



FAMILY HEALTH INTERNATIONAL
WORKING PAPERS

From Rhetoric to Reality:
Delivering
Reproductive Health
Promises through
Integrated Services

Karen Hardee
Kathryn M. Yount



About this Working Paper

This paper is the second in a series of working papers produced by the Women's Studies Project (WSP) at Family Health International. Begun in 1993, the WSP is a five-year research effort, supported by a Cooperative Agreement with the U.S. Agency for International Development, to study the impact of family planning on women's lives. The goals of the Project are to support social and behavioral science research on the immediate and long-term consequences for women of family planning programs and methods; and to improve family planning and related reproductive health policies and programs through increased knowledge of the needs and perspectives of women.

About the Authors

Karen Hardee, PhD, is a Principal Research Scientist in the Women's Studies Division and Deputy Director in the Service Delivery Research Division at FHI. She has worked on programmatic and policy issues, including quality of care, for 15 years. More recently her work has focused on gender issues and reproductive health.

Kathryn M. Yount is a doctoral candidate in the Department of Population Dynamics at Johns Hopkins University School of Hygiene and Public Health and is currently working on measurement of the links between women's status and child mortality. Previously, she worked with the EVALUATION Project at the Carolina Population Center, University of North Carolina,. During the preparation of this paper, she worked as an intern and consultant at FHI.

Table of Contents

I.	Executive Summary	1
II.	Introduction	3
III.	Definitions of Reproductive Health and Proposed Service Delivery Packages	4
IV.	Rationales for Integrated Services	8
V.	Challenges to the Integration and Delivery of Reproductive Health Services	14
VI.	Costs and Funding for Reproductive Health Services	23
VII.	Summary and Policy Actions.....	26
VIII.	References	27

Acknowledgments

This paper was supported through FHI's Women's Studies Project (USAID/CCP-3060-A-00-3021-00 and Contraceptive Technology Cooperative Agreement (USAID/DPE-3041-A-00-0043-00), both funded by U.S. Agency for International Development (USAID) Office of Population. The authors are particularly indebted to Barbara Crane and Nancy Williamson for their comments during the writing of this paper. The authors also wish to thank Steven Sinding, Barbara Janowitz, Judith Fortney, Henry Mosley, and Mary Ann Lehmkuhl, who reviewed drafts of the working paper and provided helpful comments. We would like to thank Barbara Barnett, who served as editor. The authors welcome further comments. The views expressed in the paper do not necessarily reflect those of USAID.

I. Executive Summary

The 1994 International Conference on Population and Development (ICPD) Programme of Action calls for a comprehensive, client-centered view of reproductive health and for the promotion of reproductive health in addition to family planning. If countries are to translate these broad and ambitious reproductive health goals into programs that meet clients' needs, they will have to select those services that provide the widest reproductive health benefits for the most people, taking into consideration epidemiological trends, services currently offered, client demand, and resources available.

This paper seeks to address two interrelated and overlapping audiences: those who have been involved in many family planning and other reproductive health programs and those who have primarily been advocates for comprehensive and integrated approaches to reproductive health.

There is increasing interest in implementing reproductive health services through integrated programs. Will integrated programs be a successful mechanism for meeting reproductive health needs? This paper identifies policy and service delivery challenges and takes an historic view of past experiences in formulating, implementing, and evaluating integrated services of national public-sector programs in developing countries. Among the issues discussed are:

Reproductive health services. Many organizations have identified services they believe should be part of comprehensive reproductive health care packages. There are similarities among proposed packages, which list 16 broad categories and 76 specific services or related activities. In addition to family planning, all groups support the provision of maternity care and STD/AIDS services. Most organizations support some type of pregnancy termination care.

Integration. In family planning, "integration" has referred to various types of administrative and service integration. Undertaking reproductive health service delivery requires improved understanding of the conceptual and practical linkages between administration and service delivery to best utilize a limited pool of resources. Two main rationales have been offered for integrated service delivery of reproductive health services: integrated services may better meet clients' needs; and integrated services may improve the efficiency and effectiveness of services.

Challenges to service delivery. Establishing a structure for service integration can facilitate but does not guarantee implementation of services, due to the complexity of reproductive health service packages, the existence of established vertical programs, and weak administrative capacity in some countries. These challenges, listed on the following page, are common to most service delivery programs but are exacerbated in integrated programs.

Donor level challenges. Effective donor collaboration greatly facilitates the implementation of reproductive health service delivery. Different donor priorities may result in an unbalanced evaluation of integrated services. Donors must address these concerns as well as those of resource sharing, assuming joint responsibility for successes and failures, and balancing local priorities with agency interests.

