies*. London: DFID Health Systems Resource Center; 2001. Available at: www.dfid-healthrc.org/shared/publications/Issues_papers/Health_financing_pro-poor.pdf.

Berer M. Health sector reforms: implications for sexual and reproductive health services. *Reproductive Health Matters*. 2002;10(20):6–15.

Berer M. HIV/AIDS, sexual and reproductive health: intersections and implications for national programmes. *Health Policy and Planning*. 2004;19(suppl 1):i62–i70.

Berer M. Integration of sexual and reproductive health services: a health sector priority. *Reproductive Health Matters*. 2003;11(21):6–15.

Bernal Verbel LC, Mehta M, Ndong I, Diallo M. Transforming men into clients: men's reproductive health services in Guinea. *Compass*. 2003;2:1–4. Available at: http://engenderhealth.org/pubs/compass/pdf/03-02.pdf.

Bernstein S. The changing discourse on population and development: toward a new political demography. *Studies in Family Planning*. 2005;36(2):127–132.

Bertrand JT, Hardee K, Magnani RJ, Angle MA. Access, quality of care and medical barriers in family planning programs. *International Family Planning Perspectives*. 1995;21(2):64–69,74.

Bertrand JT, Sullivan T. Quick Investigation of Quality (QIQ): monitoring quality of care in clinic-based family planning programs. *MEASURE Evaluation Bulletin*. 2000;1:1–3. Available at: www.rhrc.org/resources/general_fieldtools/toolkit/otherResources/PNACN334.pdf.

Bitran R, Giedion U. *Waivers and Exemptions for Health Services in Developing Countries*. Washington, DC: World Bank; 2003. Social Safety Net Primer Notes, No. 9. Available at: www1.worldbank.org/sp/safetynets/Primers/Notes_HlthServices.pdf.

Blanc AK, Tsui AO. The dilemma of past success: insiders' views on the future of the international family planning movement. *Studies in Family Planning*. 2005;36(4):263–276.

Bloom DE, Canning D, Sevilla J. *The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change*. Santa Monica, CA: RAND; 2003.

Boonstra H. *The Role of Reproductive Health Providers in Preventing HIV*. Geneva and New York: UNAIDS and the Alan Guttmacher Institute; 2004. Issues in Brief series, No. 5. Available at: www.guttmacher.org/pubs/ib2004no5.pdf.

Bott S, Calzadilla L, Claramunt MC, Flores M, Medina S. *¡Basta!* 2000;Summer issue:1–12. Available at: www.ippfwhr.org/publications/download/serial_issues/basta-2000summer_e.pdf.

Brown SF. *Small Successes, Big Ideas—Jamaica's Adolescent Reproductive Health Focus*. Washington, DC: Population Reference Bureau; 2003. Available at www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=8726. Accessed February 22, 2006.

Bruce J. Fundamental elements of the quality of care: a simple framework. *Studies in Family Planning*. 1990;21(2):61–91.

Canadian International Development Agency (CIDA). *CIDA Primer on Program-Based Approaches*. Gatineau, Quebec: CIDA; 2003.

Carr D. *Improving the Health of the World's Poorest People*. Washington, DC: Population Reference Bureau, 2004. Health Bulletin, No. 1. Available at: www.phishare.org/files/1530_ImprovingtheHealthWorld.pdf.

Carrin G, Waelkens M-P, Criel B. Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems. *Tropical Medicine and International Health*. 2005;10(8):799–811.

Children's Vaccine Program at PATH. *Guidelines for Implementing Supportive Supervision: A Step-by-Step Guide with Tools to Support Immunization*. Seattle: PATH; 2003. Available at: www.childrensvaccine.org/files/Guidelines_for_Supportive_Supervision.pdf.

Coady DP, Filmer DP, Gwatkin DR. PROGRESA for progress: Mexico's health, nutrition, and education program. *Development Outreach*. 2005;7(2):10–12. Available at: www1.worldbank.org/devoutreach/may05/article.asp?id=296.

Cohen SI, Burger M. *It Takes 2: Partnering With Men in Reproductive and Sexual Health*. New York: UNFPA; 2003. UNFPA Programme Advisory Note. Available at www.unfpa.org/upload/lib_pub_file/153_filename_ItTakes2.pdf

Conde-Agudelo A, Belizána JM, Breman R, Brockman SC, Rosas-Bermudez A. Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. *International Journal of Gynecology and Obstetrics*. 2005;89:S34–S40. Available at: www.women-shealth-elsevier.com/doc/journals/ijgo_si_89-1/04.pdf.

Corbett MR, Turner KL. Essential elements of post-abortion care: origins, evolution and future directions. *International Family Planning Perspectives*. 2003;29(3):106–111. Available at: www.guttmacher.org/journals/ifpp.html.

Corrêa S, Piola S, Arilha M. *Reproductive Health in Policy & Practice: Brazil*. Washington, DC: Population

Reference Bureau; 1998. Available at: www.prb.org/pdf/RHPPBrazil.pdf.

Crossette B. Reproductive health and the Millennium Development Goals: the missing link. *Studies in Family Planning*. 2005;36(1):71–79.

Curtis SL, Neitzel K. *Contraceptive Knowledge, Use, and Sources*. Calverton, MD: Macro International Inc.; 1996. DHS Comparative Studies, No. 19. Available at: www.measuredhs.com/pubs/details.cfm?ID=27.

Dehne K, Snow R. *Integrating STI Management into Family Planning Services: What are the Benefits?* Geneva: World Health Organization; 1999. Available at: www.who.int/reproductive-health/publications/integrating_stis_into_fp_services/.

Deschner A, Cohen SA. Contraceptive use is key to reducing abortion worldwide. *The Guttmacher Report on Public Policy*. 2003;6(4):7–10. Available at: www.guttmacher.org/pubs/tgr/06/4/gr060407.html.

Diaz M, Simmons R, Diaz J, et al. Action research to enhance reproductive choice in a Brazilian municipality: the Santa Barbara Project. In: Haberland N, Measham D, eds. *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*. New York: Population Council; 2002:355–375.

Diop FP, Butera JD. Community-based health insurance in Rwanda. *Development Outreach*. 2005;7(2):19–22. Available at: www1.worldbank.org/devoutreach/may05/article.asp?id=299.

DiPrete Brown L, Franco LM, Rafeh N, Hatzell T. *Quality Assurance of Health Care in Developing Countries*. Bethesda, MD: Quality Assurance Project; 2000. Quality Assurance Methodology Refinement Series. Available at: www.qaproject.org/pubs/PDFs/DEVCONT.pdf.

Dixon G. *Contraceptive Logistics Guidelines for Refugee Settings*. Arlington, VA: Family Planning Logistics Management Project; 1999. Available at: www.jsi.com/JSIInternet/Publications/familyplanning.cfm.

Dmytraczenko T, Rao V, Ashford, L. *Health Sector Reform: How It Affects Reproductive Health*. Washington, DC: Population Reference Bureau; 2003. MEASURE Communication Policy Brief. Available at: www.prb.org/pdf/HealthSectorReformbw.pdf.

Doherty J. Public-private interactions: implications for sexual and reproductive health services [policy brief]. Johannesburg: The Initiative for Sexual & Reproductive Rights in Health Reforms, Women's Health Project, School of Public Health, University of the Witwatersrand; 2005. Available at: www.wits.ac.za/whp/rightsandreforms/policy.htm.

Ekman B. Community-based health insurance in low-income countries: a systematic review of the evidence. *Health Policy and Planning*. 2004;19(5):249–270.

EngenderHealth. *Choices in Family Planning: Informed and Voluntary Decision Making*. New York: EngenderHealth; 2003[b]. Available at: www.engenderhealth.org/res/offc/ic/choices/.

EngenderHealth. *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum. Participant's Handbook*. New York: EngenderHealth; 2003[c]. Available at: www.engenderhealth.org/res/offc/counsel/ccrh/index.html.

