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INFO Project
Center for Communication Programs

Elements of Success in Family Planning Programming

How family planning professionals can improve programs by applying 10 important elements

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Key Points

The overarching strategy of family planning programs is to offer clients easy access to a wide range of affordable contraceptive methods through multiple service delivery channels in a good-quality, reliable fashion. What do program managers do to work toward success?

Make services accessible. Offering services through a variety of delivery points makes methods available to more potential users.

Make services affordable. Partnerships between public- and private-sector services encourage clients to pay what they can while public programs serve the poor for free or for low fees.

Offer client-centered care. Planning and providing services with the clients in mind help to make sure their needs are met and their preferences are honored.

Rely on evidence-based technical guidance. Up-to-date service delivery guidelines, tools, and job aids can help translate research findings into better practice.

Communicate effectively. Communication grounded in behavior theory and sensitive to local norms motivates clients to seek services and helps them make good family planning choices.

Assure contraceptive security. A strong logistics system and a long-term plan for contraceptive security ensure that a variety of methods, and the supplies and equipment to provide them, are always available.

Work for supportive policies. Showing how family planning contributes to development goals makes the case for continued support for family planning programs.

Coordinate. When governments, donor agencies, and implementing partners work together, they streamline efforts and avoid duplication.

Build a high-performing staff. Programs can keep workers motivated and on the job by creating a good working environment, matching skills with tasks, and rewarding a job well done.

Secure adequate budget, use it well. Spending wisely, doing more with less, and finding ways to recover costs can help ensure financial sustainability.

Base decisions on evidence. Research, monitoring, and evaluation yield important information to guide decision-making, and they need not be expensive.

Lead strongly, manage well. Strong leadership helps programs navigate change. Good management solves operational problems.

Integrate services appropriately. Programs can address a wider range of health needs by integrating services where appropriate and offering referrals where it is not.

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Family Planning Programs

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Join colleagues around the world in the "Elements of Family Planning Success" Online Community at www.fpsuccess.org

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Cover Photo: Over the past five decades, family planning programs have improved the lives of millions of individuals by helping them choose whether and when to have children. In the Mindanao island of the Philippines, a family stands in front of the Canlib bakery.

Working Toward Success

To help them better their own lives, people the world over want control over whether and when they have children. Many look to family planning services for help. Family planning services are growing. The need for services is growing even faster. To keep up with demand, family planning programs must become more efficient and effective (9).

Family planning program managers and planners can learn from each other's experiences. Sharing knowledge strengthens programs efficiently. Sharing knowledge helps avoid costly, time-consuming trial-and-error. Sharing knowledge helps growing programs to succeed more quickly and successful programs to improve further (see box, below). This issue of *Population Reports* distills the most important lessons learned about 10 crucial elements of successful family planning programs.

Past Success, Future Challenges

The impact of family planning programs over the past five decades is tremendous. Benefits can be seen at the levels of the individual, the family, and the society:

- **Family planning helps individuals and families**. Family planning has improved millions of lives by helping people to decide for themselves whether and when to have children. Longer intervals between births benefit the health of mothers and their children, and smaller families can be more prosperous. These effects continue over time. For example, in the Matlab district of Bangladesh, villages received door-to-door outreach family planning and maternal-child health services from 1977 to 1996. A study found substantial decreases in fertility and child mortality in the villages, as well as positive effects on women's health, earnings and household assets, use of preventive health services, and health and schooling of children (*121*).

- **Family planning saves lives**. By preventing unintended pregnancies and helping to space births, family planning reduces infant, child, and maternal mortality. Estimates from 2003 indicate that programs in the developing world meet the family planning needs of more than 500 million women each year.

Overarching Strategy of Successful Programs

The overarching strategy of successful family planning programs is to make contraceptive methods as accessible as possible to clients in a good-quality, reliable fashion. This includes offering a wide range of affordable contraceptive methods, making services widely accessible through multiple service delivery channels, making sure potential clients know about services, following evidence-based technical guidance that promotes access and quality, and providing client-centered services.

New Online Community Combines Global Evidence and Local Knowledge for Program Success

"Elements of Family Planning Success" is a new knowledge-sharing initiative from the INFO Project of the Johns Hopkins Bloomberg School of Public Health's Center for Communication Programs, with support from USAID. This activity takes a unique approach to help family planning programs succeed, by merging evidence-based information gathered worldwide with local program experiences. The activity constitutes a discussion and exchange of ideas. The exchange takes place through various modes of communication, ranging from print materials, including this issue of *Population Reports*, to the latest social networking tools on the World Wide Web.

The activity has rolled out in stages. In November 2007 some 445 health care professionals in 98 countries responded to an online survey. They identified the top 10 program elements most important to the success of family planning programs. They also indicated which elements are hardest to achieve. In December 2007 a two-week online discussion forum took place through the Implementing Best Practices (IBP) Consortium's online Knowledge Gateway (http://www.ibpinitiative.org) (265). Some 280 health care professionals in 68 countries joined the discussion (*104*).

Then, based on the survey results, the online forum, and a synthesis of existing research, the INFO Project in April 2008 launched an interactive Web site. The site covers the elements of successful family planning programming. It serves as the home base for the virtual community. Members can tailor information to their specific areas of interest, engage in discussions, and network with other family planning professionals around the world.

The activity is designed to take advantage of the interactive potential of new Web-based tools. These tools make possible continual updating and exchange of information. Through features such as blogs and discussion boards, the site enables programmers to share and discover successes, best practices, and lessons learned. For example, the Web site presents audio and video interviews with family planning experts and programmers around the world.

Family planning professionals worldwide are invited to join this virtual community at http://www.fpsuccess.org.

Family Planning: A Cost-Effective Strategy

Donor funding for family planning has decreased in recent years (*124*). Still, global investments in family planning are substantial, and they have a substantial effect. A 2003 analysis calculated that total expenditures for family planning in developing countries amounted to US$7.1 billion. This spending prevented an estimated 187 million unintended pregnancies (*204*). Every dollar invested in preventing unintended pregnancies results in substantial cost savings that can be invested to improve the quality of health care, education, and other social services.

A number of studies measure this relationship. For example, a 1993 analysis estimated that averting one unintended pregnancy in a typical low-fertility Latin American country cost an estimated US$133. At the same time, it saved the government US$1,600 in health and education costs (42). Similarly, a study in Vietnam projected that every dollar invested in family planning between 1979 and 2010 would save about US$8 in health, education, and other social services (247). Similar comparisons can help illustrate to decision-makers the importance of continued investments in family planning.

These programs prevent an estimated 187 million unintended pregnancies each year, including 60 million unplanned births and 105 million abortions. They also avert 2.7 million infant deaths and 215,000 pregnancy-related deaths each year (*204*).

- **Family planning benefits societies**. On a broader level family planning has reduced fertility in developing countries from six to about three births per woman over the past 40 years (*41*). Lower birth rates contribute to slower population growth, which enables social progress (250). This trend, known as the "demographic dividend," occurs when populations of young people are smaller than populations of adults. Fewer investments are needed to meet the needs of the youngest age groups and resources are instead invested in economic development and family welfare (188). The environment benefits, too, from slower growth in demands on natural resources including food supplies and water (23).

Despite these advances, the agenda remains unfinished (*41*). It is estimated that half of all pregnancies are unplanned or unintended (*9*). Many women who want to space or limit births do not currently use contraception—a condition described as "unmet need" (*127*, 139, 250). Some 201 million women in developing countries—about one in seven women of reproductive age—are estimated to have unmet need for contraception (*204*, 211). This number includes many who have discontinued their family

Coordinating Efforts Is Key

In most countries many diverse groups have a stake in family planning and reproductive health initiatives. These stakeholders, including governments, donors, and service delivery and communication organizations, can and should coordinate their efforts. Coordination can help ensure that resources are sufficient, applied where most needed, and used efficiently, with minimal duplication of effort. Strategies to improve coordination vary depending on a country's specific needs, and may include, for example, forming an advisory group, pooling funds, and using centralized information systems.

- **Form an advisory group**. Establishing a central group to plan and oversee initiatives can improve coordination. In Rwanda, for example, donor agencies and the Ministry of Health formed the Family Planning Technical Working Group in 2005 to improve coordination, minimize duplication of effort, and to establish a clear joint action plan (*208*). Similarly, the Ethiopia Country Team of the Implementing Best Practices (IBP) Initiative brings together the Ministry of Health and cooperating agencies working in reproductive health to identify areas of greatest need and to work together to address those needs (103).

- **Combine resources**. Some countries combine resources from various sources, and governments, donors, and other stakeholders together make decisions about where to spend the pooled money. Donors can also improve their coordination. For example, the United Nations (UN) "Delivering as One" pilot initiative began in 2007 to test how consolidating the efforts of various UN agencies at the country level can deliver the range of UN development services in a more coordinated way in Albania, Cape Verde, Mozambique, Pakistan, Rwanda, Tanzania, Uruguay, and Vietnam. The objective of the Delivering as One initiative is to improve the efficiency of UN development efforts and achieve faster progress toward the Millennium Development Goals (241, 242).

- **Use centralized information systems**. Online information systems improve coordination by keeping donors, governments, and programs abreast of each other's activities. For example, to better coordinate procurement of contraceptive supplies, the Web-based system RHInterchange (http://rhi.rhsupplies.org) provides detailed information about shipments of donor-supplied contraceptives and related supplies to countries around the world. Program managers can track the supplies they have ordered from the International Planned Parenthood Federation (IPPF), the United Nations Population Fund (UNFPA), and the U.S. Agency for International Development (USAID), and determine if they will arrive on time and in the correct quantities. This resource helps programs avoid stockouts caused by incomplete orders and shipment errors (*182*).

planning methods and now risk unintended pregnancies. An estimated 1 million of the 11 million infant deaths each year could be averted simply by ensuring that children are born more than two years apart. Similarly, preventing unintended pregnancy has the potential to avert about one-third of maternal deaths and nearly 10% of childhood deaths (*9*).

Furthermore, programs must expand to serve growing numbers of clients. The world's population is expected to reach seven billion by 2012, an increase of one billion in just 13 years (236). Between 2000 and 2015 the number of contraceptive users worldwide is expected to increase by over 40%—from 523 million to 740 million—due to both population growth and larger proportions using contraception. In sub-Saharan Africa the number of contraceptive users is expected to triple between 2000 and 2015. In Asia the number is expected to rise from 3.9 million to 5.2 million (191).

At the same time, programs face new financial and administrative changes—for example, reductions or shifts in donor funding, decentralizing of service systems, and integration with related health care services such as HIV/AIDS care. To cope with these changes and to maintain political support, advocacy efforts can position family planning as a cost-effective strategy that contributes importantly to better social, health, and economic outcomes (see box, opposite page, at top).

Defining Success

There are many reasons why it is important for family planning programs to succeed. Still, all the benefits of strong family planning programs come from their pursuit of a common goal: to offer reliable, good-quality services that address the varying needs of all potential clients. This involves offering a wide range of contraceptive methods, making services widely accessible through numerous outlets, following evidence-based technical guidance that promotes access and quality, and providing client-centered services at low cost. Coordination of efforts among all stakeholders is essential to ensure that programs use resources efficiently and minimize duplication of effort (see box, opposite page, at bottom).

Scope of This Report

This issue of *Population Reports* offers an overview of the core factors contributing to the success of family planning programs. Family planning professionals around the world helped to identify these 10 crucial program elements (104, 105). This report highlights program experiences, best practices, and evidence-based guidance derived from nearly six decades of experience in international family planning. The private sector collectively can and often does make a substantial contribution to a country's level of contraceptive use. This report, however, focuses on the operation of programs in the public sector and those of nongovernmental organizations (NGOs). The lessons presented can help managers of these programs, donor agency staff, policy makers, and other family planning professionals to plan new programs, improve existing programs, and prepare for future developments and challenges.

Supportive Policies

Family planning programs need high-level support to operate successfully. Supportive policies, statutes, and regulations, at both the national and the operational levels, lay groundwork for family planning service delivery (*48*, 264). Advocacy efforts with a focus on the benefits of family planning can build political will, support, and commitment.

Endorsement at the Top Sets the Tone for the Entire System

Policies that increase access to information and services support family planning. Policies that limit access are restrictive—for example, allowing only doctors and nurses to give injectable contraceptives or requiring a physician's prescription for oral contraceptives (228). Family planning "champions"—advocates who mobilize support for family planning—can bring key issues to the attention of policy makers, define needs for policy changes, and work toward supportive policies.

Supportive national policies provide vision, framework, and financial support. National policies can ensure that family planning has a prominent place on the national agenda and that services receive adequate public resources. Supportive national policies help programs succeed by:

- **Establishing favorable laws and regulations**. National policies often control the approval and regulation of contraceptives, their promotion in the mass media, their sales and distribution or delivery of services, who can receive services, and health insurance coverage (120). For example, Madagascar recently modified national service delivery guidelines, and now community-based distributors can provide injectable contraceptives (*248*). National policies that specifically concern vasectomy, female sterilization, and integration of services need to be considered as well. Many national policies control the activities of all family planning providers, not just those of government-funded programs.

Operational policies are the link between national policy and service delivery performance.

- **Assuring availability of contraceptive supplies**. Supportive laws, regulations, duties, and taxes can facilitate the importation of contraceptive supplies or support local manufacturing (71). Including contraceptives on a country's list of national essential medicines can guide the procurement and supply of contraceptives in the public sector, systems that reimburse costs, donations of contraceptives, and local pharmaceutical manufacturers. The World Health Organization (WHO) Model List of Essential Medicines can help a country decide which methods to include in its national list (see box, p. 15) (266).

Historically, Western governments have been the sole source of donated contraceptives. Recently, however, China has begun to donate contraceptives to Africa (161).

- **Providing money**. Policies at the national level determine the amount of government financial resources that go to family planning services. A dedicated line item for family planning in a country's budget is not necessary, but it encourages ongoing government support (117). In 2006 only 4 of 10 African countries surveyed had a line item for family planning in the national budget or the Ministry of Health budget (64). Establishing a line item does not mean that government can or will cover all costs, however. In 2007 the government of Rwanda included a line item of US$200,000 in the budget for contraceptives. The allocation increased to a projected $900,000 in 2008. Still, these amounts cover only a small fraction of the current and projected costs of commodities for Rwanda (*208*). Donors' help remains important to cover the increasing costs of growing services (see box, p. 7).