National program-level challenges. Reproductive health policies are most likely to succeed if national policy includes a wide range of constituencies, such as policy-makers, women's advocacy groups, grass-roots organizers, service providers, and client representatives, among others. An assessment of the reproductive health care services currently available and research on what clients want will provide a useful basis for policy discussions on service gaps. Budget planning should accompany policy development, particularly if the policy will be implemented through an integrated program. Limited programs focusing on priority needs are likely to have a greater health impact and can achieve higher quality of care than comprehensive programs that become overextended. Phased implementation of service components allows programs time to adjust the logistical and service delivery systems to accommodate program growth. Even with consistent national policies, the organization of government ministries makes integration challenging when personnel, resources, and policies are organized vertically.

Service delivery challenges. Issues identified at the service delivery level that require special attention in expanded reproductive health services include: infrastructure and referral systems; medical support, supplies and logistics; updated reproductive health service delivery guidelines; integrated record systems; delegation of activities; competence of personnel: training for staff and supervisors; supervision; and evaluation of integrated programs.

Costs and funding. Implementing proposed reproductive health services is a very ambitious task. The United Nations Population Fund (UNFPA) has estimated that globally, basic reproductive health services will cost U.S. \$17 billion in the year 2000. This assumes that countries contribute two-thirds of the resources for reproductive health, and donors, the remaining one-third. These estimates are useful; however, more work is required at the country level to estimate resource needs and to identify funding sources.

Policy actions. The challenge of the ICPD is the implementation of broad goals into concrete policies and programs at the country level. The historic consensus reached at the ICPD offers countries an unique opportunity to expand beyond family planning to more client-centered reproductive health care. We hope the process of policy formation and the design, implementation, and evaluation of reproductive health programs will benefit from previous lessons learned about services. Careful planning, coupled with consideration of clients' needs, is necessary in order to expand services and increase women and men's access to quality reproductive health care.

II. Introduction

The current emphasis on reproductive health (RH) in population programs began years ago when human rights and women's health advocates began to question the rationale of traditional policies that mainly focused on reducing population growth through the provision of family planning services (Dixon-Mueller, 1993a; Sinding and Ross, 1994). The increasing prevalence of sexually transmitted diseases (STDs) and AIDS sparked further discussion about the best ways to provide family planning services and treatment for STDs and HIV. Client expectations began to change, often as a result of work by organized groups of health care advocates, and women began to ask more from family planning than contraception (Sciarra, 1993). The 1994 International Conference on Population and Development (ICPD) in Cairo further focused the international community's attention on reproductive health. At the ICPD, there was consensus among national delegations on the need for a more comprehensive, client-centered view of reproductive health and for implementation of reproductive health programs in addition to family planning.

To translate broad and ambitious reproductive health goals into programs that meet clients' needs, policy-makers — working with program managers, health care advocates, service providers and others — must determine, from an array of proposed reproductive health options, what package of services to provide. They must also decide on the structure of expanded reproductive health programs, funding requirements and the sources of funding. These decisions will be difficult, since programs will require coordinated efforts and will compete with other priorities for limited domestic and international funding.

To meet clients' broader needs for reproductive health, programs will have to expand the range of services offered. At the same time, there is an unfinished agenda to increase access to and improve the quality of existing services. While there have long been discussions of the merits of integrated services, the 1994 ICPD intensified the interest in implementing reproductive health services through integrated programs. As governmental and non-governmental organizations (NGOs) begin to develop strategies for implementing ICPD recommendations at the local level, an important question remains: Will integrated programs be a successful mechanism for meeting reproductive health needs?

The purpose of this paper is to identify the challenges faced at the policy and service delivery levels of implementing reproductive health programs through integrated services.¹ We first summarize efforts to define reproductive health and corresponding

1. Another key outcome of the 1994 ICPD was the focus on reproductive rights and the activities needed to ensure their enforcement. This paper focuses on reproductive health rather than on the broader theme of reproductive rights.

service delivery packages. The authors then discuss challenges to implementing national reproductive health services by taking an historic view of past experiences in formulating, implementing, and evaluating integrated services of national, public-sector programs. The authors also examine experimental design interventions and demonstration projects. Finally, the authors address international and local resource issues. ²

III. Definitions of Reproductive Health and Proposed Service Delivery Packages

The consensus definition of reproductive health ratified at the 1994 ICPD represents an important initial step in the process of health service transformation.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (ICPD, 1994).

According to Faundes et al., (1989:117), "An important and necessary step forward in the process of improving reproductive health is a consensus on concepts. Such agreement, however, will not help women ... if clearer directions on how to transform the conceptual framework into practice are not available" (Faundes et al., 1989:117).