EngenderHealth. *COPE® Handbook: A Process for Improving Quality in Health Services, Revised Edition*. New York: EngenderHealth; 2003[a]. Available at: www.engenderhealth.org/res/offc/qi/cope/handbook/index.html.

Family Health International (FHI). *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents*. Arlington, VA: FHI; 2000. Available at: www.fhi.org/en/RH/Pubs/servdelivery/adolguide/index.htm.

FHI. *Provider Checklists for Reproductive Health Services: Reference Guide*. Research Triangle Park, NC: FHI; 2002. Available at: www.fhi.org/en/RH/Pubs/servdelivery/checklists/index.htm.

FHI. *Quick Reference Chart for the Medical Eligibility Criteria of the WHO: For Initiating and Continuing the Use of Combined Oral Contraceptives, Noristerat, Depo-Provera, and Copper IUDs*. Research Triangle Park, NC: FHI; 2004. Available at: www.fhi.org/en/RH/Pubs/servdelivery/quickreferencechart.htm.

Family Planning Logistics Management (FPLM) and John Snow, Inc (JSI). *Programs that Deliver: Logistics' Contributions to Better Health in Developing Countries*. Arlington, VA: FPLM/JSI; 2000.

Finkle C. Ensuring contraceptive supply security. *Outlook*. 2003;20(3):1–8. Available at: www.path.org/publications/pub.php?id=741.

Fleischman Foreit KG, Hardee K, Agarwal K. When does it make sense to consider integrating STI and HIV services with family planning services? *International Family Planning Perspectives*. 2002:28(2):105–107. Available at: www.guttmacher.org/journals/ifpp.html.

FOCUS on Young Adults. *Advancing Young Adult Reproductive Health: Actions for the Next Decade. End of Program Report*. Washington, DC: FOCUS on Young Adults; 2001. Available at: www.futuresgroup.com/abstract.cfm/2569.

Fuchs N. *Priorities for Family Planning and HIV/AIDS Integration*. Washington DC: USAID; 2005. Global Health Technical Briefs. Available at: www.maqweb.org/techbriefs/tb11integration.pdf.

Garcia-Moreno C, Jansen HAFM, Ellsberg M, Heise L, Watts C. *WHO Multi-Country Study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes, and Women's Responses*. Geneva: WHO; 2005. Available at: www.who.int/gender/violence/who_multicountry_study/en/index.html.

Gillespie DG. Whatever happened to family planning and, for that matter, reproductive health? *International Family Planning Perspectives*. 2004;30(1):34–38. Available at: www.guttmacher.org/pubs/journals/3003404.html.

Hardee K, Smith J. *Implementing Reproductive Health Services in an Era of Health Sector Reform*. Washington DC: The POLICY Projects/Futures Group International; 2000. The POLICY Project Occasional Papers, No. 4. Available at: http://pdf.dec.org/pdf_docs/Pnacj059.pdf.

Hare L, Hart C, Scribner S, Shepherd C, Pandit T (ed.), Bornbusch A (ed.). *SPARHCS: Strategic Pathway to Reproductive Health Commodity Security. A Tool for Assessment, Planning, and Implementation*. Baltimore, MD: INFO Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health; 2004. Available at: www.rhsupplies.org/resources/doc/SPARHCS_publication.pdf.

Haslegrave M, Olatunbosun O. Incorporating sexual and reproductive health care in the medical curriculum in developing countries. *Reproductive Health Matters*. 2003;11(21):49–58.

Herrick J, Turner K, McInerney T, Castleman L. *Woman-centered Postabortion Care: Reference Manual*. Chapel Hill, NC: Ipas; 2004.

Hope RL. Paying in potatoes: community-based health insurance for the rural and informal sector. *Lancet*. 2003;362:827–828.

Huezo CM, Carignan CS. *Medical and Service Delivery Guidelines for Family Planning*. 2nd ed. London: International Planned Parenthood Federation; 1997.

INFORM Unit, Center for Leadership and Management, Management Sciences for Health (MSH). *Information for Health Management: The MSH Approach*. Boston: MSH; 2005. Available at: http://erc.msh.org/toolkit/pdf/HIS_MSH_Approach.pdf.

International Consortium for Emergency Contraception (ICEC). *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines*. 2nd ed. Washington, DC: ICEC; 2003. Available at: www.cecinfo.org/files/Guidelines%202ndnewt%20(2).pdf.

International Planned Parenthood Federation (IPPF). *Advocacy Guide for Sexual and Reproductive Health and Rights*. London: IPPF; 2001.

Jacobson JL. Transforming family planning programmes: toward a framework for advancing the reproductive rights agenda. *Reproductive Health Matters*. 2000;8(15):21–32.

Jamison DT, Mosley WH, Measham AR, Bobadilla J-L (eds). *Disease Control Priorities in Developing Countries*. New York: Oxford University Press for the World Bank; 1993.

Janowitz B, Measham D, West C. *Issues in the Financing of Family Planning Services in sub-Saharan Africa*. Research Triangle Park, NC: Family Health International; 1999. Available at: www.fhi.org/en/RH/Pubs/booksReports/fpfinancing/index.htm.

Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU CCP) and Health Communication Partnership. HEART program offers Zambian youth hope for an HIV/AIDS-free future. *Communication Impact!* 2004;17:1–2. Available at: www.jhuccp.org/pubs/ci/17/17.pdf.

Kane MM, Colton TC. *Integrating SRH and HIV/AIDS Services: Pathfinder International's Experience Synergizing Health Initiatives*. Watertown, MA: Pathfinder International; 2005. Available at: www.pathfind.org/site/DocServer/FP_HIV_Integration_web_copy.pdf?docID=3461.

Karim AM. *The Influence of Family Planning Logistics Systems on Contraceptive Use* [working paper]. Arlington, VA: John Snow, Inc. (JSI)/DELIVER; 2005. Available at: http://portalprd1.jsi.com/portal/page?_pageid=93,3144386,93_3144425&_dad=portal&_schema=PORTAL.

Kobilke A. *Pharmacist Training Improves Family Planning Services*. Washington DC: PSI; 2002. Available at: www.psi.org/news/081602b.html.

Kols A, Sherman J. Family planning programs: improving quality. *Population Reports*. 1998;J(47):1–40. Available at: www.infoforhealth.org/pr/online.shtml.

Krause SK, Jones RK, Purdin SJ. Programmatic responses to refugees' reproductive health needs. *International Family Planning Perspectives*. 2000;26(4):181–187. Available at: www.guttmacher.org/pubs/journals/2618100.html.

Lande RE. Performance improvement. *Population Reports*. 2002;J(52):1–28. Available at: www.infoforhealth.org/pr/online.shtml.

Lande RE, Geller JS. Paying for family planning. *Population Reports*. 1991;J(39):1–31.

Langer A, Nigenda G, Catino H. Health sector reform and reproductive health in Latin America and the Caribbean: strengthening the links. *Bulletin of the World Health Organization*. 2000;78(5):667–676. Available at: http://whqlibdoc.who.int/bulletin/2000/Number percent205/78(5)667–676.pdf.

LaVake, SD. *Applying Social Franchising Techniques to Youth Reproductive Health/HIV Services*. Arlington, VA: Family Health International, YouthNet Program; 2003. Youth Issues Papers, No. 2. Available at: www.fhi.org/NR/rdonlyres/eijal2kvvmtazwuqnkoqk4hbxmdazuanzwojv55tghflkma7sj2k2gusgfv6276emct5uxnwl6iamc/YI4.pdf.

León FR, Rios A, Zumaran A, de la Cruz M, Brambila C, Bratt JH. *Enhancing Quality for Clients: The Balanced Counseling Strategy*. Washington, DC: Population Council; 2003. FRONTIERS Program Brief, No. 3. Available at: www.popcouncil.org/pdfs/frontiers/pbriefs/balance_counseling_brf.pdf.

