



Advance
Africa

4301 North Fairfax Drive, Suite 400, Arlington, VA 22203-1627

Tel: (703) 310-3500, Fax: (703) 524-7898

www.advanceafrica.org

Technical Brief

Expanding family planning and reproductive health services in Africa

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SCALING UP FAMILY PLANNING AND REPRODUCTIVE HEALTH PROGRAMS

Program managers have always encountered challenges in their attempts to take reproductive health programs to scale. There are numerous barriers to increasing demand for, access to, and quality of family planning/reproductive health (FP/RH) interventions. Past expansion efforts have been associated with a process of incremental change in technologies, systems, and behaviors. In today's environment, "scaling up" suggests a combination of strategies and technologies designed to help expand programs with greater rapidity and on a larger scale. Perhaps the best way to define the current sense of what is meant by "going to scale" is to examine the indicators of achieving scale:

- Barriers have been overcome. Scaling up should permanently lower unmet need for family planning services and reduce rates of total fertility. Related problems, like infant and maternal mortality, should be dramatically decreased. As a result of a smaller demographic burden, national-level challenges, like availability of resources for education and other social services, will be alleviated.
- Priorities for population and reproductive health policy change. In a scaled-up FP/RH program, the reproductive health needs of the population as a whole change with the dramatic decrease in the total fertility rate. Policy makers can shift their focus from increasing contraceptive prevalence to improving the quality of services or addressing the needs of the aging and other special target groups. In some countries, when contraceptive prevalence reaches high levels, the issue of family planning is replaced by broader issues related to reproductive and sexual health.
- Clients and client profiles change. In scaling up reproductive health programs, providers will find that their clientele change over time. For example, in the early stages of an FP/RH program, new clients will usually be women with relatively high parity. As programs expand and increasing numbers of young women access services, client parity will be more diverse. When an FP/RH program reaches scale, the majority of new clients will likely be women with zero parity, as family planning decisions are made early on, in adolescence. Once programs are at scale, cyclical changes can be expected in client profiles, the timing of contraception, and the reasons for practicing contraception as new cohorts of women and men enter their reproductive years.

- New strategies for maintaining resources for scaled-up programs emerge. Although solving some programmatic problems may result in cost savings, the debate about continued financing of scaled-up reproductive health programs may shift. The source of budgets allocations to FP/RH services may evolve from special funds to regular revenues from local taxes or insurance schemes. Governments may decide to shift financial responsibility from the public to the private sector. The debate will move from using resources to meet basic needs to using resources to promote choice and maximize efficiency, equity, and access in the distribution of high-quality services.
- Specific roles of decision makers, planners, and managers are defined. Action on scaling up cannot be undertaken without the close collaboration of decision makers, planners, and health services managers. Decision makers are responsible for creating the enabling environment for going to scale. They enact policies and legislation that support the mobilization of resources, and they stimulate societal and institutional support over the long term. Planners bring together the technical and managerial expertise needed to create a common framework for all implementing partners. They coordinate the development of coherent and interrelated plans and budgets. Local program managers have to translate national plans for scaling up to specific local practices that will succeed in increasing demand and access to reproductive health services. Decision makers, planners, and managers must come together in a common vision of the desired impact within the realities of the local context. A comprehensive overview of desired impact and situational context is presented below.

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Characteristics of Scaled-Up Reproductive Health Programs