Operational policies enable programs to provide services successfully. For program success, national policies must be translated into operational policies. Operational policies—also known as "service delivery policies"—are the link between national policy and service delivery performance. National policies often describe what should be done. Operational policies often explain how it should be done and establish systems for delivering services. They can include the regulations, codes, guidelines, plans, budgets, and procedures for programs and services (see Case Study, left) (48). Decentralized systems, in which local administrators set and carry out operational policies, often improve access to family planning services because they can respond better to local needs (60, 233, 253). Putting service policies into practice also is important (see box, p. 9).

CASE STUDY

Zambia's Family Planning Policy Improves Service Delivery, Expands Access

In Zambia the government gave family planning programs minimal support until the late 1980s. Attitudes toward family planning began to change at that time, following the establishment of a new government and a new national population policy in 1989. The new policy recognized the effects of rapid population growth, the need to take account of population concerns in national development and planning, and the benefits of family planning for women, children, and families. It also recognized access to information and services as a human right. This policy shift resulted in a focus on family planning during the 1990s, with a number of champions ensuring that it received strong support.

To help service delivery programs operationalize the national policy, in 1997 the Ministry of Health developed a policy framework that outlined strategies for improving access to and quality of family planning services. These strategies included removing unnecessary medical policy and practice barriers to contraceptive use, developing service-delivery guidelines based on the WHO Medical Eligibility Criteria, and appointing a champion at the Central Board of Health to strengthen logistics. With the help of these new supportive policies, use of modern contraception among married women of reproductive age in Zambia rose from 9% in 1992 to 23% in 2002.

Source: Solo 2005 (210)

What Should Advocates Do?

Successful advocacy requires identifying decision-makers and stakeholders, knowing how to reach them, and appealing to their specific interests and concerns (*170*). A combination of the following advocacy strategies is most effective:

- **Identify influential leaders**. Key leaders who are motivated to be family planning champions can lobby persuasively with policy makers for specific solutions to problems. For example, to address low levels of contraceptive use in Malawi in the early 1990s, a group of family planning champions advocated posting a family planning coordinator in each district. The policy change has contributed to the nearly universal availability of contraception in Malawi (209).

- **Involve all stakeholders in policy and program development**. Programs need support not only from clients but also from the general public, health officials, policy makers, funding agencies, the news media, health care providers' professional associations, women's organizations, and religious, community, and business leaders (200). Identifying supporters in these key audiences and involving them in decision-making and advocacy can help assure more responsive policies and at the same time promote their commitment to family planning policy and programming.

- **Draw upon data and case studies to back up key messages**. Decision-makers are more likely to endorse a policy when convinced that it is high priority, that many people will benefit, and that the costs do not exceed the benefits. Factual evidence—from surveys, studies, and expert analyses, for example—can show policy makers the benefits of investing in family planning (*246*). A strategy for reaching influential audiences with this information is important. Also, effective policy advocates often present the stories of ordinary people to bring the data to life. Such stories show how family planning improves people's lives or how its lack can lead to tragedy. Family planning providers who deal with clients every day are in a good position to find these stories.

Obtaining Adequate Budget Requires Good Management, Strong Advocacy

In the 2007 global survey family planning professionals most frequently identified adequate budget as one of the most difficult elements for family planning programs to achieve (*104*). Programs around the world face decreases in donor or government funding for family planning (6, 169, 212, 243). Between 1995 and 2005, for example, international donor funding for family planning decreased 34% — from US$723 million to $477 million (272).

Many programs can no longer depend as much on public or donor funding as they did in the past. Managers must seek other ways to ensure financial sustainability. Finding creative ways to do more with less, advocating increased funding, and spending wisely can help programs cope (*113*).

Finance creatively. Managers can find new ways to recover costs (141, 144). Strategies range from introducing fees for those who can afford to pay (see p. 21) to using revenues from some services to support other services (cross-subsidization). For example, Profamilia in Colombia uses revenues earned from infertility treatments to subsidize family planning services (207) (see Case Study, p. 11). For public programs supportive policies allow programs to decide for themselves how to use their revenues, rather than requiring revenue to be sent to a central treasury.

Advocate strategically. If the budget is not enough to meet objectives, the program will need additional funding from external sources. To argue for more resources, managers and other advocates frame family planning as an important social investment (85) (see p. 5). For example, a cost-benefit analysis in Egypt demonstrated to policy makers that further investment in family planning would result in substantial net savings for the government on social service expenditures such as education and food subsidies (40).

Family planning programs everywhere need advocacy for policy and funding priority. In some countries a new resource allocation system makes strong advocacy especially important. These countries now pool all health sector resources, whatever their source, and allocate funds based on perceived relative need (14). This strategy, known as the Sector Wide Approach (SWAp), brings together governments, donors, and other stakeholders to make decisions about where to spend the pooled money. Donors no longer fund specific sectors or projects directly (225). SWAps began in the early 1990s. Today 20 countries in sub-Saharan Africa, Asia, and Latin America have adopted this approach or plan to (224).

In SWAps support for family planning often is not identified or monitored separately. Vocal and convincing advocacy and rigorous monitoring and evaluation are needed to keep family planning from getting overlooked in the SWAp process (*9*, 212, 223).

Spend wisely. Most importantly, the program manager should match activities to the current budget. When programs try to do too much with too little, they risk becoming ineffective.

Furthermore, the budget needs to be allocated among various costs so as to maximize output. Knowing how much things cost and understanding how expenditures influence activities help managers determine the best way to allocate resources. For example, managers of a program seeking to serve an increasing number of clients may consider hiring more doctors. They may decide, however, that hiring more doctors is too expensive a way to increase services. Instead, they may choose to reduce the increasing workloads of the current doctors by shifting some of their tasks to other cadres of providers (for more information about task-shifting, see p. 16) (*262*). Staffing usually accounts for the majority of costs in family planning programs (141).

Evidence-Based Programming

Successful family planning programs use research, monitoring, and evaluation to guide design and implementation. By providing crucial information, these tools help program managers decide wisely how to take new directions, solve problems, assess effectiveness, and make adjustments.

Research Helps Tailor Programs to Their Context

Programs maximize their chances for success by learning from others. First, they can choose evidence-based operational strategies—that is, strategies proved to have their intended impact. Evaluations of programs elsewhere, or perhaps pilot studies, have shown that these strategies worked. In addition, global technical guidelines cover how and to whom to provide specific contraceptive methods. Such guidelines from the WHO reflect research findings and global consensus among experts on their implications for service delivery (see p. 9).

Still, each program must suit its own unique circumstances. Formative research informs program managers and planners about the local context. Operations research tests what works in that context. Formative and operations research can be simple, and a local university may be able to help.

Formative research provides in-depth understanding of the intended clientele. Formative research—that is, research conducted beforehand to help design and implement a new activity—can provide a detailed understanding of the intended clients and how to serve them effectively. For example, formative research can find out what influences people's health-care seeking behavior or their access to information and services. It can also identify myths and misperceptions about fertility and contraceptives or the prevailing norms about family planning and family size. With that understanding, program managers can devise ways to remove barriers and enhance benefits. For example, prior to implementing an initiative

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In Bangladesh a family planning researcher interviews a man in the community. Formative research conducted before the start of a new activity provides in-depth understanding of the intended clients and how to serve them. Involving both men and women is essential for obtaining a balanced gender perspective.

CASE STUDY

Scaling Up Operations Research in Guatemala

Findings from operations research can guide programming and solve problems. In the 1990s the Population Council conducted a series of operations research studies to improve integrated reproductive health services in the Mayan Highlands of Guatemala. In part, the research sought ways to improve the Mayan people's access to a wider range of contraceptive methods.

Researchers found a key reason for high unmet need for contraception among Mayan women: Health care providers did not tell women about reproductive health services when they visited a clinic for curative care. Therefore, the Population Council and the Ministry of Health developed a job aid to help providers identify women's unmet needs and offer reproductive health services at the same visit. They tested the job aid in several public clinics.

Monitoring and evaluation found that, in the last nine months of 1996, clinics using the job aid had more than twice as many new family planning clients as they had previously. In contrast, clinics that did not have the job aid saw numbers of new family planning clients increase by about one-fifth. These results demonstrated the benefits of using a simple job aid. The Ministry of Health later scaled up the strategy nationwide.

Source: Brambila 2007 (27)

to revitalize use of the IUD in Kenya, researchers conducted a formative assessment in 12 health care sites to determine factors that contributed to low use of IUDs. The assessment found, for example, that providers were not confident in their IUD insertion and removal skills, and that many potential clients did not have accurate information about the IUD and did not know where to access services. The initiative used these findings to develop provider training programs and a communication campaign to address client concerns (*177*). Good formative research takes much of the guesswork out of planning new activities.

Operations research tests what works best in a particular setting. Before launching a full-scale activity, some programs start with operations research to test various approaches (see Case Study, left). Operations research may take the form of pilot projects. Pilot projects are usually designed with the assumption that, if effective, they will be scaled up. For example, in northern Ghana the Navrongo Community Health and Family Planning Project conducted a series of pilot projects in the mid-1990s. They wanted to find out how best to launch and sustain community health services. This operations research found that the most effective staffing consisted of a team comprising a community nurse and a volunteer outreach worker. This staffing pattern contributed to increased contraceptive use and to a 15% reduction in fertility levels between 1997 and 2003. These findings prompted the Ghana Ministry of Health to adopt this staffing pattern as the nationwide model (61, 166).

It is important to plan for evaluation at the start of a program.

Operations research is not always needed. It can be costly and time-consuming. It may be enough to learn from research projects in other settings and to use formative research to adapt the strategies to the local context.

Monitoring and Evaluation Informs and Strengthens Planning and Management

Monitoring and evaluation is a continual process of collecting and analyzing information about the program and its effects. Its goal is to inform planning and management (78). Monitoring and evaluation helps program managers to:

- Make informed decisions about current program design and operations,
- Ensure the most effective and efficient use of resources, and
- Assess impact.

Also, reporting requirements may call for monitoring and evaluation.

Monitoring collects and analyzes data that measure progress toward objectives. For example, monitoring can track the use of resources, the delivery of services, and the satisfaction of clients. Monitoring can detect changes in program performance and cost-effectiveness and help to explain why they occurred. Then managers can make mid-course corrections, if necessary, to improve performance. Monitoring should be conducted throughout the life of the program (72).

Evaluation measures a program's accomplishments and costs. At the end of a program or at a significant turning point, evaluation can determine if the program achieved its original objectives. Evaluation

also may try to determine how much credit a program or project can take for changes in ultimate outcomes, such as increases in contraceptive use or reduction in unmet need for family planning.

Evaluations guide planning for future programs. Also, for ongoing programs periodic evaluations help decide whether major changes are needed. While evaluations usually take place at the end of programs, it is important to plan for them at the start. Data for evaluation must be collected throughout the program so that comparisons over time can be made.

Data collection supports program implementation. The types of data that a program collects depend on its goals and its budget. In general, monitoring and evaluation uses four types of indicators to measure different aspects of performance (21, 78). Monitoring focuses primarily on the first two types of indicators, while evaluation focuses largely on the last two:

- **Input indicators** report whether resources, such as personnel, equipment, and supplies, are being implemented as planned. These data tell, for example, whether supplies are coming in on schedule or if expenditures are within budget. If not, then the manager can address any problems quickly.

- **Process indicators** reflect how well program activities, such as training staff and counseling clients, are carried out. For example, these data can suggest why oral contraceptive users who visit one clinic are more likely to continue their methods than oral contraceptive users who visit other clinics. With the reason in hand, the manager can make improvements at all the clinics.

- **Output indicators** check whether intended improvements occurred in the products and services—for example, in accessibility, quality of care, or service utilization. Using output data and data on the cost of inputs, the manager can calculate efficiency and invest the budget in the most productive way.

- **Outcome indicators** show whether expected changes occurred among the clients or in the population from which clients come—for example, increases in contraceptive use or declines in fertility. They suggest how the program is affecting health and well-being.

Selecting indicators that are truly relevant to program priorities improves the efficiency of monitoring and evaluation activities. The choice of indicators should be driven by the objectives, goals, activities, and scale of the program or activity. Additionally, programs should consider the time and money it costs to collect and analyze data for each indicator. As a rule of thumb, a mature program might spend 10% of its budget on monitoring and evaluation (20). (For additional information on indicators, see http://www.cpc.unc.edu/measure/publications/pdf/ms-94-01.pdf)

Global Technical Guidelines Support Good-Quality Services

The World Health Organization (WHO) issues and periodically updates global guidelines on the provision and use of contraceptive methods (*256*, *257*) (http://www.who.int/reproductive-health/family_planning/guidelines.htm). The WHO guidelines reflect the up-to-date body of scientific evidence and expert consensus on its implications for service delivery practices. These guidelines address, for example, medical eligibility criteria, when to start methods, and treatment of side effects. Currently, they generally do not address programmatic issues.

National service delivery guidelines that are based on these global recommendations help providers offer services of good quality, free from unnecessary requirements and medical barriers. Programs can periodically update their own service delivery guidelines to reflect the latest evidence-based technical guidance (*91*).

From Guidelines to Practice

To be effective, national service delivery guidelines must be translated into actual practice. Studies reveal that providers do not always follow guidelines. They may impose unnecessary medical barriers based on their own opinions or apply restrictions based on outdated scientific information. Common barriers identified in a review of studies included refusing to give contraceptive advice unless a woman is menstruating when she comes to a clinic and requiring spousal consent to start a method (36). These barriers account for a substantial proportion of unintended and unwanted pregnancies (174).