Lynam PF, Dwyer JC, Bradley J. *Inreach: Reaching Potential Family Planning Clients Within Health Institutions*. New York: Association for Voluntary Surgical Contraception (AVSC); 1994. AVSC Working Paper No. 5. Available at: www.engenderhealth.org/pubs/workpap/wp5/wp_5.html.

Maceira D. Decentralisation and implications for sexual and reproductive health services [policy brief]. Johannesburg: The Initiative for Sexual & Reproductive Rights in Health Reforms, Women's Health Project, School of Public Health, University of the Witwatersrand; 2005[a]. Available at: www.wits.ac.za/whp/rightsandreforms/policy.htm.

Maceira D. Financial health sector reforms and sexual and reproductive health [policy brief]. Johannesburg: The Initiative for Sexual & Reproductive Rights in Health Reforms, Women's Health Project, School of Public Health, University of the Witwatersrand; 2005[b]. Available at: www.wits.ac.za/whp/rightsandreforms/policy.htm.

Magwaza S, Cooper D, Hoffman M. *The Delivery of Integrated Reproductive Health Services at District Levels*. Durban, South Africa: Health Systems Trust; 2002. Available at: www.hst.org.za/publications/476.

Management Sciences for Health (MSH). Managing integrated services. *The Manager*. 1994;3(3). Available at: http://erc.msh.org/mainpage.cfm?file=2.2.5.htm&module=health&language=English. Accessed February 27, 2006.

MSH, ed. *The Family Planning Manager's Handbook*. Bloomfield, CT: Kumarian Press; 1991.

Marquez L, Kean L. *Making Supervision Supportive and Sustainable: New Approaches to Old Problems*. Washington, DC: Maximimizing Access and Quality Initiative (MAQ); 2002. MAQ Papers, Vol. 1, No. 4. Available at: www.maqweb.org/maqdoc/MAQno4final.pdf.

Marston C, Cleland J. *The Effects of Contraception on Obstetric Outcomes*. Geneva: World Health Organization; 2004. Available at: www.who.int/reproductive-health/publications/2004/effects_contraception/.

Mason A, Lee S-H. *The Demographic Dividend and Poverty Reduction*. Proceedings of the Seminar on the Relevance of Population Aspects for the Achievement of the Millenium Development Goals, New York, November 17–19, 2004. New York: United Nations, Department of Economic and Social Affairs, Population Division; 2004. Available at: www.un.org/esa/population/publications/PopAspectsMDG/19_MASONA.pdf.

Mayhew SH, Lush L, Cleland J, Walt G. Implementing the integration of component services for reproductive health. *Studies in Family Planning*. 2000;31(2):151–162.

McBride J, Ahmed R. *Social Franchising as a Strategy for Expanding Access to Reproductive Health Services: A Case Study of the Green Star Service Delivery Network in Pakistan*. Washington, DC: Commercial Market Strategies; 2001. CMS Technical Paper Series. Available at: http://pdf.dec.org/pdf_docs/PNACM869.pdf.

McIntyre D. Integration, health sector reforms, and sexual and reproductive health [policy brief]. Johannesburg: The Initiative for Sexual & Reproductive Rights in Health Reforms, Women's Health Project, School of Public Health, University of the Witwatersrand; 2005. Available at: www.wits.ac.za/whp/rightsandreforms/policy.htm.

MEASURE DHS. *Service Provision Assessments (SPA) from MEASURE DHS*. Calverton, MD: MEASURE DHS; 2005. Available at: www.maqweb.org/maqtools/spabrochureupdated.pdf.

Mehta M. Communicating with men to promote family planning: lessons learned and suggestions for programming. In: *Programming for Male Involvement in Reproductive Health. Report of the Meeting of WHO Regional Advisors in Reproductive Health*. Geneva: WHO; 2002. Available at: www.who.int/reproductive-health/publications/rhr_02_3_male_involvement_in_rh/index.htm.

Merrick T. Delivering reproductive health services in health reform settings: challenges and opportunities. Prepared for: Adapting to Change: Core Course on Population,

Reproductive Health and Health Sector Reform, October 2–20, 2000; Washington, DC.

Merrick TW. Population and poverty: new views on an old controversy. *International Family Planning Perspectives.* 2002;28(1):41–46.

Mitchell MD, Littlefield J, Mitchell SG. Costing of reproductive health services. *International Family Planning Perspectives*. 1999;25(Suppl.):S17–S21,S29. Available at: www.guttmacher.org/pubs/journals/25s1799.html.

Moya C. Creating youth-friendly sexual health services in sub-Saharan Africa. *Issues at a Glance*. Washington, DC: Advocates for Youth; 2002. Available at: www.advocatesforyouth.org/publications/iag/youthfriendly.htm.

Murphy EM. *Promoting Healthy Behavior*. Washington, DC: Population Reference Bureau; 2005. Health Bulletin, No. 2. Available at: www.prb.org/pdf05/PromotingHealthyBehavior_Eng.pdf.

Murphy E, Steele C. *Client-Provider Interactions in Family Planning Services: Guidance From Research and Program Experience*. Washington, DC: Maximizing Access and Quality Initiative (MAQ); 2000. MAQ Papers, Vol. 1, No. 2. Available at: www.maqweb.org/maqdoc/vol2.pdf.

Newman K, ed. *Guidelines for the Use of the IPPF Charter on Sexual and Reproductive Rights*. London: IPPF; 1997.

Nolan B, Turbat V. *Cost Recovery in Public Health Services in Sub-Saharan Africa. EDI Technical Materials*. Washington, DC: World Bank; 1995. Available at: www-wds.worldbank.org/servlet/WDS_IBank_Servlet?pcont=details&eid=000009265_3961219111943.

Norton M. New evidence on birth spacing: promising findings for improving newborn, infant, child, and maternal health. *International Journal of Gynecology and Obstetrics*. 2005;89:S1–S6. Available at: www.womenshealth-elsevier.com/doc/journals/ijgo_si_89-1/01.pdf.

O'Sullivan GA, Yonkler JA, Morgan W, Merritt AP. *A Field Guide to Designing a Health Communication Strategy*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs; 2003. Available at: www.jhuccp.org/pubs/fg/02/index.shtml.

Palmer N, Mueller DH, Gilson L, Mills L, Haines A. Health financing to promote access in low income settings—how much do we know? *Lancet*. 2004:364(9442):1365–1370.

Piotrow PT, Kincaid DL, Rimon JG II, Rinehart W. *Health Communication: Lessons from Family Planning and Reproductive Health*. Westport, CT: Praeger; 1997.

Poirier MC, Divi RL, Olivero OA, et al. Long-term mitochondrial toxicity in HIV-uninfected infants born to HIV-infected mothers. *Acquired Immune Deficiency Syndrome.* 2003;33(2):175–183.

POLICY Project. *Strengthening Family Planning Policies and Programs in Developing Countries: An Advocacy Toolkit*. Washington, DC: POLICY Project; 2005.

Population Council. *Senegal: Expand Access to Safe Postabortion Care Services in Rural Areas*. New York: Population Council; 2004. FRONTIERS OR Summary, No. 43. Available at: www.popcouncil.org/frontiers/orsummaries/ors43.html.

Population Council. *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health: A Handbook*. New York: Population Council; 1998.

Population Services International (PSI). What is social marketing? *PSI Profile*. 2003;Winter/Spring issue:1–4. Available at: www.psi.org/resources/pubs/what_is_smEN.pdf

Quijada C, Dmytraczenko T, Mensah B. *Ensuring Contraceptive Security Within New Development Assistance Mechanisms*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.; 2004. Available at: www.phrplus.org/Pubs/Tech042_fin.pdf.

Ramchandran D, Gardner R. Coping with crises: how providers can meet reproductive health needs in crisis situations. *Population Reports*. 2005;J(53):1–20. Available at: www.infoforhealth.org/pr/online.shtml#j.