Service	Impact	Situational Context
Family Planning	<ul style="list-style-type: none"> • Contraceptive prevalence > 70%* • Total fertility rate close to desired fertility rate according to the Demographic and Health Survey and dropping toward replacement (total fertility rate = 2.1) 	<ul style="list-style-type: none"> ✓ Standards, quality guidance, and drug authorization maintained by government, but RH is entirely integrated into private, nongovernmental (NGO) and public health systems ✓ Continue education in schools, media
Maternal Health Services and General RH	<ul style="list-style-type: none"> • Maternal mortality rate has declined to a rate of < 100/100,000 live births • More than 95% of pregnant women receive prenatal care from skilled workers • Age at first pregnancy has increased 	<ul style="list-style-type: none"> ✓ Maintain norms and standards through professional regulatory bodies ✓ Finance services through national and private insurance schemes ✓ Continue information, education, communication (IEC) in schools, media
Post-abortion Care	<ul style="list-style-type: none"> • Repeat abortions are rare • Maternal mortality due to incomplete abortion almost entirely eliminated • Patient profile has changed 	<ul style="list-style-type: none"> ✓ Target IEC and FP efforts to youth to reduce incidence of abortion ✓ Maintain quality standards, defend legal status
Youth, Men, Special Target Groups	<ul style="list-style-type: none"> • RH indicators for youth and men approach the results for the general population • Special groups become smaller and even harder to serve (e.g., nomads, drug users, displaced persons, prison populations) 	<ul style="list-style-type: none"> ✓ Re-definition of special target groups, and programs for them, is ongoing through collaboration between public/private sectors ✓ Media, interest groups, NGOs active
Sexually Transmitted Infections	<ul style="list-style-type: none"> • Prevalence has declined, chronic cases are rare • STI sufferers recognize problem and seek treatment rapidly • Individuals protect themselves against STIs 	<ul style="list-style-type: none"> ✓ Widespread access to a variety of service facilities, including anonymous services providers, must be maintained ✓ Dual protection must be encouraged ✓ Continue education in schools, media
HIV/AIDS	<ul style="list-style-type: none"> • Incidence stabilizes and number of new cases declines due to prevention • Prevalence increases due to prolonged durations from diagnosis to death • Quality of life of sick persons increases due to treatment • Mother-to-child transmission declines due to treatment and FP 	<ul style="list-style-type: none"> ✓ HIV/AIDS absorbs a major percentage of health resources and is dealt with as a multisectoral issue ✓ Financing for HIV/AIDS treatment through health insurance, national health plans ✓ Continue education in schools, media ✓ Continue to strengthen voluntary counseling and testing (VCT) programs, access to drugs, routine screening, dual protection
Reproductive System Cancers	<ul style="list-style-type: none"> • Thanks to routine screening, new cancers are less severe when found • Cancer survival rates increase • Confounding effects on incidence are from higher rates of smoking, less breast-feeding among women 	<ul style="list-style-type: none"> ✓ Create policies, norms and standards for routine screening for breast, cervical, testicular, prostate cancers ✓ Finance screening through insurance and national health systems ✓ Encourage through media campaigns
Infertility	<ul style="list-style-type: none"> • As FP succeeds in lowering the total fertility rate, infertility becomes a major agenda • Couples seek and advocate for a variety of treatment options 	<ul style="list-style-type: none"> ✓ Regulate fertility services, develop norms and standards for treatments for infertility ✓ Debate and seek solutions for financing infertility care
Female Genital Cutting	<ul style="list-style-type: none"> • FGC is illegal • Incidence has disappeared; if necessary, other, culturally appropriate but nondangerous practices have been found to mark transition to adulthood 	<ul style="list-style-type: none"> ✓ Maintain vigilance and legal status ✓ Encourage development of appropriate but nondangerous transition events ✓ Provide reparatory surgery to older women as needed
Other Agendas	<ul style="list-style-type: none"> • Other agendas for RH will emerge as some problems are solved. New agendas defined in Cairo and Peking include gender-based violence and geriatric RH 	<ul style="list-style-type: none"> ✓ Participate in the debate, move with the times, but don't sacrifice advances in the basic services

For further information on scaling up family planning and reproductive health programs, please visit the Advance Africa website at http://www.advanceafrica.org/tools_and_approaches/Scaling_Up/index.html.

You may also request the scaling up series Ten Dimensions of Scaling Up Reproductive Health Programs from Samantha Ender, Dissemination Specialist, at sender@advanceafrica.org or 703-310-3500.

* Target rates in this table are adapted from "The PAI Report Card 2001: A World of Difference, Sexual and Reproductive Health and Risks," Population Action International, 2001.