Dissemination, training, and supervision are key. Translating evidence-based guidelines into practice requires good dissemination and training. Widely disseminating new or revised guidelines, as well as training, close supervision and monitoring, ensures that practices actually change (70, 91, 213). For example, in 1997 the Kenya Ministry of Health published updated family planning service delivery guidelines. The updated guidelines contained new clinical recommendations and emphasized less-restrictive medical eligibility criteria. A study testing various dissemination strategies found that providers who attended a standard training, received detailed instructions and materials for training their coworkers, and received supportive supervisory visits following the training scored 11 percentage points higher on a knowledge, attitude, and practice assessment than providers who received just the standard training (215).

Tools and job aids reinforce practice. Tools and job aids help providers give clients complete and accurate information, use appropriate criteria, or take all of the steps in a process. Good job aids make the provider's work easier while building in evidence-based practices. For example, the wall chart, "Do You Know Your Family Planning Choices?" contains method-specific information from *Family Planning: A Global Handbook for Providers* that providers can display for their clients (see http://www.infoforhealth.org/pubs/WallChart/Wallchart.shtml). Similarly, the tool, "Key Reminders About Hormonal Family Planning Methods" can help providers remember important technical information about hormonal methods (see http://www.infoforhealth.org/pubs/WallChart/hormonal.shtml). Many tools and job aids are adaptable to a local context. Adapters should make sure, however, that the adapted tool still accurately reflects the underlying technical guidance.

Strong Leadership and Good Management

In Colombia founder Fernando Tamayo and Executive Director Miguel Triás helped the nonprofit organization Profamilia grow from a single clinic in 1965 to the largest provider of family planning services in the country today, serving 65% of the country's family planning users (see Case Study, p. 11) (15, 38). In Thailand Mechai Viravaidya, a former government economist, founded the Population and Community Development Association in 1974, which fueled the country's family planning effort in its early stages (28, 79). In Indonesia physician Haryono Suyono served as head of the Indonesian National Family Planning Coordinating Board for 15 years, during which time Indonesia had the greatest reduction in its total fertility rate together with increasing contraceptive prevalence levels. Suyono helped keep family planning at the forefront of the political agenda by writing family planning into speeches of the country's president and regional political leaders, getting family planning messages into the media, and implementing an efficient monitoring and management information system that generated reports on the country's family planning activities (194).

The vision and innovation of these leaders and advocates helped to lay a strong foundation for their family planning programs. Today, as these and other programs around the world mature, strong leadership coupled with good management helps programs improve and expand services, scale up best practices, and navigate change (see box, below) (140, 157).

Program Managers Often Play Dual Roles

Leadership and management have been described as two sides of the same coin: Each is equally essential for any organization to achieve its purpose (134). Often program managers play the roles of both manager and leader. Understanding the specifics of management and leadership can help managers succeed in both roles.

Management Deals With Day-to-Day Complexities

Program managers are responsible for organizing the program to ensure smooth operation. There are five essential management functions in any health care program (83):

- **Planning** how to allocate resources so as to achieve specified objectives. For example, if the goal is to decrease unmet need for contraception in rural areas, managers can plan to expand access by increasing the number of rural service delivery points—for example, by introducing community-based distribution (see p. 19). Involving communities in decision-making helps to identify and address their needs.

- **Organizing** resources and processes to facilitate operations and activities—for instance, minimizing waiting times for clients who come to clinics for repeat injections by routing clients with problems and clients with no problems to providers with differing expertise.

IBP Framework Helps Navigate Change

The Implementing Best Practices (IBP) Consortium has developed a framework to help program managers carry out needed changes (*102*). In 2005 the Kenya Ministry of Health and its partners used this framework to revitalize interest in the IUD within the context of expanding client choice (63). They followed the framework's four phases, carrying out key activities at each stage:

1. **Define the need for change**. The first step in the process of change is to identify the problem, analyze the root causes, and reformulate the problem as a challenge. At this stage the Kenyan team identified factors contributing to the low level of IUD use. They collected data from service delivery sites and conducted interviews with clients, providers, and communities. Based on their findings, the team collaborated with key stakeholders and community leaders to develop a preliminary action plan.

2. **Planning for demonstration and scale-up**. The second step in the change process involves demonstrating an initiative, monitoring its implementation, and making strategic decisions about scaling up in the future. At this stage the Kenyan team implemented the initiative in 13 centers in the Kisii district. The initiative included trainings in counseling, contraceptive technology, and IUD insertion and removal. The team also launched a locally adaptable communication campaign addressing myths and misconceptions about the IUD.

3. **Supporting the demonstration**. The third step in the change process is to create a supportive environment for change. At this stage the Kenyan team identified key champions to advocate the initiative, including providers, community peer educators, and satisfied clients.

4. **Going to scale with successful change efforts**. The final step involves taking lessons learned from the demonstration and scaling up successes. Scaling-up involves incorporating the new practice into policies and delivery systems. The pilot project increased IUD use dramatically at the 13 sites, from 334 insertions in the 12 months prior to the start of the project (February 2004 to January 2005) to 1,068 insertions in the second year of the project (February 2006 to January 2007). The team planned to expand activities to five additional districts (102, 177). (For additional information about the IBP Framework, see http://erc.msh.org/newpages/english/toolkit/FC_Guide.pdf.)

- **Implementing** activities effectively and efficiently—for example, staffing appropriately to cover different case loads at different clinics, avoiding both overstaffing and understaffing (see p. 16).

- **Problem solving** to make day-to-day activities function smoothly—for example, transferring supplies between clinics if a stockout unexpectedly occurs.

- **Monitoring and evaluating** progress and using findings to make improvements (see p. 7).

Strategic thinking helps managers adapt to changing conditions. When managers think strategically, they assess their program's strengths, weaknesses, threats, and opportunities with a long-term vision in mind. Strategic thinking helps managers move from a purely managerial position into a leadership role (125, 142).

Leaders use creative thinking and innovation to build an overall vision for their programs.

Leadership Fosters and Nurtures Change

Health sector reforms such as decentralization or shifts in donor funding bring new challenges and responsibilities for program managers, often requiring them to adopt leadership roles. Program managers facing such challenges can strengthen their leadership capacities to navigate change and develop a vision for their programs (145). Leaders use creative thinking and innovation to build an overall vision for their programs. They also inspire others to make the changes needed to realize that vision (83, 140). There are three key roles in leadership:

- **Act as a catalyst** by identifying opportunities for change. For example, instead of seeing a new national decentralization policy as a setback, leaders look for ways to make decentralization an opportunity to strengthen the program.

- **Create an enabling environment** by encouraging teamwork, trust, open-mindedness, transparency, and shared accountability.

- **Encourage learning and innovation** to create new knowledge about what works. Available research and the lessons of the past do not have all the answers. Leaders encourage staff to challenge assumptions and look at the situation in new ways (146, 157).

Training Strengthens Leadership Capacities

Leadership skills often are not taught in conventional training and education programs. Family planning professionals who want to strengthen their leadership capacities can consider attending a leadership training program. Leadership courses are available both in-person and online (39, 149, 181). Participants in these workshops report that leadership training improved their self confidence, increased their openness to other points of view, and strengthened their persistence when dealing with challenges and barriers (181).

CASE STUDY

Strong Leadership Helps Profamilia Rise Above Change in Colombia

Most successful family planning programs have strong leaders to nurture change in the programs in response to both opportunities and challenges. One such program is the Colombian organization Profamilia. Founded in 1965, the nonprofit service delivery organization has helped to reduce the total fertility rate in Colombia by more than half—from 6.6 in 1965 to 2.4 in 2007 (33, 171). As Executive Director of Profamilia, Miguel Triás built on founder Fernando Tamayo's legacy of success, leading the organization through difficult periods of change such as diminishing donor funding and national health sector reform.

Triás solved problems in ways that actually strengthened the organization. For example, in the early 1990s birthrates in Colombia began to decline as a result of family planning program efforts. Funding from international donors began to decrease, too (15). Triás sought ways to diversify funding and thus increase the sustainability of Profamilia. One way was creating service contracts with various governmental and nongovernmental institutions and marketing Profamilia services to insurance companies (38). Triás also introduced cross-subsidization: Profits from infertility treatments helped subsidize family planning services (207). As a result, in 2002, Profamilia met 80% of its budget by income and revenue-generating sources, compared with 60% in 1990 (162).

Miguel Triás facilitated change by inspiring a shared vision among staff. For example, Colombia introduced universal health care coverage in the 1990s, creating a more competitive environment for health care providers and threatening Profamilia's market position (38). Triás convened a group to study the new health care coverage law and trained staff on how to comply with new regulations. He also restructured the administration of Profamilia, created a management information system, and carried out a market study to determine how clients perceived Profamilia (38). Throughout the process Triás shared his vision with his staff and encouraged them to participate in decision-making. This led to organization-wide support for the changes and laid the groundwork for continual improvement within Profamilia. Triás' leadership and entrepreneurship ensured that Profamilia not only survived changing times but also reestablished itself as a leader in family planning.

Effective Communication Strategies

The highest quality, most accessible health care services are pointless if people do not know about them or want them. Therefore, effective behavior change communication (BCC) activities are crucial. In family planning programs BCC activities serve various purposes. For example, communication informs people about family planning methods and services. It helps people make good family planning choices. It encourages couples to discuss their fertility desires and contraception. It also helps to make contraceptive use a community norm (123, 196, 206, 251, 252).

Ultimately, communication can encourage greater use of contraception, and it can do so at low cost. For example, between August and December 2000 a mass media campaign in the Philippines persuaded an estimated 348,700 women to start using a modern contraceptive. The campaign cost US$1.57 for each new user (132).

To promote and sustain healthy behavior, one communication product or campaign is not enough. BCC must be ongoing. Strategic BCC programs use a systematic process to develop and conduct communication, they draw on behavioral theory, and they use a mix of the three major communication channels—mass media, interpersonal, and community channels.

Communication Process Guides Programs

Successful BCC efforts follow a systematic process. For programs addressing individual behavior, they begin with analysis and progress through program design, development and pretesting of messages and materials, implementation and monitoring, and, finally, to evaluation. Following a proven process helps programs to work efficiently and to avoid mistakes.

To promote and sustain healthy behavior, one communication product or campaign is not enough.

Numerous models describe these steps. For example, the Center for Communication Programs at the Johns Hopkins Bloomberg School of Public Health designed the five-step "P-Process" (http://www.hcpartnership.org/Publications/P-Process.pdf) (*95*). The five steps are analysis, strategic design, development and testing, implementation and monitoring, and evaluation and replanning. Similarly, the National Cancer Institute of the U.S. Department of Health and Human Services organizes the process into four stages—planning and strategy development; developing and pretesting concepts, messages, and materials; implementing the program; and assessing effectiveness and making refinements (http://www.cancer.gov/pinkbook) (*158*). Other organizations have similar processes (*35*, 88, 237, 239, 267). (See *Population Reports*, "Communication for Better Health," Series J, No. 56, January 2008, at http://www.infoforhealth.org/pr/j56/, and *INFO Reports*, "Tools for Behavior Change Communication," January 2008, at http://www.infoforhealth.org/inforeports/BCCtools/.)

Some communication strategies focus more on creating social change in a community (50, 69, 98). These strategies follow a different process. They focus on participatory communication that enables people and communities to define who they are, what they want, and how they can achieve the desired change (50).

All these processes start with gaining knowledge about the intended audience, including their knowledge, attitudes, and beliefs about health and family planning; the factors that affect their health behavior; and their patterns of media usage and access to information. In addition to involving the audience, BCC programs engage other key stakeholders throughout the program process. Stakeholders may include the Ministry of Health, NGOs, health care professionals' associations, research organizations, schools, faith-based groups, and the media. Involving key stakeholders wins "buy-in" from all groups that have something to contribute or who could stand in the way. It also enhances the credibility and reach of program messages (*95*, *158*, *160*).

Theories Inform Behavior Change Communication

Behavioral theories help programs to understand why people behave as they do and how they change their behavior. With this understanding, programs develop strategies that reinforce healthy behavior or change unhealthy behavior (74, 107, 159). Two types of behavioral theories are important for BCC programs—theories of behavioral prediction and theories of behavior change.

Predictive theories address why people change behavior. They identify the internal and external factors that prompt people to perform (or not perform) a health-related behavior (73, 74, 107). Using information obtained through initial research with the intended audience, communicators identify both factors that stand in the way of the desired behavior and factors that provide crucial support for the desired behavior. Then they design messages and activities to eliminate the key negative factors and/or reinforce the key positive factors.

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In Nigeria radio talk show hosts discuss the stigmatization of people with HIV. The mass media can reach large audiences with family planning and reproductive health messages. Combined with interpersonal and community-based communication, the three channels reinforce each other and increase the influence on behavior.

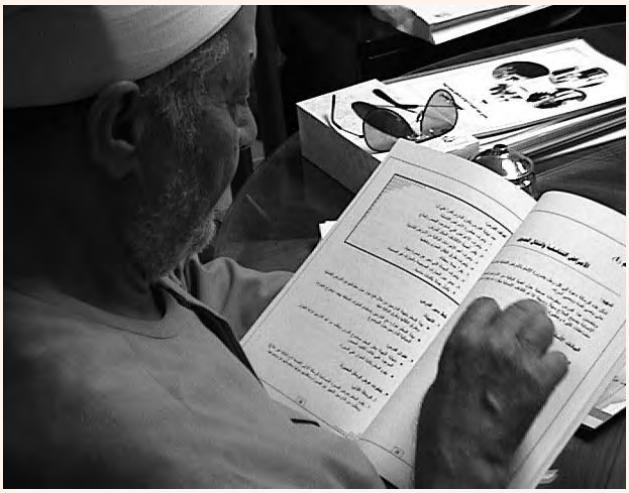
CASE STUDY

Religious Leaders Support Family Planning Campaigns

BCC programs must carefully choose who will deliver the message. Audiences listen to someone they trust.

Religious leaders are among the most trusted sources. They have participated in communication programs for family planning and reproductive health in many countries. For example, in the Accelerating Contraceptive Use Project in Afghanistan, discussions with Muslim religious leaders (mullahs) revealed that they objected to contraceptives generally because they thought contraceptives were unsafe, and not for religious reasons. Reassured about their safety, many mullahs supported the project. One mullah appeared in a national TV program discussing the positive aspects of family planning in relation to Islam (148). Another mullah teaches his congregation about oral contraceptives, injectable contraceptives, and condoms during weekly sermons because family planning improves the health of children and women (148).