Rao S. *Jordan: Contraceptive Logistics Systems, Review of Accomplishments and Lessons Learned (1997–2000)*. Arlington, VA: Family Planning Logistics Management/John Snow, Inc.; 2000.

Reynolds HW, Liku J, Maggwa NB, et al. *Assessment of Voluntary Counseling and Testing Centers in Kenya: Potential Demand, Acceptability, Readiness, and Feasibility of Integrating Family Planning Services into VCT*. Research Triangle Park, NC: Family Health International; 2003.

Ross J, Hardee K, Mumford E, Eid S. Contraceptive method choice in developing countries. *International Family Planning Perspectives.* 2002;28(1):32–40. Available at: www.guttmacher.org/journals/ifpp.html.

Ross J, Stover J. The Family Planning Program Effort Index: 1999 cycle. *International Family Planning Perspectives.* 2001;27(3):119–129.

Ross J, Stover J. *Trends and Issues Affecting Service Delivery Over the Next Decade*. Washington, DC: The POLICY Project, Futures Group; 2004. Available at www.futuresgroup.com/abstract.cfm/3327.

Ross J, Stover J, Adelaja D. *Profiles for Family Planning and Reproductive Health Programs in 116 Countries*. 2nd ed. Glastonbury: Futures Group; 2005.

Rudy S, Tabbutt-Henry J, Schaefer L, McQuide PA. Improving client-provider interaction. *Population Reports*. 2003;Q(1):1–24. Available at: www.infoforhealth.org/pr/online.shtml.

Rutstein SO. Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the demographic and health surveys. *International Journal of Gynecology and Obstetrics*. 2005;89:S7–S24. Available at: www.womenshealth-elsevier.com/doc/journals/ijgo_si_89-1/02.pdf.

Sarley D, Thompson D, Dickens T, Rao R, Hudgins T. *Promoting Security through Innovative Health Security Interventions*. Arlington, VA: John Snow, Inc./DELIVER; 2005. Available at: http://portalprd1.jsi.com/portal/page?_pageid=93,3144386,93_3144425&_dad=portal&_schema=PORTAL&p_tab_url=DEL_PUBLICATIONS_TAB&p_le_render_type=LE_PUB&p_le_pg_name=DEL_POLICY_PAPER_PG1&p_stype=148E824DB280F1E86FC0DA9D86276107.

Senderowitz J. *Making Reproductive Health Services Youth Friendly*. Washington, DC: FOCUS on Young Adults; 1999. Research, Program and Policy Series. Available at: http://pf.convio.com/pf/pubs/focus/RPPS-Papers/makingyouthfriendly.PDF.

Setty, V. Organizing work better. *Population Reports.* 2004;Q(2):1–20. Available at: www.infoforhealth.org/pr/online.shtml.

Setty-Venugopal V, Jacoby R, Hart C. Strengthening the supply chain. *Population Reports.* 2002;J(51):1–24. Available at: www.infoforhealth.org/pr/online.shtml.

Sharma RR. *An Introduction to Advocacy: Training Guide*. Washington, DC : Support for Analysis and Research in Africa (SARA) Project, Academy for Educational Development; (no date). Available at: www.dec.org/pdf_docs/PNABZ919.pdf.

Sharma S, Dayaratna V. *Creating Conditions for Greater Private Sector Participation in FP/RH: Benefits for Contraceptive Security*. Washington, DC: POLICY Project/Futures Group International; 2004. Policy Issues in Planning & Finance, No. 4. Available at: www.policyproject.com/pubs/policyissues/PF4_Eng.pdf.

Shelton J. *Contraception for Women on First-Line Antiretrovirals (ARVs)*. Washington, DC: USAID; 2005. Global Health Technical Briefs. Available at: www.maqweb.org/techbriefs/tb5arv.pdf.

Shelton JD, Angle MA, Jacobstein RA. Medical barriers to access to family planning. *Lancet*. 1992;340:1334–1335.

Shelton JD, Peterson EA. The imperative for family planning in ART in Africa. *Lancet*. 2004;364:1916–1918.

Shiffman J. Political management in the Indonesia family planning program. *International Family Planning Perspectives*. 2004;30(1):27–33. Available at: www.guttmacher.org/journals/ifpp.html.

Shittu O, Ifenne DI, Hord C. A hospital in Nigeria reinvents its reproductive health care system. In: Haberland N, Measham D, eds. *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*. New York: Population Council; 2002:223–235.

Sinding SW. Keeping sexual and reproductive health at the forefront of global efforts to reduce poverty. *Studies in Family Planning.* 2005;36(2):140–143.

Sine J, Sharma S. *Policy Aspects of Achieving Contraceptive Security*. Washington, DC: POLICY Project/Futures Group International; 2002. Policy Issues in Planning & Finance, No. 1. Available at: www.policyproject.com/pubs/policyissues/PF4English.pdf.

Singh S, Darroch JE, Vlassof M, Nadeau J. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*. New York: The Alan Guttmacher Institute/UNFPA; 2003. Available at: www.guttmacher.org/pubs/covers/addingitup.html.

Smith E. *Social Franchising Reproductive Health Services. Can It Work? A Review of the Experience*. London: Marie Stopes; 2002. Marie Stopes International Working Paper, No. 5. Available at: www.mariestopes.org.uk/pdf/working-paper-no5-social.pdf.

Solo J, Jacobstein R, Malema D. *Repositioning Family Planning—Malawi Case Study: Choice, Not Chance*. New York: The ACQUIRE Project/EngenderHealth; 2005. Available at: www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Malawi_case_study.pdf.

State Family Planning Commission of China (SFPC), UNFPA, and PATH. *Face-to-Face: Training Family Planning Counselors in China*. Beijing: SFPC; 1995.

Stinson W, Bakamjian L, Huber SC, Silimperi D. *Managing Programs to Maximize Access and Quality: Lessons Learned from the Field*. Washington, DC: Maximizing Access and Quality Initiative (MAQ); 2000. MAQ Paper Vol. 1, No. 3. Available at: www.maqweb.org/maqdoc/vol3.pdf.

Stover J, Fuchs N, Halperin D, Gibbons A, Gillespie D. Adding family planning to PMTCT sites increases the benefits of PMTCT [brief]. Washington DC: USAID;

2004. Available at: www.usaid.gov/our_work/global_health/pop/publications/docs/familypmtct.html.

Sweat MD, O'Reilly KR, Schmid GP, Denison J, de Zoysa I. Cost-effectiveness of nevirapine to prevent mother-to-child HIV transmission in eight African countries. *AIDS*. 2004;18(12):1661–1671.

United Nations (UN). *Key Actions for the Further Implementation of the Programme of Action of the ICPD — ICPD+5*. New York: UN; 1999. Available at: www.unfpa.org/icpd/icpd5.htm.

UN. Programme of Action of the International Conference on Population and Development, Cairo, Egypt, September 5–13, 1994. In: *Report of the International Conference on Population and Development*. New York: UN; 1995. Available at: www.unfpa.org/icpd/icpd_poa.htm.

UN Department of Economic and Social Affairs (UN DESA). *World Contraceptive Use 2003* [wallchart]. New York: UN; 2004. Available at: www.un.org/esa/population/publications/contraceptive2003/WallChart_CP2003.pdf.

UN Millenium Project. *Investing in Development: A Practical Plan to Achieve the Millenium Development Goals. Overview*. New York: United Nations Development Programme; 2005[a]. Available at: www.unmillenniumproject.org/reports/.

UN Millennium Project. *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*. New York: United Nations Development Programme; 2006.

UN Millenium Project. *Who's Got the Power? Transforming Health Systems for Women and Children*. Summary Report of the UN Millenium Project's Task Force on Child Health and Maternal Health. New York: United Nations Development Programme; 2005[b]. Available at: www.unmillenniumproject.org/reports/reports2.htm.

United Nations Population Fund (UNFPA). *Reducing Poverty and Achieving the Millennium Development Goals: Arguments for Investing in Reproductive Health & Rights*. New York: UNFPA; 2005[a]. Available at: www.unfpa.org/publications/detail.cfm?ID=243.

UNFPA. *Reproductive Health Commodity Security: Partnerships for Change. A Global Call to Action*. New York: UNFPA; 2001[a]. Available at: www.unfpa.org/publications/detail.cfm?ID=207&filterListType=.

UNFPA. *Reproductive Health Commodity Security: Partnerships for Change. The UNFPA Strategy*. New York: UNFPA, 2001[b]. Available at: www.unfpa.org/publications/detail.cfm?ID=86&filterListType=.

UNFPA. *Reproductive Health Essentials: Securing the Supply*. New York: UNFPA; 2001[c]. Available at: www.unfpa.org/publications/detail.cfm?ID=27&filterListType=.

UNFPA. *State of World Population 2003. Making 1 Billion Count: Investing in Adolescents' Health and Rights*. New York: UNFPA; 2003. Available at: www.unfpa.org/publications/index.cfm?filterPub_Type=5.

UNFPA. *State of World Population 2004. The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty*. New York: UNFPA; 2004. Available at: www.unfpa.org/publications/index.cfm?filterPub_Type=5.

UNFPA. *State of World Population 2005. The Promise of Equality: Gender Equity, Reproductive Health & the Millennium Development Goals*. New York: UNFPA; 2005[b]. Available at: www.unfpa.org/swp/swpmain.htm.

UNFPA, Joint United Nations Programme on HIV/AIDS (UNAIDS), and Family Care International (FCI). *The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health*. New York: UN; 2004. Available at: www.unfpa.org/publications/detail.cfm?ID=195&filterListType=4.

UNFPA, World Health Organization (WHO), and PATH. *Condom Programming for HIV Prevention: A Manual for Service Providers*. New York: UNFPA/WHO/PATH; 2005.

United States Agency for International Development (USAID). *Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs*. Washington, DC: USAID; 2003. Available at: www.usaid.gov/our_work/global_health/pop/publications/docs/fphiv.pdf.

USAID Interagency Gender Working Group (IGWG) and World Health Organization (WHO) Department of Gender, Women and Health. *A Summary of the "So What?" Report: A Look at Whether Integrating a Gender Focus into Programmes Makes a Difference to Outcomes*. Geneva: IGWG/WHO; 2005. Available at: www.prb.org/pdf05/So_What_Report_A_Look_at_Whether_Integrating_a_Gender_Focus.pdf.

Upadhyay UD. Informed choice in family planning: helping people decide. *Population Reports*. 2001;J(50):1–40. Available at: www.infoforhealth.org/pr/online.shtml.

van Kampen, J. *Dealing with Advocacy: A Practical Guide.* Hanover, Germany: RHI ComNet, EC/UNFPA Initiative for Reproductive Health in Asia (no date). Available at: www.asia-initiative.org/pdfs/advocacy_guide.pdf.

Vernon R, Foreit J. How to help clients obtain more reproductive health care. *International Family Planning Perspectives*. 1999;25(4):200–202. Available at: www.guttmacher.org/journals/ifpp.html.

Vietnam Center for Population Studies and Information and The Futures Group International (VCPSI). *Vietnam's Population and Family Planning Investments and Savings (1979–2010)*. Hanoi: The National Committee for Population and Family Planning and The Futures Group International; 1997.

Vogel CG, Vail J, Woodle D. *Issue Profiles: Lessons Learned from Five Countries*. Washington, DC: Interim Working Group on Reproductive Health Commodity Security (IWG); 2001. Meeting the Challenge: Securing Contraceptive Supplies series. Available at: www.populationaction.org/resources/publications/commodities/PDFs/PAI_07_Eng.pdf.

Walley J. The implementation of integrated mother and child health and family planning services. *Tropical Doctor*. 1997;27(2):69–72.

Waters H. *Reaching the Poor With Effective Health, Nutrition, and Population Services. What Works, What Doesn't, and Why?* Baltimore, MD: Johns Hopkins Bloomberg School of Public Health; 2004. Available at: www1.worldbank.org/prem/poverty/health/rpp/files/remarks_waters.pdf.

Wells E. Involving men in reproductive health. *Outlook*. 1997;14(3):1–7. Available at: www.path.org/publications/pub.php?id=363.

Winikoff B, Mensch B, Measham D. Postpartum care and family planning services. In: *Reproductive Health Approach to Family Planning*. New York: Population Council; 1994:52–68. Available at: www.popcouncil.org/pdfs/ebert/rephapproachfamplanning.pdf.

World Bank. *World Development Report 2004: Making Services Work for Poor People*. Washington, DC: World Bank; 2003. Available at: http://web.worldbank.org/external/default/main?menuPK=477704&pagePK=64167702&piPK=64167676&theSitePK=477688.

World Health Organization (WHO). Burden of disease in disability-adjusted life years (DALYs) by cause, sex and mortality stratum in WHO Regions, 2001. GBD 2001 Estimates by Sub-Region page. WHO website. Available at: www3.who.int/whosis/menu.cfm?path=evidence,burden,burden_estimates,burden_estimates_2001,burden_estimates_2001_subregion&language=english. Accessed May 15, 2006.

WHO. *Guidelines for the Management of Sexually Transmitted Infections*. Geneva: WHO; 2003. Available at: www.who.int/reproductive-health/publications/rhr_01_10_mngt_stis/.

WHO. *Make Every Mother and Child Count. World Health Report 2005*. Geneva: WHO; 2005[a]. Available at: www.who.int/whr/2005/en/.

WHO. *Making Decisions about Contraceptive Introduction: A Guide for Conducting Assessments to Broaden Contraceptive Choice and Improve Quality of Care*. Geneva: WHO; 2002. Available at: www.who.int/reproductive-health/publications/rhr_02_11_contraceptive_introduction/.

WHO. *Medical Eligibility Criteria for Contraceptive Use*. 3rd ed. Geneva: WHO; 2004. Available at: www.who.int/reproductive-health/publications/mec/.

WHO. *Model List of Essential Medicines*. 14th ed. Geneva: WHO: 2005[c]. Available at: www.who.int/medicines/publications/essentialmedicines/en/index.html.

WHO. *Sexually Transmitted and Other Reproductive Tract Infections—A Guide to Essential Practice*. Geneva: WHO; 2005[b]. Available at: www.who.int/reproductive-health/publications/rtis_gep/.

WHO Department of Reproductive Health and Research (RHR). *Exploring Common Ground: STI and FP Activities*. Geneva: WHO; 2001. Available at: www.who.int/reproductive-health/publications/RHR_01_20/index.html.

WHO RHR. *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets*. Geneva: WHO: 2004. Available at www.who.int/reproductive-health/publications/strategy.pdf.

WHO Division of Family Health. *Health Benefits of Family Planning*. Geneva: WHO; 1994.

WHO and Special Programme of Research, Development and Research Training in Human Reproduction (HRP). WHO statement on carcinogenicity of combined hormonal contraceptives and combined menopausal treatment. Geneva: WHO and HRP; 2005[b]. Available at: www.who.int/reproductive-health/family_planning/docs/cocs_hrt_statement.pdf.

WHO and HRP. WHO statement on hormonal contraception and bone health. Geneva: WHO/HRP; 2005[a]. Available at: www.who.int/reproductive-health/family_planning/bone_health.html.

WHO and HRP. WHO statement on hormonal contraception and risk of HIV acquisition. Geneva: WHO/HRP; 2005[c]. Available at: www.who.int/reproductive-health/family_planning/docs/hormonal_contraception_sti_acquisition.pdf.

WHO and International Pharmaceutical Federation (FIP). The role of the pharmacist in the fight against the HIV-AIDS pandemic. The Hague: FIP; 1997. Available at: www.fip.org/pdf/aidseng.pdf.