In Egypt the TAHSEEN project educated 254 male and 24 female Christian and Muslim religious leaders about family planning and reproductive health topics, including contraceptive methods, birth spacing, and the risks associated with early marriage and early childbearing (34). Before the training, religious leaders either misunderstood birth spacing or considered it unacceptable to their religion. After a series of seven seminars, most clergy came to support birth spacing and can now cite passages of scripture in support of it. Leaders now think that they can and should play a role in educating their congregations about healthy practices. As part of their training, these leaders learned how best to communicate with youth, men, and newlyweds. They spread the project's message, strengthened with verses from scripture, to their followers through counseling, sermons, and public meetings.



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In Egypt a religious leader reviews training materials from the TAHSEEN project to ensure the family planning and reproductive health messages are within the framework of religious teachings. As trusted sources in the community, religious leaders bring credibility to communication campaigns.

In contrast, behavior change theories explain how people change behavior. They describe the stages, or steps, that individuals may go through as they change their behavior. For example, the widely known Diffusion of Innovation Theory proposes that people adopt a new idea or behavior (an innovation) through a five-stage process: knowledge, persuasion, decision, implementation, and confirmation (187). Identifying the intended audience's current stage of behavior change helps tailor approaches and messages that move them to the next stage.

Combining Channels Maximizes BCC Effect

Combining mass media, interpersonal, and community channels helps to enhance the effect of a BCC program (66, 114, 133, 158, 220). Mass media channels include radio and television, widely circulated newspapers and magazines, billboards and bus advertising, and in some places the Internet. By definition, these media reach large audiences. Interpersonal channels are often one-to-one communication, such as counseling and telephone hotlines. Community channels include rallies, public meetings, street theater, and local newspapers and radio stations.

Each type of channel has its own strengths (66, 158, 238). For example, mass media entertainment can show large audiences what healthy behavior looks like. Interpersonal communication between a health care consumer and health care providers or community leaders can be more credible and specific because it takes place face-to-face with trusted sources (see Case Study, above). Community approaches spread new ideas through social networks and, over time, encourage widespread support throughout the community. In most BCC programs one type of channel has the lead role (160). Together, the three reinforce each other.

Following a proven communication process helps programs to work efficiently and to avoid mistakes.

By engaging the news media, even small BCC programs can expand their reach without a mass media component. News coverage is often people's first source of information. It also influences opinion leaders and policy makers. Like other communication efforts, working with the news media succeeds best when it is based on a strategy and follows a process. (For a step-by-step guide to working with the news media, see *INFO Reports*, "Tools for Behavior Change Communication," January 2008, at http://www.infoforhealth.org/inforeports/BCCtools/6 shtml.)

Contraceptive Security

When a program has an uninterrupted supply of a variety of contraceptives, clients can choose and use their preferred method without interruption. Without a continuous supply clients have to switch to methods they like less or else go without entirely—and the result can be unintended pregnancies (196). Successful programs provide contraceptive security—that is, they ensure that people are able to choose, obtain, and use high-quality contraceptives whenever they want them (25, 163, *230*). Offering a full range of contraceptive options is also important (see box, p. 15). Contraceptive security requires planning and commitment on several levels to ensure that the necessary commodities, equipment, and other supplies are always available.

Today, many programs are facing new challenges that could endanger contraceptive security if not properly planned for—challenges such as integration of services, shifts in donor assistance, and increases in the numbers and kinds of supplies that programs must manage (6, 169, 243). Furthermore, rising demand for family planning requires programs not just to maintain the flow of supplies but in fact to increase it.

SPARHCS and the Seven Cs of Contraceptive Security

More than 50 countries have used the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) tool to develop and carry out strategies to ensure that supplies for family planning and reproductive health programs are adequate (92, 163, *230*). For example, in 2003 the Madagascar Ministry of Health and its partners used the SPARHCS tool to analyze historical trends and make projections, develop a one-year plan of action, present findings to key stakeholders, and facilitate discussions of a long-term strategic plan (13). The new SPARHCS Process Guide helps stakeholders understand and successfully apply the SPARHCS tool. It also demonstrates how the tool can be easily adapted for use in a range of different settings (*180*). (For more information, see http://www.maqweb.org/sparhcs/.)

Making services affordable while ensuring financial sustainability is a key to contraceptive security.

The SPARHCS Guide outlines seven important factors that contribute to contraceptive security (see Figure 1, p. 15):

1. **Context**. As mentioned (see p. 5), supportive national policies and regulations enable public- and private-sector programs to secure and deliver contraceptive supplies. Also, social and economic conditions influence an individual's ability to choose, obtain, and use family planning. Both of these contextual factors affect contraceptive security.

2. **Commitment**. Contraceptive security requires leadership and the long-term commitment of all stakeholders (25). Needed are commitments to make contraceptive security a top priority, to adopt and implement supportive policies and regulations, to ensure financing, to develop coordination mechanisms, to ensure adequate staffing (for example, for managing supply chains), and to develop the necessary capacities.

3. **Capital**. Financing to ensure contraceptive security can come from many sources. For example, individuals purchase contraceptive products, governments subsidize public-sector services, and donors provide direct financing or donate products. Making services affordable while ensuring financial sustainability is a key to contraceptive security (see p. 21).

4. **Capacity**. Contraceptive security requires that providers have the skills to help clients choose and successfully use family planning (see pp. 16–18). Providers alone cannot ensure contraceptive security, however. A strong supply chain, which covers planning, procuring, transporting, storing, and distributing contraceptives and other clinical supplies and equipment, is essential for contraceptive security. Consistent supply depends upon a supply chain management system that is capable of timely and accurate estimates of needs, efficient procurement practices, proper warehousing, and reliable deliveries (see Case Study, p. 15).

5. **Coordination**. A number of stakeholders, including government agencies, donors, service providers (public, private, and NGO), program planners, manufacturers, and distributors must coordinate to ensure complete coverage and decrease duplication of effort. Developing a joint strategy for contraceptive security is useful. Often the government or the Ministry of Health takes the lead in coordinating efforts (see box, p. 4, at bottom).

6. **Commodities**. Availability and accessibility of a range of quality family planning commodities is central to contraceptive security. Contraceptives may be imported or produced locally; they may be procured by governments, donors, multilateral agencies, NGOs, or the private sector. The public sector, NGOs, social marketing programs, and the commercial sector all have unique and important roles in providing family planning commodities to meet the needs of all clients (see p. 21).

7. **Clients**. Clients are the ultimate beneficiaries of contraceptive security. Efforts to improve contraceptive security should focus on meeting clients' unique needs. All individuals who wish to use family planning—regardless of economic status, education, ethnicity, geographic location, or other characteristic—should be able to access family planning methods that suit their particular needs.

Tools and Frameworks Help Programs Ensure Contraceptive Security

Several resources are available to help programs understand the local context and ensure contraceptive security. For example, the Contraceptive Security (CS) Index helps decision-makers measure a country's level of contraceptive security, make comparisons with other countries and regions, and determine areas of contraceptive security in greatest need of resources (*53*). The 2006 CS Index scores 63 countries according to 17 indicators relating to supply chain, finance, health and social environment, access, and utilization of services. The CS Index also can make comparisons over time. For example, measurements taken in 2003 and 2006 show that countries in sub-Saharan Africa made significant improvements in supply chains (*53*, *119*).

Another tool, the Contraceptive Security Ready Lessons, can help donor agency staff, program managers, and other family planning professionals work toward contraceptive security. The series of 10

booklets covers key strategies to establish and maintain secure supplies of contraceptives and condoms (*230, 235*). (For more information, see http://www.maqweb.org/ReadyLessons/.)

The Supplies Information Database is a new online reference library with over 6,000 records on the status of reproductive health supplies in more than 230 countries. The library's studies, assessments, and other publications can help managers and program planners assess the status of reproductive health supplies in their countries (*183*). (For more information, see http://www.rhsupplies.org/resources/supplies_information_database_sid.html.)

How Many Methods?

Programs should offer a sustainable, well-balanced range of contraceptive methods that will allow clients to choose the method that best suits their needs (87, *190*, 197). Without that access, some clients may discontinue use or not seek services at all (46). For each additional contraceptive method that is widely available in a country, the percentage of married women using contraception increases by an average of 3.3 percentage points, according to analysis of data from Demographic and Health Surveys in 44 countries (*22*, 186).

In considering which methods to offer, programs should keep in mind that there is no perfect method mix. In general, programs should strive to offer as many contraceptive methods as they can reliably supply to meet the needs of different individuals and couples (254). A reasonable mix includes methods that are short-acting and long-acting, client-controlled and provider-dependent, natural and clinical.

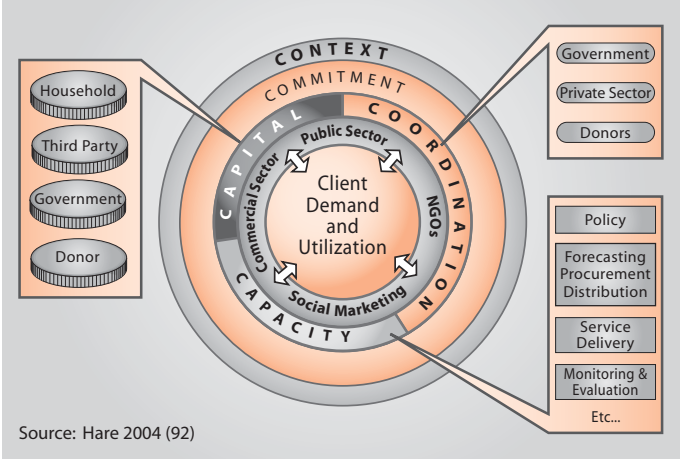
The contraceptives currently contained in the WHO Model List of Essential Medicines are:

- Oral contraceptives (combined and progestin-only),
- Emergency contraceptive pills,
- Progestin-only injectable contraceptives (NET-EN and DMPA),
- Copper IUDs,
- Barrier methods (condoms and diaphragms), and
- Levonorgestrel implants (263).

This list is meant to guide countries in selecting essential medicines, including contraceptives, for their national lists. A country's national list, in turn, guides programs in deciding which methods to stock. Of course, a program may also choose to offer methods that are not on the WHO Essential List, such as monthly (combined) injectables and fertility awareness methods. (For more information, see http://www.who.int/medicines/publications/EML15.pdf.)

Making long-acting and permanent methods (LAPMs) available is particularly important. This group of methods includes implants, IUDs, female sterilization, and vasectomy. These are the most effective and cost-effective contraceptives, and they require little action by the client. But they are often difficult for clients to access and are not used as widely as other methods (3). Because LAPMs are highly effective, their wider availability and use would reduce fertility rates more than would wider use of most other methods. Also, countries would be able to meet their reduced fertility goals more cost-effectively.

FIGURE 1.
Client Needs Are Central in the SPARHCS Framework



Source: Hare 2004 (92)

CASE STUDY

Innovative Delivery System Ensures Contraceptive Supply in Zimbabwe

In 2004 Zimbabwe adopted an innovative plan to improve the availability of contraceptives at health care facilities. It is called the "Delivery Team Topping Up" (DTTU) delivery system. Every four months delivery teams consisting of a driver and a technical advisor carry contraceptives in large trucks, or "moving warehouses," to health care facilities (11, 222). The technical advisor counts the supplies on hand, calculates the average monthly consumption for the previous four months, and, using this number to estimate needs for the next four months, "tops up," or replenishes, the supplies to this level.

The DTTU system shifts the responsibility for inventory management from overburdened clinical staff to the delivery team. Also, clinics no longer have to place orders with central warehouses. Thus, there is no need to train health workers continually in ordering and reporting procedures.

The DTTU system has greatly reduced stockouts. In 2005 and 2006 nationwide stockout rates for male and female condoms, the injectable contraceptive DMPA, and oral contraceptives were below 5% (18, 49). Before the project started, stockout rates in some facilities were over 20% (10). The improvement is especially noteworthy given the severe economic downturn and rapid deterioration of the health system that Zimbabwe has experienced in recent years. The system now serves nearly 99% of all health care facilities, or more than 1,200 clinics (18).

High-Performing Staff

According to the 2007 worldwide poll of nearly 500 health care professionals, a sufficient, well-trained, supervised, and motivated staff is the most important element of success in family planning programs (*104*). Many programs around the world face a severe shortage of health care workers. According to WHO, an estimated 2.4 million doctors, nurses, and midwives are needed to meet shortfalls in 57 of the world's countries (259, 260). Even when jobs are filled, programs face challenges of training and supervision, staff turnover, and inadequate budgets for salaries. Programs can address these challenges by strengthening human resource systems that create a supportive working environment, improve performance, and build the sustainability of the health care workforce. Task-shifting and performance improvement interventions will both increase the efficiency of the existing staff and the quality of its work. They also can decrease attrition rates and help keep workers satisfied and on the job.

Task-Shifting to Strengthen Workforce

Addressing structural problems is a first step. Programs around the world are exploring innovative ways to make more efficient use of their human resources. One frequent solution is task-shifting—that is, moving appropriate tasks to less specialized health care workers (261). Either current workers can take on new roles and responsibilities, or programs can develop new cadres of workers. A strong referral system, with clear guidance on when to refer, is essential when task-shifting. Taking on new roles usually requires additional training and supervision (*262*).

Current workers take on new roles. Some programs have used task-shifting, in the form of community-based distribution (CBD), for nearly 30 years. Today programs are shifting new tasks to this cadre of workers—for example, training them to give injectable contraceptives. This allows more highly trained providers to focus on providing clinical methods and helping clients with problems. Community-based workers in Madagascar and Uganda have started providing injectables in addition to condoms and oral contraceptives. This shift not only uses staff more efficiently. It also makes injectable contraceptives more available, particularly in rural communities (see "Community-based services," p. 19) (*248*).

Some countries are addressing shortages of physicians and nurses by training less specialized cadres of health care workers to conduct simple surgical procedures (58, 62). For example, in Malawi some clinical officers are trained to perform obstetric fistula repair surgery. Special policies are usually required to allow these cadres to conduct surgeries, however. In Malawi, unlike some other countries, any cadre of clinical or medical officer can be trained to do fistula repair (244).