WHO RHR and INFO Project at the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU CCP). *Decision-Making Tool for Family Planning Clients and Providers* [PowerPoint presentation]. Geneva: WHO and Baltimore: JHU CCP; 2005. Available at: www.who.int/reproductive-health/family_planning/tool.html.

WHO, UNFPA, UNAIDS, and IPPF. *Sexual and Reproductive Health & HIV/AIDS: A Framework for Priority Linkages*. Geneva, New York, and London: WHO, UNFPA, UNAIDS, and IPPF; 2005. Available at: www.unfpa.org/publications/detail.cfm?ID=250&filterListType.

WHO, UNFPA, and United Nations High Commissioner for Refugees (UNHCR). *Reproductive Health in Refugee Situations: An Interagency Field Manual*. Geneva: UNHCR; 1999. Available at: www.unfpa.org/emergencies/manual/.

WHO, UNFPA, and UNICEF Study Group of Programming for Adolescent Health. *Programming for Adolescent Health and Development*. Geneva: WHO; 1999. WHO Technical Report Series, No. 886. Available at: www.who.int/child-adolescent-health/publications/publist.htm.

WHO and UNHCR. *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons, Revised Edition*. Geneva: WHO; 2005. Available at: www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/.

Zhu B-P. Effect of interpregnancy interval on birth outcomes: findings from three recent US studies. *International Journal of Gynecology and Obstetrics*. 2005;89:S25–S33. Available at: http://www.womenshealth-elsevier.com/doc/journals/ijgo_si_89-1/03.pdf.

Additional resources

Following is a compilation of practical tools, handbooks, and other resources that can help program managers ensure that services are accessible, available, affordable, and of good quality.

1 Health sector reform and the MDGs

Management Sciences for Health. Reforming Health Systems and Programs section. The Manager's Electronic Resource Center website. Available at: http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=health&language=English. Accessed February 23, 2006.

United Nations Development Group. *Millennium Development Goals Toolkit*. Available online only at: http://mdgtoolkit.undg.org/. Accessed February 23, 2006.

2 Advocacy

Manuals

Aradeon SB. *Advocacy for Population and Reproductive Health: A Introductory Manual for Advocates and Trainers, Part 1: Preparing the Ground Work*. New York: UNFPA; 2000. Available at: www.un.org/popin/regional/asiapac/fiji/advocacy.htm.

Center for Development and Population Activities (CEDPA). *Advocacy: Building Skills for NGO Leaders*. Washington, DC: CEDPA; 1999. CEDPA Training Manual Series, Vol. IX. Available at: www.cedpa.org/publications/pdf/advocacy.htm.

International Planned Parenthood Federation (IPPF). *Advocacy Guide for Sexual and Reproductive Health and Rights*. London: IPPF; 2001.

POLICY Project. *Networking for Change: An Advocacy Training Manual*. Washington, DC: The Futures Group, 1999. Available at: www.policyproject.com/pubs/AdvocacyManual.pdf.

Sharma RR. *An Introduction to Advocacy: Training Guide*. Washington, DC: Support for Analysis and Research in Africa (SARA) Project, Academy for Educational Development; (no date). Available at: www.dec.org/pdf_docs/PNABZ919.pdf. Accessed February 23, 2006.

Sprechmann S, Pelton E. *Advocacy Tools and Guidelines*. Atlanta: CARE; 2001. Available at: www.careusa.org/getinvolved/advocacy/tools.asp.

van Kampen, J. *Dealing with Advocacy: A Practical Guide*. Hanover, Germany: RHI ComNet, EC/UNFPA Initiative for Reproductive Health in Asia; (no date). Available at: www.asia-initiative.org/pdfs/advocacy_guide.pdf. Accessed February 23, 2006.

Materials

Daulaire N, Leidl P, Mackin L, Murphy C, Stark L. *Promises to Keep: The Toll of Unintended Pregnancies on Women's Lives in the Developing World*. Washington, DC: Global Health Council; 2002. Available at: www.global-health.org/assets/publications/PromisesToKeep.pdf.

POLICY Project. *Strengthening Family Planning Policies and Programs in Developing Countries: An Advocacy Toolkit*. Washington, DC: POLICY Project; 2005.

Population Action International. How access to sexual & reproductive health services is key to the MDGs [factsheet 31]. Washington, DC: Population Action International; 2005. Available at: www.populationaction.org/resources/factsheets/factsheet_31.htm.

Ross J, Stover J, Adelaja D. *Profiles for Family Planning and Reproductive Health Programs in 116 Countries*. 2nd ed. Glastonbury: Futures Group; 2005.

Singh S, Darroch JE, Vlassof M, Nadeau J. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*. New York: The Alan Guttmacher Institute/UNFPA; 2003. Available at: www.guttmacher.org/pubs/covers/addingitup.html.

United Nations Development Group. *MDG Toolkit, Module 4: Advocacy and Campaigning* [series of professional development tools and materials]. Available at: http://mdgtoolkit.undg.org/course/view.php?id=30. Accessed February 24, 2006.

United Nations Development Programme (UNDP). *The Blue Book: A Hands-on Approach to Advocating for the Millennium Development Goals*. New York: UNDP; 2004. Available at: www.un-ngls.org/MDG/blue-book.pdf.

United Nations Population Fund (UNFPA). *Reducing Poverty and Achieving the Millennium Development Goals: Arguments for Investing in Reproductive Health & Rights*. New York: UNFPA; 2005[a]. Available at: www.unfpa.org/publications/detail.cfm?ID=243.

Upadhyay UD, Robey B. Why family planning matters. *Population Reports*. 1999;J(49):1–32. Available at: www.infoforhealth.org/pr/online.shtml.

World Health Organization (WHO). *Communicating Family Planning in Reproductive Health: Key Messages for Communicators*. Geneva: WHO; 1997. Available at: www.who.int/reproductive-health/publications/fpp_97_33/fpp_97_33_abstract.en.html.

Informational websites

Center for Reproductive Rights: www.crlp.org

PLANetWIRE: www.planetwire.org

Population Action International: www.populationaction.org

Population Reference Bureau: www.phishare.org

UNFPA: www.unfpa.org/issues/index.htm

WHO: www.who.int/reproductive-health/family_planning/index.html

3 Integrated services

Management Sciences for Health. Managing integrated services. *The Manager*. 1994;3(3). Available at: http://erc.msh.org/mainpage.cfm?file=2.2.5.htm&module=health&language=English. Accessed February 27, 2006.

United States Agency for International Development (USAID). *Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs*. Washington, DC: USAID; 2003. Available at: www.usaid.gov/our_work/global_health/pop/publications/docs/fphiv.pdf.

Gender

International Planned Parenthood Federation (IPPF). *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. London: IPPF; 2004. Available at: www.ippfwhr.org/publications/publication_detail_e.asp?PubID=63.

IPPF/Western Hemisphere Region. *Gender-based Violence: Guidelines and Tools for Managers and Providers*. Available at: www.ippfwhr.org/publications/publications_by_topic_e.asp?CategoryID=5&CategoryName=violence.

South African AIDS Trust (SAT). *Counselling Guidelines on Domestic Violence*. Harare: SAT and Canadian International Development Agency (CIDA); 2004. HIV Counselling Series, No. 4. Available at: www.satregional.org/attachments/Publications/Skills percent20Training percent20E/Domestic percent20Violence.pdf.

United Nations Population Fund (UNFPA). *A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers*. New York: UNFPA; 2001. Available at: www.unfpa.org/publications/detail.cfm?ID=69&filterListType=.

USAID Interagency Gender Working Group (IGWG) and World Health Organization (WHO) Department of

Gender, Women and Health. *A Summary of the "So What?" Report: A Look at Whether Integrating a Gender Focus into Programmes Makes a Difference to Outcomes*. Geneva: IGWG/WHO; 2005. Available at: www.prb.org/pdf05/So_What_Report_A_Look_at_Whether_Integrating_a_Gender_Focus.pdf.