Building new cadres of health care workers. Some countries are training new cadres of workers to provide family planning and other routine primary health care. Countries that do not currently have community-based distribution workers may create such cadres to address shortages of physicians and nurses and to provide services within communities. These cadres typically handle tasks that require less clinical judgment, which can take years of training to develop. For example, they may counsel clients about choice of family planning methods, provide condoms and other supply methods, and make referrals for clinical methods. In some cases they are now being trained to provide injectable contraceptives, as noted. Since 2003 Ethiopia's Health Extension program has trained more than 24,000 Health Extension Workers—a new cadre of providers created to help expand family planning and other primary health care services in rural areas (165).

Supporting Human Resources

People need the right knowledge and the right skills to do a good job. They also need good working conditions, support from their organizations, and motivation to perform well. (*136*). A Performance Improvement (PI) approach has proved to be effective in supporting human resources (see *Population Reports*, "Performance Improvement," Series J, No. 52, Spring 2002, at http://www.infoforhealth.org/pr/j52/j52.pdf). It helps programs address performance problems, set up a new job, or add a new skill to the responsibilities of an employee or a group of employees.

People need the right knowledge and the right skills to do a good job.

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In Nepal health workers listen to a training program on the radio. Such distance education programs can improve the knowledge and skills of staff without asking them to leave the workplace.

Performance Improvement interventions generally fall into six categories:

- **Clarifying job expectations**. Staff members perform better if they understand what is expected of them. Various approaches can help—for example, distribution of guidelines with training, accreditation programs, and clear job descriptions.

- **Offering performance feedback**. To let staff members know if their performance meets expectations, organizations can train supervisors to give feedback better, encourage comments from clients, or give staff members structured opportunities to assess themselves and their coworkers, for example, through a 360 degree review.

Electronic Resources Offer Flexible Learning Opportunities

As Internet connectivity improves around the world, electronic learning (eLearning) courses are becoming an important way to quickly update skills and knowledge. The USAID Global Health eLearning Center (http://www.globalhealthlearning.org) offers 22 free online courses, including 6 that are specific to family planning and reproductive health. A total of 48 courses are planned (234).

Programs in sub-Saharan Africa are increasingly using eLearning strategies. For example, the African Medical and Research Foundation (AMREF) and the Nursing Council of Kenya and partners are using eLearning to help 20,000 Kenyan nurses at the certificate level to become registered nurses by 2011 (4, 5).

Online discussion fora and social networking opportunities also provide an alternative to conventional learning approaches. The Implementing Best Practices (IBP) Knowledge Gateway (http://www.ibpinitative.org) is an electronic communication tool designed to share experiences on effective practices, success stories, lessons learned, and issues and concerns in reproductive health (265). As of May 2008 over 10,000 health care professionals were members of this free resource hosted by WHO. The Elements of Family Planning Success Web site (http://www.fpsuccess.org) uses social networking to connect family planning programmers around the world (*105*) (see box, p. 3).

- **Ensuring adequate workspace, equipment, supplies**. Health care workers need the right equipment to do their jobs. This can include, for example, supplies for disinfecting instruments, to job aids and tools, to well-equipped exam rooms.

- **Offering bonuses**. When health care providers are motivated, they perform better (100). Bonuses are a tool that some programs can use to keep a skilled and experienced workforce (112). Programs can link bonuses to the quality of service provision (150). In contrast, quantity-linked bonuses can have unintended consequences, such as leading to coercive behavior or pressure tactics on the part of providers. Opportunities for career development, recognition for good work, or flexible working arrangements can also help retain and motivate staff (108).

- **Supportive supervision**. Effective supervision emphasizes mentoring, joint problem-solving, and two-way communication between supervisors and staff members. Supervisors who use positive techniques to improve staff performance, rather than inspection and fault-finding, find that workers are more likely to be satisfied with their jobs and perform more efficiently (*147*, 176). The Standards-Based Management and Recognition (SBM-R) approach, for example, helps supervisors focus not on problems but rather on the standardized level of performance and quality to be attained (116).

- **Improving knowledge and skills**. Strengthening pre-service education and conducting in-service training are the main approaches to improving knowledge and skills. Programs may use distance education as an alternative or as a supplement to classroom-based training (43). Distance education strategies for family planning have used media ranging from radio broadcasts (220) to computer-based learning (234) (see box, above).

Client-Centered Care

When clients receive services that are tailored to their needs, they are more likely to find a suitable method, continue using family planning, and return to a provider when they need help or another method (115). Client-centered care means that clients' needs guide the planning and implementation of services. It also means that services meet medical standards, which requires providers' commitment and expertise (1, 37).

Programs, providers, and clients all play roles in achieving client-centered care.

What Do Client-Centered Services Look Like?

Programs, providers, and clients all play roles in achieving client-centered care.

Programs put physical, administrative, and operational systems in place to ensure good-quality services. Policies and service delivery guidelines ensure safety and maximize access. Facilities are clean, well-staffed, and well-organized, with clinic hours and waiting times that are convenient for clients. Clients' opinions about the organization and quality of services can gauge achievements and suggest improvements (see Case Study, p. 18).

Providers tailor family planning sessions to a client's individual needs (175, 195, 269). They are competent, friendly, respectful, and empathic regardless of a client's age, marital status, or socioeconomic group. They actively listen to clients and encourage them to ask questions, while ensuring privacy and confidentiality. Most importantly, they enable clients to make their own well-informed decisions—for example, helping them to consider how different contraceptive methods might fit their reproductive goals, individual circumstances, and lifestyles (*31*, 245).

Clients understand that their own preferences and needs guide their decision-making. With the help of programs' communication activities, they are well-informed about method choices, side effects, and how to use their method (251). Clients participate actively in counseling by asking questions, expressing concerns, and disclosing appropriate information. Clients should always make their own decisions, with providers' help, whether to practice family planning and which method to use (203).

Tailored Services Enhance Client-Centered Care

Tailoring services to the individual client is important to client-centered care. Family planning clients generally fall into four groups, each with its own needs. Providers should quickly assess each client's needs and meet them efficiently and effectively (203).

- **New clients who know what they want**. Many new clients already have a family planning method in mind (*80*, 130). Providers should determine if the client understands the method correctly and whether the client has any medical conditions that would make their preferred method unsafe. If the client can safely use the method, providers should discuss with the client how to use the method correctly and consistently (*179*). Studies around the world have shown that clients are more likely to continue using family planning when they receive the method of their choice (99, *164*). For example, in East Java, Indonesia, among 1,679 women who received their first choice of method, only 9% stopped using that method over the next 12 months. In contrast, among 266 women who were unnecessarily denied their first choice, 72% discontinued (*164*).

- **New clients who need help choosing a method**. Counseling sessions for these clients should focus on their reproductive intentions and the characteristics they are looking for in a method (179).

- **Satisfied users who return for supplies or routine follow-up**. In most programs the majority of clients fall into this category. They should receive the service or supplies that they came for without unnecessary delays and a brief offer of any other help they might want.

- **Clients who return with problems or concerns**. These clients should be given careful attention and counseling. If problems cannot be overcome, providers should offer to help clients choose another contraceptive method.

Some clients, such as unmarried couples or young people, may need special attention. An analysis of data from Demographic and Health Surveys in six diverse countries found that first-time users of family planning and users under age 24 had the highest rates of discontinuation (8). Reaching out especially to these people can help assure them that they will receive client-centered services. For example, messages to young people can emphasize that services are youth-friendly and ensure confidentiality. A tool, the Clinic Assessment for Youth Friendly Services, can help program managers and providers tailor services to meet the needs and preferences of young people (199). (For more information, see http://www.pathfind.org/site/DocServer/mergedYFStool.pdf?docID=521.)

Involving men in family planning is particularly important (185). Men are often the primary decision-makers in the family when it comes to health and fertility. Addressing men's interests and concerns helps couples reach healthy decisions jointly and removes a common barrier to women's use of family planning. In Turkey the "Men As Partners" initiative provided information, counseling, and services specifically for men, using existing opportunities within the health system. For example, the Turkish State Railway workers' health care system increased access to family planning information through educational sessions targeting male railway workers (168).

Job aids help providers achieve client-centered care. Some job aids purposefully take a client-centered approach. The WHO's Decision-Making Tool for Family Planning Clients and Providers tailors counseling sessions to help clients make informed choices and learn to use their method correctly (see http://www.who.int/reproductive-health/family_planning/counselling.htm). Studies evaluating the impact of this tool on counseling in Indonesia, Mexico, and Nicaragua found that it helped providers identify and respond to client needs, involve clients in the decision-making process, and educate new clients about their chosen method (128, 129, 131).

Another tool, the Population Council's Balanced Counseling Strategy, helps providers structure counseling sessions to focus on the client's needs, support the client's choice, and improve information provided on the method (see http://www.popcouncil.org/Frontiers/bestpractices/BCSpage_082007.html). It uses a combination of an algorithm and job aids to improve the quality of counseling (138). In Peru researchers found that quality scores, as assessed by simulated clients, were 63% higher for providers using job aids from the Balanced Counseling Strategy than for providers who did not use the job aids (138).

CASE STUDY

Peruvian Project Builds Bridges Between Providers and Clients

Involving the community in defining good-quality care attracts new clients and helps to improve services. In the Puno region of Peru, the Puentes Project (Building Bridges for Quality) brought together community members and district health care providers to define quality of care and discuss how to improve services. They jointly produced and discussed video dramatizations that showed how the two groups defined quality. These reenactments of real-life conflicts helped the groups to understand each other's viewpoint and to identify areas for improvement. Together, the groups developed action plans and goals. The groups met every three months to monitor progress toward quality improvement.

Less than one year after implementation of the action plan, the project had made noticeable improvements, including:

- 24-hour coverage at the health post,
- Complete drug stocks,
- A feedback system for clients and providers,
- Publicly posted price lists and schedules, and
- Walkways, lighted areas, fences, and general remodeling of the facilities.

The Ministry of Health reported that such improvements resulted in measurable increases in the use of family planning and child survival services, better treatment of clients, improved client-provider interaction, and increased community demand for and attendance at health education sessions. The Ministry has since expanded the project to two more regions.

Source: Heerey 2003 (96)

Easy Access to Services

Where clients can easily obtain services, they are better able to use family planning and to obtain help when they want it. In the broadest sense, a population has good access to services when service delivery points are conveniently available to everyone; everyone knows where to find these services; everyone feels welcome; services are free of unnecessary administrative and medical barriers; and people can choose from a range of contraceptives (*201*, 249).

Offering Services Through Multiple Channels Increases Access

It is very important that people can find family planning services nearby (24, 32, 218). Some women will go to great trouble to obtain contraception (47, 90). In Thailand in the 1960s, for example, many women traveled to Bangkok from around the country to visit the only clinic that offered IUDs (67). Still, the farther people have to travel for services or supplies, the less likely they are to use family planning (7, 219, 227).

© 1997 Intermarkets/Egypt, Courtesy of Photoshare

In Egypt a pharmacist from the "Ask…Consult" Private Sector Project counsels a customer about family planning. The project encourages women to seek advice and service at private-sector pharmacies and clinics bearing the "Ask…Consult" logo, a symbol of high-quality services. Pharmacies are an important channel for making contraceptive methods available conveniently to potential users.

In general, family planning services can be offered through clinics (public, NGO, or private), CBD, private providers' offices, and mobile or temporary facilities. Also, a variety of retail outlets sell contraceptives. Many programs use a mix of service delivery points to make methods available to all potential users (*51*).

The farther people have to travel for services or supplies, the less likely they are to use family planning.

Clinics are a conventional source of family planning services, and remain the backbone of delivery systems in most countries (*41*). Clinical facilities can be at the primary, secondary, and tertiary levels in the government health care system, or run by private establishments or NGOs. Most government and NGO family planning programs provide clinic-based services that are free or at very low cost to users. Regardless of the type of clinic, convenient hours of service and short waiting times are important for good access (192). Clinics often offer other health services in addition to family planning, which is convenient for clients (see p. 22).

Clinics are usually placed in a location that can serve many people. This requires some people to travel long distances, which is inconvenient for them. Mobile clinics are sometimes used to reach communities that are far from other service delivery points. Some mobile clinics are equipped to provide long-acting and permanent methods, including implants, IUDs, and male and female sterilization (*143*).

Community-based services train community residents to provide family planning within their communities. This strategy is particularly useful where health care infrastructure is weak or the population is widely dispersed (*82*, 97). For example, in sub-Saharan Africa nearly 7 of every 10 people live in rural areas (240). Even where a clinic is close by, clients may find CBD a convenient and comfortable alternative.

Community-based programs typically offer just condoms and oral contraceptives, and refer people to clinics for other methods. Increasingly, community-based programs are considering injectables. Pilot programs in such a wide range of countries as Bangladesh, Bolivia, Ethiopia, Ghana, Guatemala, Kenya, Peru, and Uganda have demonstrated that well-trained community-based workers can safely provide injectable contraceptives (68, 137, 151, 167, *216*). Madagascar, for one, is scaling up the practice nationwide (*248*). The handbook "Provision of Injectable Contraception Services Through Community-Based Distribution" helps programs introduce injectables into existing CBD programs (see http://www.fhi.org/en/rh/pubs/booksreports/cbd_dmpa_imp.htm). For lessons learned about CBD programs, see box, p. 20.

Private-sector providers are usually in business for themselves. They charge their clients enough to provide themselves with an income. In contrast to the public sector, which often has the mandate to serve everyone, the private sector serves those who can afford to pay. Many people choose private-sector providers and services because of perceived higher quality, greater privacy, and shorter waits (57, 270).

Retail outlets sell family planning supplies or services, either at subsidized prices through social marketing, or at full retail price. Pharmacies, drug shops, and kiosks sell condoms and oral contraceptives. These outlets offer easy and convenient access in familiar surroundings for those who can afford to pay (226).

Expanding the Role of the Private Sector

Strong private-sector provision of family planning benefits everyone, including public-sector programs. For example, the private sector may have capacity to handle increases in demand that could overwhelm public facilities. Also, when marketing directs those who can afford to pay to the private sector, the public-sector can serve more poor clients (see p. 21).