Postabortion care

Herrick J, Turner K, McInerney T, Castleman L. *Woman-centered Postabortion Care: Reference Manual*. Chapel Hill, NC: Ipas; 2004.

HIV/STIs

Eldis. *HIV and AIDS Resource Guide to Sexual and Reproductive Health: The Relationship with HIV and AIDS*. Available online only at: www.eldis.org/hivaids/sexualreprohealth.htm.

EngenderHealth. *Sexually Transmitted Infections and HIV and AIDS* [online minicourses]. Available online only at: www.engenderhealth.org/res/onc/index.html.

International Planned Parenthood Federation (IPPF) South Asia Regional Office and United Nations Population Fund. *Integrating HIV Voluntary Counseling and Testing Services into Reproductive Health Settings: Stepwise Guidelines for Programme Planners, Managers and Service Providers*. New York:UNFPA; 2004. Available at: www.unfpa.org/upload/lib_pub_file/245_filename_hiv_publication.pdf.

IPPF/Western Hemisphere Region (WHR). *Have You Integrated STI/HIV Prevention into your Sexual and Reproductive Health Services?* [checklist]. New York: IPPF/WHR; 2002. Available at: www.ippfwhr.org/publications/publication_detail_e.asp?PubID=39.

Morrison C, Best K. *Hormonal Contraception and HIV: An Update*. Research Triangle Park, NC: Family Health International; 2004. Available at: www.fhi.org/en/RH/Pubs/booksReports/hcandhiv.htm.

Vail J, Nguyen T, Sherris J, Wittet S. *A Tool to Assess Program Capacity: Adding Services to Manage Reproductive Tract Infections*. Seattle: PATH; 1999. Reproductive Health Reports, No. 3.

World Health Organization. *Guidelines for the Management of Sexually Transmitted Infections*. Geneva: WHO; 2003. Available at: www.who.int/reproductive-health/publications/rhr_01_10_mngt_stis/.

WHO. *Sexually Transmitted and Other Reproductive Tract Infections—A Guide to Essential Practice*. Geneva: WHO; 2005. Available at: www.who.int/reproductive-health/publications/rtis_gep/.

4 Contraceptive security

Management Sciences for Health. Managing Drugs and Supplies section. The Manager's Electronic Resource Center website. Available at: http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=drugs&language=English. Accessed February 23, 2006.

World Health Organization (WHO) and United Nations Population Fund (UNFPA). *Essential Drugs and Other Commodities for Reproductive Health Services* [draft discussion document]. Geneva: WHO; 2003. Available at: www.who.int/reproductive-health/publications/essential_drugs/text.pdf.

Guidance and management tools

DELIVER: http://deliver.jsi.com

The Supply Initiative: www.rhsupplies.org/

Hare L, Hart C, Scribner S, Shepherd C, Pandit T (ed.), Bornbusch A (ed.). *SPARHCS: Strategic Pathway to Reproductive Health Commodity Security. A Tool for Assessment, Planning, and Implementation*. Baltimore, MD: INFO Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health; 2004. Available at: www.rhsupplies.org/resources/doc/SPARHCS_publication.pdf.

United Nations Population Fund (UNFPA). Tools to help countries manage their own supplies page. UNFPA website. Available at: www.unfpa.org/supplies/tools.htm.

5 Quality of care

EngenderHealth. *COPE® Handbook: A Process for Improving Quality in Health Services, Revised Edition*. New York: EngenderHealth; 2003. Available at: www.engenderhealth.org/res/offc/qi/cope/handbook/index.html.

Management Sciences for Health. Managing for Quality section. The Manager's Electronic Resource Center website. Available at: http://erc.msh.org/quality/. Accessed February 24, 2006.

Management Sciences for Health. Managing Quality & Clinical Services section. The Manager's Electronic Resource Center website. Available at: http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=quality&language=English. Accessed February 24, 2006.

Pathfinder International. Comprehensive Reproductive Health and Family Planning Training Curriculum [series of training modules]. Available at: www.pathfind.org/

site/PageServer?pagename=Publications_Training_and_Capacity_Building_CRHFP. Accessed February 24, 2006.

Population Council. *Quality/Calidad/Qualité* [quarterly publication series]. Available at: www.populationcouncil.org/publications/qcq/default.htm. Accessed February 24, 2006.

PRIME II and JHPIEGO Corporation. *Transfer of Learning: A Guide for Strengthening the Performance of Health Care Workers*. Chapel Hill, NC: PRIME II; 2002.

Reerink L, Campbell B. *Improving Reproductive Health Care Within the Context of District Health Services: A Hands-on Manual for Planners and Managers*. Amsterdam: Royal Tropical Institute; 2004. Available at: www.kit.nl/publishers/assets/images/bw._SRH_Final.pdf.

6 Informed choice and contraceptive counseling

International Consortium for Emergency Contraception: www.cecinfo.org/

EngenderHealth. *Choices in Family Planning: Informed and Voluntary Decision Making*. New York: EngenderHealth; 2003. Available at: www.engenderhealth.org/res/offc/ic/choices/.

EngenderHealth. *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*. New York: EngenderHealth; 2003. Available at: www.engenderhealth.org/res/offc/counsel/ccrh/index.html.

Family Health International (FHI). *FHI's Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use*. Research Triangle Park, NC: FHI; 2004. Available at: www.fhi.org/NR/rdonlyres/eozy2edy6g34hjicrq3qesqgo6yhrkxfv4wdmnvdt7v4lhnfgro7f5tjpbdt6m4qaypo7fa4hj7kfp/EnglishMECFINAL1.pdf.

FHI. *Provider Checklists for Reproductive Health Services: Reference Guide*. Research Triangle Park, NC: FHI; 2002. Available at: www.fhi.org/en/RH/Pubs/servdelivery/checklists/index.htm.

PATH. *Resources for Emergency Contraceptive Pill Programming: A Toolkit*. Seattle: PATH; 2004. Available at: www.path.org/publications/pub.php?id=828.

World Health Organization (WHO). *Making Decisions about Contraceptive Introduction: A Guide for Conducting Assessments to Broaden Contraceptive Choice and Improve Quality of Care*. Geneva: WHO; 2002. Available at: www.who.int/reproductive-health/publications/rhr_02_11_contraceptive_introduction/.

WHO. *Medical Eligibility Criteria for Contraceptive Use*. 3rd ed. Geneva: WHO; 2004. Available at: www.who.int/reproductive-health/publications/mec/.

WHO. *Selected Practice Recommendations for Contraceptive Use*. 2nd ed. Geneva: WHO; 2004. Available at: www.who.int/reproductive-health/publications/spr/index.htm.

WHO Department of Reproductive Health Research (RHR) and INFO Project at the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU CCP). *Decision-Making Tool for Family Planning Clients and Providers* [PowerPoint presentation]. Geneva: WHO and Baltimore: JHU CCP; 2005. Available at: www.who.int/reproductive-health/family_planning/tool.html.

7 Overcoming barriers to reach under-served groups

Adolescents

EngenderHealth. *Youth-Friendly Services: A Manual for Service Providers*. New York: EngenderHealth; 2002. Available at: www.engenderhealth.org/res/offc/qi/yfs/index.html.

Family Health International (FHI). *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents*. Arlington, VA: FHI; 2000. Available at: www.fhi.org/en/RH/Pubs/servdelivery/adolguide/index.htm.

Senderowitz J, Solter C, Hainsworth G. *Clinic Assessment of Youth-Friendly Services: A Tool for Improving Reproductive Health Services for Youth*. Watertown, MA: Pathfinder International; 2003. Available at: www.pathfind.org/site/DocServer/mergedYFStool.pdf?docID=521.