In most countries the primary private-sector sources of modern contraceptives are pharmacies, shops, private hospitals, and private clinics. Various approaches have strengthened private-sector

Seven Lessons Learned About Community-Based Distribution

Since the 1970s CBD programs have brought information and services directly into communities. Lessons learned over the past 30 years include:

1. **Keep training brief**. Keeping training programs as short as possible, while assuring that workers are competent at their tasks, keeps down costs. It also makes it easier to recruit workers who cannot leave their shops or families to attend long trainings. Of course, the length of training depends on the skills covered. For example, training workers to give injectable contraceptives, condoms, and oral contraceptives will require more time than training them to deliver just condoms and oral contraceptives.
2. **Let CBD workers sell the contraceptives and keep all or part of the profits**. Paying CBD workers can be expensive and unsustainable. Allowing workers to charge a small amount for contraceptives and to keep some of the profits can help keep them motivated.
3. **Train more distributors than are likely to be needed**. Recruiting and training more workers will help keep coverage consistent even when some workers leave.
4. **Ensure adequate supervision**. CBD workers need help to assure that they always have adequate supplies. They also need reliable answers to problems and questions.
5. **Keep records simple.** Requiring CBD workers to keep complex records can overwhelm them. Simple records, covering limited client information and receipt and dispersement of supplies, are enough.
6. **Keep supply systems simple**. Offering one or two methods simplifies storage, distribution, and ordering. Referrals to clinics for other methods helps clients get the methods they want.
7. **Bring CBD workers together to exchange ideas**. They can learn from each other and also give managers feedback on problems, lessons learned, and best practices.

Adapted from Potts 1997 (173).

provision of family planning and standardized their services—for example, branding, as in the case of Indonesia's Blue Circle program and franchising, as in the Philippines' Friendly Care clinics (205).

Social marketing efforts are growing. Social marketing uses retail outlets and private providers to sell branded products and services at subsidized prices that are set to maximize use (172). Social marketing programs brand their products and services and promote their high quality. They are also marketed as ordinary consumer products, which decreases stigma and makes them more appealing (93). Family planning social marketing programs typically offer supply methods, such as male condoms, oral contraceptives, and injectables. Some programs also offer IUDs and female condoms (55).

The number of couples who receive family planning through social marketing is increasing. Sales of social marketing programs in 68 countries contributed 39 3 million couple-years of contraceptive protection (CYP) in 2006, an increase of 20% since 2004 (see Table, below) (55, 94). (One CYP is protection from pregnancy for one woman for one year.)

Access and Quality Go Hand in Hand

Access is not just a matter of convenient outlets. Also, those outlets should be free of unnecessary restrictions and conditions on who can be served. On a national level supportive policies can eliminate barriers such as requirements for a certain age or parity, spousal consent, or married status from service delivery guidelines (see p. 5). At the service delivery level, good training and simple job aids and tools can help reduce common medical barriers and facilitate evidence-based practices.

For example, the checklist "How to be reasonably sure a client is not pregnant" can help providers recognize opportunities to provide hormonal methods and IUDs to women even if they are not having monthly bleeding at the time (see http://tinyurl.com/6rkcar) (30, 155, 217). Among new family planning clients, the number of clients who were denied their desired method because they were not menstruating decreased significantly after the introduction of the checklist, from 16% to 2% in Guatemala and from 11% to 6% in Senegal (214).

Similarly, checklists available for nearly every method help providers to apply the WHO Medical Eligibility Criteria and to avoid outdated or incorrect criteria. (See, for example, *Family Planning: A Global Handbook for Providers*, at http://www.fphandbook.org (268).) Offering family planning information and services at key times, such as to postpartum women in delivery facilities, also increases access (see p. 22).

TABLE. Social Marketing Sales Rise

Contraceptive Method	2004 Sales[1]	2006 Sales[1]	% Increase
Condoms	1,752,418,759	2,079,141,502	19%
Oral Contraceptives	113,343,253	145,190,118	28%
Injectable Contraceptives	14,232,519	21,977,073	54%
Emergency Contraceptive Pills	2,497,979	3,961,931	59%
IUDs	459,576	709,835	54%
Implants	5,625	14,536	158%

[1]Statistics for programs in 68 countries with 10,000 or more CYPs

Source: DKT International (54,55)

Affordable Services

As the number of contraceptive users increases worldwide, growth is fastest among those least able to pay for services (189). At the same time, many programs face decreases in government assistance and donor funding for family planning (81, 117, 169, 243). This scenario challenges programs to keep services affordable while ensuring that people are able to choose, obtain, and use high-quality contraceptives whenever they want them. Targeting subsidies to low-income users while encouraging people to pay what they can keeps services affordable for all clients. It also contributes to the financial sustainability of programs.

Public-Private Partnerships Help Address Financial Challenges

The goal of the public sector is to make a range of family planning methods available to those who need them. Public-sector resources are often not sufficient to address the family planning needs of an entire population, however. Shifting users who can afford to pay from the public sector to the for-profit private sector can reduce financial pressures on governments, donors, and NGOs (193). This can be done if private-sector care is an attractive alternative for clients who do not need subsidized services.

Shifting users who can afford to pay from the public sector to the private sector can reduce financial pressures on governments, donors, and NGOs.

A "whole market approach" helps target services to appropriate groups. Understanding how demand and supply are segmented across different socioeconomic groups helps managers make services more affordable and target subsidies more efficiently. This strategy is known as a whole market approach. A market segmentation analysis helps determine where and on whom public, commercial, and NGO programs each should focus marketing efforts.

Using demographic and market research data—for example, from Demographic and Health Surveys—a market segmentation analysis divides a population into five segments, ranging from high to low on an index of standard of living (see Figure 2, right). It identifies both who is being served in the family planning marketplace and who is underserved. Marketing then can lead clients in higher economic quintiles to partially subsidized or unsubsidized social marketing or commercial services, while subsidized public-sector services can focus on poorer populations (111). For example, in Romania a market segmentation analysis found that a large percentage of potential family planning users in urban areas were both willing and able to pay commercial prices. Consequently, free public supplies were targeted to rural family planning clinics and low-income urban areas, and the private sector scaled up services in wealthier urban areas (52).

Programs can also use results from a market segmentation analysis to target branded products to different economic groups. For example, in Bangladesh the Raja condom is promoted as a mainstream condom brand, while the higher-priced Sensation condom brand targets a more upscale market (93).

Various Financing Approaches Make Services Affordable

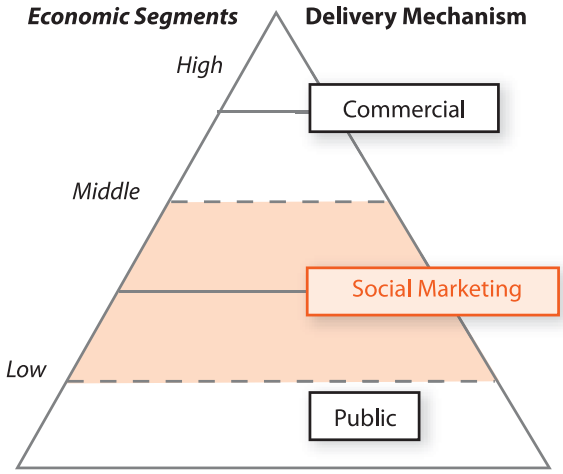
A variety of strategies can help public and NGO programs target subsidies and establish appropriate fees.

Establish fees that people can pay. Instituting or increasing fees may be necessary or desirable in some cases. If so, programs must find a way to ensure that services remain available to those who cannot pay (56). Means testing, needs assessments, and wealth index can help programs decide who can and cannot pay for services. These approaches can be difficult and time-consuming. In some cases the cost of designing and implementing means testing can be so high that it seriously offsets the revenues gained from the fees (111). Other financing mechanisms are available, such as voucher systems and insurance schemes.

Vouchers make private-sector services affordable for the poor. Research around the world indicates that many people—including those in lower economic quintiles—prefer private-sector health care because of perceived higher quality (57, 270). One way to make private-sector services affordable is by subsidizing poorer clients directly, through voucher systems—also known as output-based aid (110). Vouchers usually take the form of certificates or other tokens that people can redeem with providers who meet certain standards—often a pool of pre-approved providers.

Vouchers contributed to the success of family planning programs in South Korea and Taiwan in the 1960s and 1970s (86, 110). More recently, small-scale programs in Bangladesh, China, India, Kenya, Nicaragua, and Uganda have experimented successfully with voucher systems to subsidize vasectomy, female sterilization, and IUD services, and safe deliveries (*109*). These are services with one-time costs that many people cannot afford (see Case Study, p. 22).

FIGURE 2.
Market Segmentation by Economic Quintile:
A Tool to Help Target Services to Appropriate Economic Groups



Source: U.S. Agency for International Development 2007 (232)

CASE STUDY

Kenyan Voucher System Aims to Improve Access for the Poor

Kenya has developed a unique approach for providing high-quality family planning and reproductive health services at low cost to poor clients. Through a partner NGO, the government sells family planning service vouchers, or certificates, to low-income clients at a subsidized price amounting to US$1.40 each for any family planning method (135). The clients give the vouchers to the providers that they select among accredited facilities. The facilities and providers, including governmental, nongovernmental, and faith-based organizations, and private physicians and midwives, are accredited for meeting quality standards. The provider submits claims to a voucher management agency to obtain reimbursement for the services provided (106, 135). The German development bank KfW (Kreditanstalt für Wiederaufbau) funds the project currently in three rural districts and two informal settlement areas in Nairobi.

Conventionally, the government would pay facilities according to the inputs they would need to provide services, such as labor, supplies, and equipment. The voucher system, however, is called "output-based" because it links payment to actual services provided. Thus, it encourages facilities to provide more services. Also, by creating competition, it encourages providers to offer high-quality services that attract clients. Experience has shown this approach to be less costly and provide better quality services than conventional approaches (29).

Between June 2006 and October 2007 clients purchased 65,000 vouchers for safe motherhood services, family planning, and services for recovery from gender-based violence. The majority of the vouchers—69%—were for safe motherhood services (106). To increase demand for family planning vouchers, the project undertook communication activities and started using mobile clinics that provided contraceptives, including procedures such as female sterilization. As the project makes further progress, it will eventually extend to other regions of the country and include a broader range of services (106).

Voucher programs can target specific groups, such as young people or expectant mothers. For example, in Nicaragua a program distributed nearly 29,000 vouchers over 15 months to adolescents in poor areas of the capital city. The vouchers entitled them to free sexual and reproductive health services in selected public, private, and NGO clinics (154).

Other financing mechanisms. Health insurance is another financing mechanism that can help make private-sector services affordable. In general, consumers make regular affordable payments (premiums) to a third-party insurer. This entitles them to health care coverage for a range of private-sector services. The insurer reimburses the consumers for health fees paid or else pays the providers directly, eliminating or significantly reducing large out-of-pocket payments (44, *118*, 198). Many countries have added family planning and reproductive health services to health insurance plans (26).

Health insurance programs can be privately or publicly funded. For public health insurance, the government may be the insurer or it can subsidize insurance by paying consumers' premiums. The government finances public insurance programs from general revenue or with payroll taxes (26). Private health insurance is financed by individuals, families, or employers. It competes with other insurers for customers, and plans have different prices and benefits packages. Many developing countries have private insurance programs that serve primarily middle-class households. In 2001, for example, 25 developing countries had private insurance markets contributing to more than 5% of their total health expenditure (198).

More information and resources about the private sector and health financing are available on the Web site of the PSP-One Project (http://www.psp-one.com).

Appropriate Integration of Services

A couple visits a clinic for family planning, and the provider offers them testing for HIV and other STIs. A mother who brings her baby for immunization can learn about her family planning options and obtain services. A woman with HIV who comes for antiretroviral treatment also receives information about her contraceptive choices and an offer of supplies and services. These examples of integrated services illustrate how programs can address a wider range of health needs conveniently for clients (19).

Integrated Services Can Increase Program Efficiency and Clients' Convenience

Offering multiple health care services at the same facility or through a community-based program can benefit clients, providers, and programs.

- **Clients**. Offering multiple services at one location can increase access and convenience for people seeking health care. In addition, women with HIV often prefer to obtain family planning from their HIV care provider rather than disclose their HIV status to another health care provider (45).

- **Providers**. Integration of services can enable providers to address the health of their clients more holistically. Some providers report that they like the opportunity to offer clients multiple services. They caution, however, that adequate resources, training, and support are necessary. Otherwise, the new responsibilities may overburden them (16).

(continued on p. 24)

FIGURE 3.

Systematic Screening Instrument, from the Population Council

The tool below can help providers to identify family planning clients' needs for additional reproductive health and child health services. For additional information about how to implement systematic screening, see http://www.popcouncil.org/pdfs/frontiers/Manuals/SystematicScreening.pdf.

Screening Instrument				
Today's date:				
How old are you?	Administer checklist only if woman is between 15–44 years of age. If she is not between 15–44, thank her and terminate the interview.			
To be filled in by screener				**Provider**
Screening Questions Note: Be sure to include reason for visit in required services.		**Follow-Up Questions**	**Discuss and Circle Requested Service(s)**	**Service Outcome**
What is the reason for today's visit?		Reason for the visit:		1. Provided 2. Scheduled 3. Referral
1	Are you pregnant? 1. Yes → 2. No: go to 2	Are you attending a prenatal clinic? 1. No → 2. Yes: go to 5	Prenatal Care and go to 5	1. Provided 2. Scheduled 3. Referral
2	Are you trying to get pregnant? 1. No → 2. Yes: go to 4	Are you using a contraceptive method? 1. No → 2. Yes: go to 3	Family Planning and go to 4	1. Provided 2. Scheduled 3. Referral
3	Are you happy with your contraceptive method? 1. No → 2. Yes: go to 4	Would you like to use another contraceptive method? 1. Yes → 2. No: go to 4	Family Planning and go to 4	1. Provided 2. Scheduled 3. Referral
4	When did you have your last pap smear for cervical cancer? 1. DK/more than 3 years ago → 2. Less than 3 years ago: go to 5	Would you like to have a pap smear today? 1. Yes → 2. No: go to 5	Pap Smear and go to 5	1. Provided 2. Scheduled 3. Referral
5	Do you have any children less than 5 years of age? 1. Yes → 2. No: go to 7	Are you taking them in for well child services and growth monitoring? 1. No → 2. Yes: go to 6	Growth and Development Evaluation and go to 6	1. Provided 2. Scheduled 3. Referral
6	Have all your children under age 5 been completely vaccinated? 1. No/DK → 2. Yes: go to 7	Would you like to schedule vaccination for your child(ren)? 1. Yes → 2. No: go to 7	Vaccination and go to 7	1. Provided 2. Scheduled 3. Referral
7	Is there any other service you would like to receive today, or would like to be referred for? 1. Yes → 2. No: End interview	List service(s)		1. Provided 2. Scheduled 3. Referral
Observations (screener):				
Observations (provider):				
After completing the screening, attach this form to the client's clinical chart or give it to her to present to the service provider.				

Source: Vernon 2008 (271)

(*continued from p. 22*)

- **Programs**. Integrated services can be more efficient and so can serve more people for the same expenditures. Program managers of integrated services report that they avoid duplication of effort and save money that might have been spent maintaining separate facilities (122).

Of course, many services—particularly government services—are already integrated at the primary care level. This is most apparent where one provider, at a rural health post, provides all types of primary care to the community.

Deciding Whether to Integrate Services

Integrated services have advantages in many cases, but integration is not always the best approach. Integrated services place new demands on service-delivery systems, such as increasing provider workloads or complicating logistics systems. This can be a challenge where resources are few. Also, the demand and requirements for providing one service, particularly a curative one, may squeeze out another service, particularly a preventive one. Three guiding principles can help managers determine the advisability of integrated services:

- All of the interventions being integrated must be effective in meeting their specific health objectives.
- The interventions should address the same clientele.
- Integrating the interventions should create synergies that enhance the impact of all the services integrated (*202*).

Assessment of available resources and capacity, such as providers' time, also is important. Integrating services usually requires additional training, strengthening infrastructure, and improving logistics management.

Deciding Which Services to Integrate

Family planning can be added into other existing health care services, or other health care services can be added into existing family planning services. The services most commonly integrated with family planning are HIV/STI care and prevention and maternal, newborn, and child health care (65). Postabortion care services also integrate family planning information and services. These combinations can make sense because the services address the same clientele. In addition, they may create synergies that result in better health for clients. For example, helping women wait at least 24 months before attempting another pregnancy reduces the risks to both mothers and their children (258).

Integrated services have advantages in many cases, but integration is not always the best approach.

HIV care and prevention services. Integrating family planning into HIV care and prevention services can increase access to family planning. At the same time, preventing unintended pregnancies in women with HIV is an important and cost-effective strategy for preventing new infections through mother-to-child transmission (184) (see *Population Reports*, "Family Planning Choices for Women With HIV," Series L, No. 15, August 2007, at http://www.infoforhealth.org/pr/l15/). Integrating HIV testing and counseling into family planning can give family planning clients easier access to these services, and perhaps with less stigma attached. USAID recommends integrating family planning and HIV services in countries where the HIV epidemic is generalized and thus the number of people who need both family planning and HIV services is likely to be large (*229*). In contrast, where HIV infection is concentrated in specific groups, comprehensive integrated services may not be as cost-effective. Still, programs can explore opportunities to link these services through referrals.

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Marketing branded products and services can help attract clients, as in Bangladesh's "Green Umbrella" campaign, a nationwide effort to promote integrated family planning and maternal and child health services. Over 3,000 people attended the launch of the campaign in 1996. Offering multiple services at one location increases access and convenience for clients.

Maternal, newborn, and child health care. Integrating family planning into these services expands women's access to important information about postpartum return to fertility, the value of birth spacing, and to family planning options. It helps women to start a method at crucial opportunities, such as after delivery or during visits for childhood immunizations (2, 84, 152) (see box, p. 26). Pediatric clinic visits offer another opportunity for mothers to obtain family planning information and services. Family planning is often integrated with clinic-based services. Experience integrating family planning into community-based postpartum and newborn care is relatively limited, however. Training community-based workers to offer counseling, services, and referrals for postpartum family planning can help reach the many women who give birth at home. A pilot study testing this strategy is underway in Bangladesh (153).

The Population Council has developed an online tool to help programs assess linkages and determine whether integrating services is appropriate. The Assessing Integration Methodology (AIM) Handbook helps programs evaluate the capacity of health facilities to offer integrated services. It can also be used to monitor and evaluate currently integrated services (81, 178). (For more information, see http://www.popcouncil.org/frontiers/projects_pubs/topics/SLR/AIM_Manual.html.)

Systematic Screening and Referral Systems Are Alternatives to Integration

Some health care systems may not be able to integrate family planning with other services. Others may want to consider small

(*continued on p. 26*)

Checklist: Assessing the Elements of Success in Your Program

The questions below can help family planning professionals assess their programs. They can help decide what elements of a family planning program are already well in place and what should be strengthened. How a program prioritizes these questions will depend on the local context. Members of the online community, Elements of Family Planning Success (http://www.fpsuccess.org), reviewed this checklist.

UNDERSTAND THE CONTEXT

- ❑ At what stage is the country's modern contraceptive prevalence rate (CPR)?
  - o "Emergent" (less than 8%)
  - o "Launch" (8%–15%)
  - o "Growth" (16%–34%)
  - o "Consolidation" (35%–49%)
  - o "Mature" (50% and higher)
- ❑ What do data from Demographic and Health Surveys (DHS) and other sources indicate about family planning trends and gaps? (for example, unmet need, contraceptive knowledge and use)
- ❑ Does the local context present any special considerations? (for example, "fragile state," refugee populations, natural emergencies, conflict-affected areas)
- ❑ Which donors contribute to family planning?
- ❑ Do governments, donors, and service delivery and communication organizations coordinate their activities?
- ❑ What are the competing health priorities?

SUPPORTIVE POLICIES

- ❑ Does the current policy environment support family planning programming?
- ❑ Is there active support from the Ministry of Health and/or other ministries?
- ❑ Do policies need to be put in place or revised to support program priorities?
- ❑ Has the program identified champions to support advocacy efforts?
- ❑ Do advocacy efforts use facts, case studies, and personal stories to show the benefits of investing in family planning?
- ❑ Do advocacy efforts link family planning to other development goals?
- ❑ Are contraceptives included in the national list of essential medicines?
- ❑ Are the national service delivery guidelines for family planning updated with the latest evidence-based guidance?

EFFECTIVE COMMUNICATION STRATEGIES

- ❑ Is there an effective strategy to inform potential clients of available services?
- ❑ Do communication activities apply principles of behavior change communication (BCC), and are they grounded in behavioral theory?
- ❑ Does development of BCC programming follow a proven process, including planning, implementing, monitoring, and evaluating?
- ❑ Does communication use a combination of mass media, interpersonal, and community channels?
- ❑ Are investments in strategic BCC ongoing?
- ❑ Do communication strategies address both men and women?

ADEQUATE BUDGET

- ❑ Is funding sufficient to meet program goals?
- ❑ Is there a dedicated line item for family planning in the national budget or the Ministry of Health budget?
- ❑ Are needs forecasts used when setting the annual budget?
- ❑ Do programs explore creative ways to recover costs? (for example, cross-subsidization)
- ❑ Is budget allocated among various costs so as to maximize output?

EVIDENCE-BASED PROGRAMMING

- ❑ Is formative research used to help design and direct new activities?
- ❑ Is operations research used, when needed, to test strategies?
- ❑ Is a monitoring and evaluation plan in place?
- ❑ Are indicators relevant to program priorities?
- ❑ Do findings from monitoring and evaluation guide decision-making?

STRONG LEADERSHIP AND GOOD MANAGEMENT

- ❑ Do managers address setbacks with a problem-solving approach?
- ❑ Do staff members share a collective vision for the program?
- ❑ Are staff members inspired to change for the better?
- ❑ Does a task force or committee meet regularly to discuss new developments?

CONTRACEPTIVE SECURITY

- ❑ Do service delivery sites have adequate stocks of contraceptives and other necessary supplies?
- ❑ Is a logistics management information system (LMIS) in place to collect and report data?
- ❑ Is a long-range plan for contraceptive security in place, covering forecasting, financing, procuring, and delivering?
- ❑ Is there a balanced mix of contraceptive methods? Are long-acting and permanent methods offered?
- ❑ Are policies and quality control procedures and capacity in place to ensure product quality?

HIGH-PERFORMING STAFF

- ❑ Are tasks assigned to the appropriate level?
- ❑ Is the work environment conducive to good performance?
- ❑ Do workers have the equipment and supplies needed to do their jobs?
- ❑ Is supervision ongoing and supportive?
- ❑ Do staff members have opportunities to update their knowledge and skills?
- ❑ Are systems in place to maintain staff motivation and increase retention?

CLIENT-CENTERED CARE

- ❑ Are services tailored to clients' individual needs?
- ❑ Are evidence-based tools and job aids used to help providers maintain good-quality care and to help clients make informed choices?
- ❑ Are service delivery guidelines based on current global standards? (for example, WHO Medical Eligibility Criteria and Selected Practice Recommendations)
- ❑ Are strategies in place to increase male involvement in family planning?
- ❑ Is a system in place to encourage feedback from clients?

EASY ACCESS TO SERVICES

- ❑ Do all people who want family planning have physical access to services?
- ❑ Are services offered through multiple service delivery points convenient to everyone who might want them?
- ❑ Do multiple sectors offer services? (for example, public, private, NGO)
- ❑ Do sectors that offer family planning services cooperate and plan jointly?
- ❑ Are strong referral links in place to assure that clients reach the services they want?
- ❑ Have unnecessary medical and administrative barriers been removed or avoided at all levels, from service delivery guidelines to individual providers' practices?

AFFORDABLE SERVICES

- ❑ Are clients paying what they can for services?
- ❑ Are subsidized services offered to those truly in need?
- ❑ Has a market segmentation analysis been conducted to determine where and to whom public, commercial, and NGO programs each should market their products and services?
- ❑ Has the public sector established partnerships with the private sector?
- ❑ Are systems in place to help low-income clients afford private-sector services? (for example, vouchers or insurance)

APPROPRIATE INTEGRATION OF SERVICES

- ❑ Have linkages between family planning and related health care services been assessed?
- ❑ Have services been integrated where appropriate?
- ❑ Do providers offer clients other available services when appropriate?
- ❑ Do providers offer referrals to clients who want services that are not available at that site?

(*continued from p. 24*)

steps toward integration. When integration is not practical or feasible, strategies that link services, such as systematic screening and referral, help clients obtain a wider range of services (65, 126).

Identified as a best practice in reproductive health by USAID, systematic screening is a simple intervention to address more health care needs during a single clinic visit (231). This screening does not involve routine physical examinations or laboratory tests. Instead, clients fill out a brief questionnaire to help providers identify their reproductive health care needs and desires (see Figure 3, p. 23). Services are then offered at the same facility, if available, or through referral to another facility (76). Operations research in Africa, Asia, and Latin America has found that this systematic screening helps providers identify unmet reproductive health needs and offer clients more comprehensive services (*77*). Several countries are now scaling up pilot projects. In Guatemala national service delivery guidelines require all providers to use systematic screening (76).

Referral systems help family planning and other health care facilities offer clients better and faster access to specialized services and follow-up care (221). Referral systems are standing arrangements between providers or facilities to send and to accept clients for specified services. Referral systems range from an agreement between two clinics to extensive networks of clinics and providers. The Greenstar Network in Pakistan, for example, links more than 16,000 family planning and other health care providers. Thus, for example, when a client who wants an IUD visits a Greenstar clinic that is not equipped for this service, the provider refers her to a Greenstar Plus clinic, where IUD insertions are performed (89).

A Good Match: Integration of Family Planning and Infant Immunization Services

In Bangladesh, Madagascar, and Rwanda, research or pilot projects currently are underway to explore integrating family planning and immunization services (17, 59, 153). Infant immunization programs are an opportunity to reach postpartum women with family planning messages and services or referrals (59, 101). Both types of services share a common clientele of postpartum women. Furthermore, many women who might not seek health care services for themselves appear to obtain health care services for their children, including routine infant immunizations. Throughout the 1990s over 70% of infants worldwide were immunized with three doses of DPT (diphtheria, tetanus, and pertussis) (255).

In Togo a study in the early 1990s assessed the effectiveness of linking family planning services to Expanded Program of Immunizations (EPI) services. In eight clinics EPI service providers gave postpartum women who brought their infants for immunizations a short referral message about family planning services offered in the same clinics. After six months, awareness of family planning services among EPI clients increased significantly by 18 percentage points. The average monthly number of new family planning clients in the eight clinics rose significantly by 54%. In eight comparison clinics that did not provide systematic referral messages, there was no significant change in awareness or in the number of new family planning clients (101). Studies in Bangladesh, Burundi, and Zaire report similar findings (12, 75, 156).

Putting It All Together

Working toward success in family planning programming is part science and part art. The science behind managing family planning programs requires understanding both the factors that contribute to success and the context and environment of the program. The art to managing programs involves orchestrating activities with an understanding of how changes in one element of programming will affect other areas.

Working toward success in family planning programming is part science and part art.

Achieving success in family planning programming is an ongoing process. No program reaches the point at which its managers say, "Nothing more needs to be done." Even the most successful programs face new challenges and work hard to sustain their success. Indeed, this is how they continue to succeed—by facing challenges and working hard.

There will always be people wanting family planning, and so the job will never be finished. Its satisfaction comes each day, from helping people, one at a time, to improve their lives—and thus, in sum, making the world a better place.

Bibliography

This bibliography includes citations to the materials most helpful in the preparation of this report. In the text, reference numbers for these citations appear in italic. The complete bibliography can be found on the INFO Web site at: http://www.populationreports.org/j57/ The links included in this bibliography were up-to-date as of publication.