WHO, UNFPA, and UNICEF Study Group of Programming for Adolescent Health. *Programming for Adolescent Health and Development*. Geneva: WHO; 1999. WHO Technical Report Series, No. 886. Available at: www.who.int/child-adolescent-health/publications/publist.htm.

Refugees

CARE. *Moving from Emergency Response to Comprehensive Reproductive Health Programs. A Modular Training Series*.

Washington, DC: CARE; 2002. Available at: www.rhrc.org/pdf/FinManual.pdf.

Dixon G. *Contraceptive Logistics Guidelines for Refugee Settings*. Arlington, VA: Family Planning Logistics Management Project; 1999. Available at: www.jsi.com/JSIInternet/Publications/familyplanning.cfm.

Reproductive Health Response in Conflict (RHRC) Consortium. *Field Tools/Guidelines* [collection of documents]. Available at: www.rhrc.org/resources/index.cfm?type=guideline.

World Health Organization (WHO), United Nations Population Fund (UNFPA), and United Nations High Commissioner for Refugees (UNHCR). *Reproductive Health in Refugee Situations: An Interagency Field Manual*. Geneva: UNHCR; 1999. Available at: www.unfpa.org/emergencies/manual/.

Men

EngenderHealth. *Men's Reproductive Health Curriculum*. New York: EngenderHealth; 2003. Available at: www.engenderhealth.org/res/offc/map/mrhc/index.html.

EngenderHealth. Men's reproductive health services model page. EngenderHealth website. Available at: www.engenderhealth.org/ia/wwm/emrhm0.html. Accessed February 24, 2006.

EngenderHealth. *Programming for Male Involvement in Reproductive Health: A Practical Guide for Managers*. New York: EngenderHealth; 1997. Available at: www.engenderhealth.org/ia/wwm/wwmpfmirh.html.

8 Behavior change communication

AIDSCAP. *How to Create an Effective Communication Project*. Research Triangle Park, NC: Family Health International; (no date). Available at: www.fhi.org/en/HIVAIDS/pub/guide/BCC+Handbooks/effectivecommunication.htm.

O'Sullivan GA, Yonkler JA, Morgan W, Merritt AP. *A Field Guide to Designing a Health Communication Strategy*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs; 2003. Available at: www.jhuccp.org/pubs/fg/02/index.shtml.

World Health Organization (WHO). *Communicating Family Planning in Reproductive Health: Key Messages for Communicators*. Geneva: WHO; 1997. Available at: www.who.int/reproductive-health/publications/fpp_97_33/fpp_97_33_abstract.en.html.

9 Lowering economic barriers

Day LM. *Designing a Family Planning User Fee System: A Handbook for Program Managers*. Boston: John Snow International/SEATS; 1993. Available at: http://seats.jsi.com/publications/pub21_24.html.

Management Sciences for Health. Charging fees for family planning services. *The Manager*. Available at: http://erc.msh.org/mainpage.cfm?file=2.1.3.htm&module=finance&language=English. Accessed February 24, 2006.

10 Sustainability

Janowitz B, Bratt JH. *Methods for Costing Family Planning Services*. New York: UNFPA and Family Health International; 1994. Available at: www.popcouncil.org/pdfs/frontiers/Capacity_Bldg/unpf0050.pdf.

Management Sciences for Health. Using cost and revenue analysis tools. *The Manager*. 1993;2(1). Available at: http://erc.msh.org/mainpage.cfm?file=2.1.1.htm&module=finance&language=English. Accessed February 27, 2006.

Management Sciences for Health. *Financial Sustainability* [collection of documents and tools]. Available at: http://erc.msh.org/mainpage.cfm?file=2.1.0.htm&module=Finance&language=English. Accessed February 24, 2006.

Management Sciences for Health. Keeping Your Organization Sustainable section. The Manager's Electronic Resource Center website. Available at: http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=sustain&language=English. Accessed February 24, 2006.

United Nations Millennium Project. *MDG Needs Assessments: Excel Tools and User Guides for Maternal & Reproductive Health* [collection of documents]. Available at: www.unmillenniumproject.org/policy/needs03.htm.

Photos

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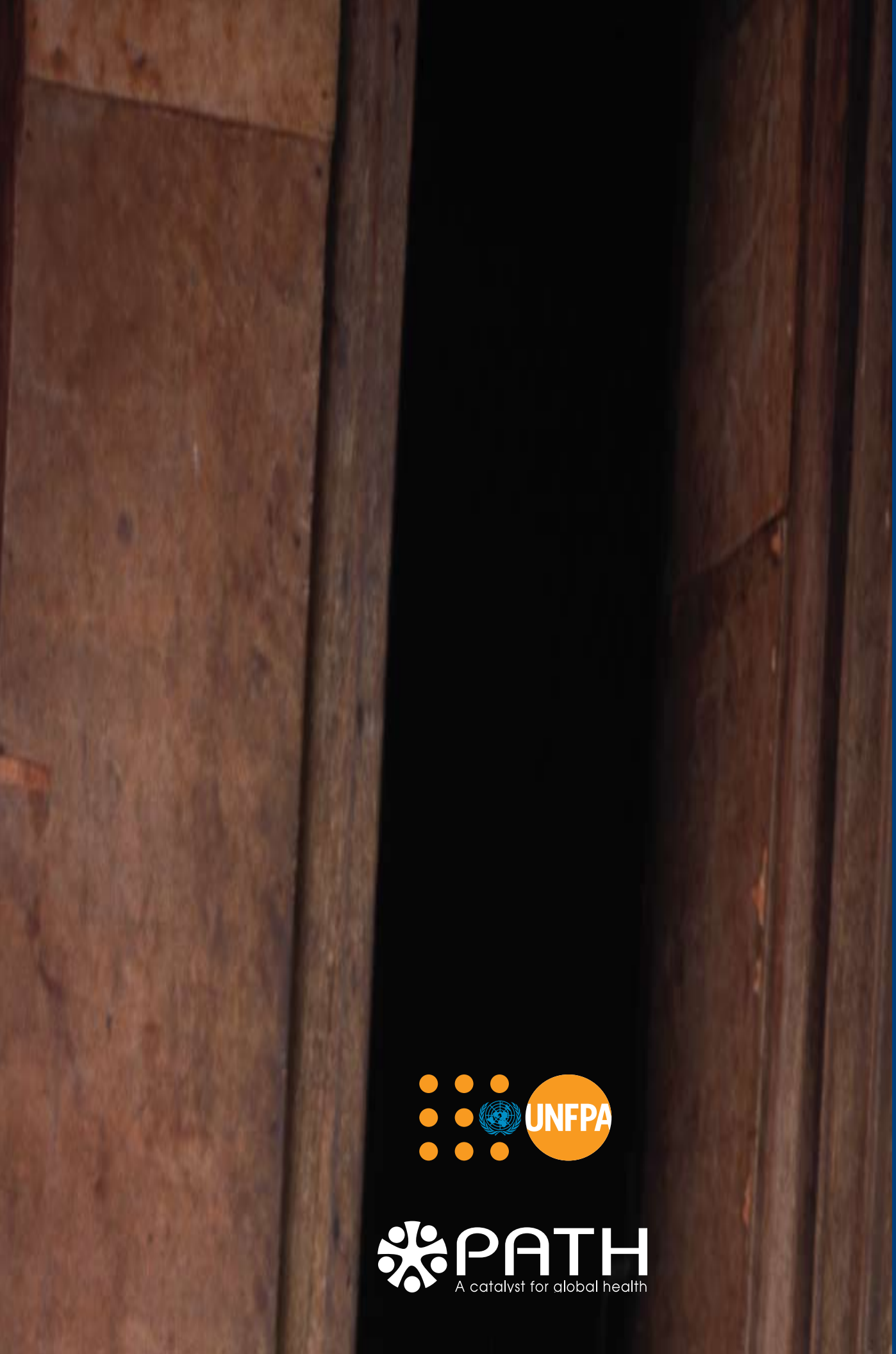

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