9. ALL PARTY PARLIAMENTARY GROUP ON POPULATION DEVELOPMENT AND REPRODUCTIVE HEALTH. Return of the population growth factor: Its impact upon the millennium development goals. London, All Party Parliamentary Group on Population Development and Reproductive Health, Jan. 2007. 70 p. (Available: http://www.appg-popdevrh.org.uk/Publications/Population%20Hearings/APPG%20Report%20-%20Return%20of%20the%20Population%20Factor.pdf)

21. BERTRAND, J.T., MAGNANI, R.J., and KNOWLES, J.C. Handbook of indicators for family planning program evaluation. Chapel Hill, North Carolina, University of North Carolina at Chapel Hill, Carolina Population Center, Evaluation Project, 1994. 218 p. (Available: http://www.cpc.unc.edu/measure/publications/pdf/ms-94-01.pdf)

22. BHUSHAN, I. Understanding unmet need. Baltimore, Johns Hopkins University Center for Communication Programs, Nov. 1997. (Working Paper No. 4) 55 p. (Available: http://www.jhuccp.org/pubs/wp/4/4.pdf)

31. BRUCE, J. Fundamental elements of quality of care. Studies in Family Planning 21(2): 61–91. 1990.

35. CABAÑERO-VERZOSA, C. Strategic communication for development projects. Washington D.C., International Bank for Reconstruction and Development/World Bank, 2003. 185 p. (Available: http://siteresources.worldbank.org/EXTDEVCOMMENG/Resources/toolkitwebjan2004.pdf)

41. CLELAND, J., BERNSTEIN, S., EZEH, A., FAUNDES, A., GLASIER, A., and INNIS, J. Family planning: The unfinished agenda. Lancet 368(9549): 1810–1827. Nov. 18, 2006.

48. CROSS, H., HARDEE, K., and JEWELL, N. Reforming operational policies: A pathway to improving reproductive health programs. Washington, D.C., The Futures Group International, Dec. 2001. (POLICY Occasional Papers No. 7) 36 p. (Available: http://www.policyproject.com/pubs/occasional/op-7.pdf)

51. DEBPUUR, C., PHILLIPS, J.F., JACKSON, E.F., NAZZAR, A., NGOM, P., and BINKA, F.N. The impact of the Navrongo Project on contraceptive knowledge and use, reproductive preferences, and fertility. Studies in Family Planning 33(2): 141–164. 2002. (Available: http://www.popcouncil.org/pdfs/councilarticles/sfp/SFP332Debpurr.pdf)

53. DELIVER and TASK ORDER ONE OF THE USAID HEALTHY POLICY INITIATIVE. Contraceptive security index 2006: A tool for priority setting and planning Arlington, Virginia, DELIVER, for the U.S. Agency for International Development, Dec. 2006. (Available: http://deliver.jsi.com/dhome/topics/health/famplan/fpresources/fppubs)

70. FINGER, W.R. Guidelines require comprehensive steps. Network 19(1). Family Health International. 1999. (Available: http://www.fhi.org/en/RH/Pubs/Network/v19_1/GuidelineSteps.htm)

73. FISHBEIN, M. and CAPPELLA, J.N. The role of theory in developing effective health communications. Journal of Communication 56(Suppl. 1): S1–S17. Aug. 2006.

77. FOREIT, J. Systematic screening: A strategy for determining and meeting clients' reproductive health needs. Washington, D.C., Population Council, 2006. (FRONTIERS Program Brief No. 6)

80. FREEDMAN, R. Do family planning programs affect fertility preferences? A literature review. Studies in Family Planning 28(1): 1–13. Mar. 1997.

82. FRONTIERS IN REPRODUCTIVE HEALTH PROGRAM (FRONTIERS), FAMILY HEALTH INTERNATIONAL (FHI), and ADVANCE AFRICA. Best practices in CBD programs in sub-Saharan Africa: Lessons learned from research and evaluation. Washington D.C., Population Council/FRONTIERS, Dec. 2, 2002. 14 p. (Available: http://www.popcouncil.org/pdfs/frontiers/CBD_seminar.pdf)

91. HARDEE, K., JANOWITZ, B., and STANBACK, J. What have we learned from studying changes in service guidelines and practices? International Family Planning Perspectives 24(2): 84–90. Jun. 1998.

92. HARE, L., HART, C., SCRIBNER, S., and SHEPHERD, C. SPARHCS: Strategic pathway to reproductive health commodity security. A tool for assessment, planning, and implementation. Baltimore, INFO Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health, 2004.

95. HEALTH COMMUNICATION PARTNERSHIP (HCP). The new P-Process: Steps in strategic communication. Baltimore, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, Dec. 2003. 12 p. (Available: http://www.hcpartnership.org/Publications/P-Process.pdf)

96. HEEREY, M., MERRITT, A.P., and KOLS, A.J. Improving the quality of care: Quality improvement projects from the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs. Baltimore, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, Feb. 2003. (Center Publication No. 101) 27 p. (Available: http://www.jhuccp.org/pubs/cp/101/101.pdf)

102. IMPLEMENTING BEST PRACTICES (IBP) CONSORTIUM. A guide for fostering change to scale up effective health services. Cambridge, Management Sciences for Health (MSH), 2007. 55 p. (Available: http://erc.msh.org/newpages/english/toolkit/FC_Guide.pdf)

104. INFO PROJECT. Elements of successful family planning programs: Online survey and forum discussion. Baltimore, INFO Project, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, Dec. 2007. (Unpublished)

105. INFO PROJECT. Elements of success in family planning programming. INFO Project, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, Apr. 2008. (Available: http://www.fpsuccess.org)

109. ISLAM, M. Vouchers for health: A focus on reproductive health and family planning services. Bethesda, Maryland, Private Sector Partnerships One (PSP-One), Abt Associates, May 2006. 12 p. (Available: http://www.psp-one.com/files/3003_file_Voucher_Primer.pdf)

113. JANOWITZ, B., MEASHAM, D., and WEST, C. Issues in the financing of family planning services in sub-Saharan Africa. Research Triangle Park, North Carolina, Family Health International, 1999. (Available: http://www.fhi.org/en/RH/Pubs/booksReports/fpfinancing/index.htm)

118. JOHN SNOW and PSP-ONE. Ten best public and private sector practices in reproductive health and family planning in Europe and Eurasia region. Jul. 2008.

119. JOHN SNOW/DELIVER and FUTURES GROUP/POLICY PROJECT. Contraceptive security index 2003: Technical manual. Arlington, Virginia, John Snow/DELIVER, for the U.S. Agency for International Development, 2004. (Available: http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/CSInde_2003_TechManu.pdf)

121. JOSHI, S. and SCHULTZ, T.P. Family planning as an investment in development. Evaluation of a program's consequences in Matlab, Bangladesh. Feb. 2007. (Yale University Economic Growth Center Discussion Paper No. 951) (Available: http://ssrn.com/abstract=962938)

124. KATES, J., LEIF, E., and PEARSON, J. Donor funding for health in low- & middle- income countries 2001–2006. Henry J. Kaiser Family Foundation, Jul. 2008. 13 p. (Available: http://www.kff.org/hivaids/upload/7679_02.pdf)

127. KHAN, S., MISHRA, V., ARNOLD F., and N., A. Contraceptive trends in developing countries. Calverton, Maryland, Measure DHS, Dec. 2007. (16) (Available: http://www.measuredhs.com/pubs/pdf/CR16/CR16.pdf)

136. LANDE, R. Performance improvement. Series J, Number 52, Baltimore, Johns Hopkins Bloomberg School of Public Health, Population Information Program, Spring 2002. 28 p.

143. MANAGEMENT SCIENCES FOR HEALTH (MSH). Bringing services to hard to reach populations. The Manager 6(4): 1–22. MSH. Winter 1997/1998. (Available: http://erc.msh.org/TheManager/English/V6_N4_En_Issue.pdf)

147. MANAGEMENT SCIENCES FOR HEALTH (MSH). Clinic supervisor's manual. Cambridge, MSH, 202 p. (Available: http://erc.msh.org/newpages/english/toolkit/Clinic_Supervisors_Manual.pdf)

158. NATIONAL CANCER INSTITUTE (NCI). Making health communication programs work. A planner's guide. Washington, D.C., U.S. Department of Health and Human Services (DHHS), 2001. 262 p. (Available: http://www.cancer.gov/PDF/41f04dd8-495a-4444-a258-1334b1d864f7/Pink_Book.pdf)

160. O'SULLIVAN, G.A., YONKLER, J.A., MORGAN, W., and MERRITT, A.P. A field guide to designing a health communication strategy. A resource for health communication professionals. Baltimore, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, Mar. 2003. 300 p. (Available: http://www.jhuccp.org/pubs/fg/02/)

164. PARIANI, S., HEER, D.M., and VAN ARSDOL, M.D. Does choice make a difference to contraceptive use? Evidence from East Java. Studies in Family Planning 22(6): 384–390. Nov.–Dec. 1991.

170. POPULATION COMMUNICATION SERVICES, CENTER FOR COMMUNICATION PROGRAMS, and JOHNS HOPKINS SCHOOL OF PUBLIC HEALTH. "A" frame for advocacy. 1999. (Available: http://www.infoforhealth.org/pr/advocacy/aframe.pdf)

173. POTTS, M. Community-based distribution of contraceptives. IPPF Medical Bulletin 31(2): 2–3. Apr. 1997.

177. RAJANI, N. Revitalizing the IUD in Kenya. New York, Acquire Project/EngenderHealth, 2006. (Acquiring Knowledge No. 2) 4 p. (Available: http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/ACQUIRE-Knowledge-Kisii-final.pdf)

179. RAMCHANDRAN, D. Developing a continuing-client strategy: How to meet clients' changing family planning needs. Population Reports Series J, No. 55. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Mar. 2007. 28 p. (Available: http://www.infoforhealth.org/pr/j55/index.shtml)

180. RAO, R., OLSON, N., BORNBUSCH, A., and PILZ, K. The SPARHCS process guide: A planning resource to improve reproductive health commodity security. Baltimore, INFO Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health, 2008. 56 p.

182. REPRODUCTIVE HEALTH SUPPLIES COALITION. 2008. RHInterchange. <http://rhi.rhsupplies.org/>

183. REPRODUCTIVE HEALTH SUPPLIES COALITION. Supplies Information Database. 2008. (http://www.rhsupplies.org/resources/supplies_information_database_sid.html)

190. ROSS, J., HARDEE, K., MUMFORD, E., and EID, S. Contraceptive method choice in developing countries. International Family Planning Perspectives 28(1): 32–40. Mar. 2002. (Available: http://www.agi-usa.org/pubs/journals/2803202.pdf)

201. SHELTON, J.D., ANGLE, M.A., and JACOBSTEIN, R.A. Medical barriers to access to family planning. Lancet 340(8831): 1334–1335. Nov. 28, 1992.

202. SHELTON, J.D. and FUCHS, N. Opportunities and pitfalls in integration of family planning and HIV prevention efforts in developing countries. Public Health Reports 119(1): 12–15. Jan.–Feb. 2004.

204. SINGH, S., DARROCH, J.E., VLASSOFF, M., and NADEAU, J. Adding it up: The benefits of investing in sexual and reproductive health care. New York, Alan Guttmacher Institute, 2003. (Available: http://www.guttmacher.org/pubs/addingitup.pdf)

208. SOLO, J. Family planning in Rwanda: How a taboo topic became priority number one. IntraHealth International, Jun. 2008. 34 p. (Available: http://www.intrahealth.org/assets/uploaded/countries/FP_in_Rwanda.pdf)

211. SONFIELD, A. Working to eliminate the world's unmet need for contraception. Guttmacher Policy Review 9(1). Guttmacher Institute. Winter 2006. (Available: http://www.guttmacher.org/pubs/gpr/09/1/gpr090110.html)

216. STANBACK, J., MBONYE, A.K., and BEKIITA, M. Contraceptive injections by community health workers in Uganda: A nonrandomized community trial. Bulletin of the World Health Organization 85(10): 768–773. Oct. 2007.

217. STANBACK, J., QURESHI, Z., SEKADDE-KIGONDU, C., GONZALEZ, B., and NUTLEY, T. Checklist for ruling out pregnancy among family-planning clients in primary care. Lancet 354(9178): 566. Aug. 14, 1999.

229. U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID). Family planning/HIV integration: Technical guidance for USAID–supported field programs. Washington D.C., USAID, 2003. 33 p. (Available: http://www.usaid.gov/our_work/global_health/pop/publications/docs/fphiv.pdf)

230. U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID). Contraceptive security: Ready lessons. Washington, D.C., USAID, Commodity Security and Logistics Division, Jan. 2004. 60 p. (Available: http://www.maqweb.org/ReadyLessons/)

235. U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID). Overview: Contraceptive security in a changing global health environment. Pilz, K. and Bornbusch, A., eds. In: Contraceptive Security Ready Lessons II. Washington, D.C., USAID, Commodity Security and Logistics Division, Sep. 2008.

246. UPADHYAY, U. and ROBEY, B. Why family planning matters. Population Reports, Series J, No. 49. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Jul. 1999. 32 p. (Available: http://www.infoforhealth.org/pr/j49edsum.shtml)

248. WEIL, B., KRUEGER, K., STANBACK, J., and HATZELL HOKE, T. Provision of injectable contraception services through community-based distribution: An implementation handbook. Research Triangle Park, North Carolina, Family Health International, 2008. (Available: http://www.fhi.org/en/rh/pubs/booksreports/cbd_dmpa_imp.htm)

256. WORLD HEALTH ORGANIZATION (WHO). Medical Eligibility for Contraceptive Use. Geneva, WHO, 2004. 186 p. (Available: http://www.who.int/reproductive-health/publications/mec/mec.pdf)

257. WORLD HEALTH ORGANIZATION (WHO). Selected Practice Recommendations. Geneva, WHO, 2004. (Available: http://whqlibdoc.who.int/publications/2004/9241562846.pdf)

262. WORLD HEALTH ORGANIZATION (WHO). Task shifting: Global recommendations and guidelines. Geneva, WHO, 2007. 92 p. (Available: http://www.who.int/healthsystems/TTR-TaskShifting.pdf)

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