2. While NGOs in many countries may be better equipped to provide expanded reproductive health services because they generally have small programs that are more flexible, the majority of women and men worldwide will not receive reproductive health services without the active participation of the public-sector programs in service expansion. This paper thus focuses on public-sector programs. Many of the lessons learned from national programs, however, are applicable to NGO and private sector programs.

Ten international organizations have proposed the services necessary for comprehensive reproductive health care, as shown in Figure 1 (the organizations are listed at the bottom of Figure 1, pages 6-7). We have divided the activities between health services and related activities to differentiate those activities that can be undertaken through the health system and those that will require the participation of other ministries and organizations.

There are general similarities among proposed packages, which list 16 broad categories and 76 specific services or related activities. In terms of health services, in addition to family planning, all groups support the provision of maternity care services, including the sub-components of prenatal care, safe delivery, and postpartum care. All groups support the provision of STD/AIDS services, with more organizations mentioning treatment than prevention. While all groups support the provision of counseling, there is little agreement on substantive issues. The majority of groups have recognized a need for infertility services, but few organizations have specified the nature of the services. Most organizations support some type of pregnancy termination care (mostly management of complications and postabortion family planning).

In terms of related activities, which include, for example, linkages with other sectors and public education, there is less agreement among organizations. Related activities should differentiate between those activities that can be undertaken through the health system and those that will require the participation of other ministries and organizations.

The list in Figure 1 is extensive, and clearly, not all programs will be able to offer the full array of reproductive health services. National programs will have to select those services that provide the widest array of reproductive health benefits for the most people, taking into consideration epidemiological trends, services currently offered, client demand and resources available.

National programs also will have to consider numerous questions: To what degree should programs be fully integrated; under which government ministry or ministries should program responsibility lie; should a National Reproductive Health Commission, similar to the National Population Commissions common in many countries, be appointed to oversee and coordinate activities at the policy level; if a country was able to implement all 76 services and related activities which ministries would be involved. It is conceivable that several government ministries would need to play a role — for example, the Ministry of Health, the Ministry of Population (for service delivery), the Ministry of Education (for sex education), the Ministry of Social Affairs (for introducing parenting skills and household management education), the Ministry of

**Figure 1: Elements of Reproductive Health Services
Suggested by International Organizations**

<p>Family planning Range/choice of methods Delayed childbirth for adolescents Male responsibility Attention to unmet need/increasing demand Safety/side effects research Sterilization reversal Implant removal Quality services</p> <p>Pregnancy care Prenatal Tetanus toxoid Iron folate/iodine supplements Safe delivery Access to cesarean section Access to blood transfusions High-risk births Screening Transport Detection/management/referral for pregnancy complications Postpartum care Postpartum contraception</p> <p>STD/AIDS services Prevention Condom promotion/distribution Treatment/referral/screening Prenatal screening (syphilis) Symptomatic case management Adolescent treatment Identification of high-risk takers Policy dialogue Data collection for surveillance</p>	<p>Counseling and IEC Sex/sexuality education Safe sex Male support Women's support Parental/family support Pre-/early adolescent AIDS/STDs Abortion Family planning/methods Sterilization</p> <p>Breastfeeding Lactational Amenorrhea Method (LAM) Lactation management Breastfeeding for newborn/child care</p> <p>Infertility services (Prevention and management)</p> <p>Reproductive cancers Diagnosis Cervical cancer screening Breast cancer screening Treatment</p> <p>Mammogram</p> <p>Periodic gynecological exam Menstrual disorders Gynecological infections Care for women during menopause</p> <p>Nutrition services</p>
--	--

Abortion-related services

Management of complications
Pregnancy termination
Postabortion family planning
Improved sex education and
family planning services where
restrictions on abortion exist

Provider training

Technical competence in RH
Gender sensitivity
Adolescent nutrition
Appropriate training for physicians, nurses,
midwives and TBAs

**Management information system
(MIS) focusing on male/female clients****Public education**

Violence against women/gender discrimination
Female genital mutilation
Legalities of abortion
Nutrition
Sexuality/reproductive health rights
Unintended pregnancy
STDs
Smoking/substance abuse

Newborn/child care

Immunization
Oral rehydration therapy
Warming
Treatment for infection
Other child care

Other linkages

Child survival
Female literacy
Women's income
Women's status
Environment
Democracy
Safe motherhood
STD management

Note: The activities listed under the main components, particularly family planning, are not complete because most organizations focused their lists on the activities under each heading that require additional attention to fully promote the reproductive health of clients. This list of activities also does not identify special target groups that should be covered under reproductive health programs (e.g., adolescents, men, older women). Nor does the list address the challenges of breaking down what constitutes primary level reproductive health services and what can only be done at other levels of the system where more highly skilled providers are available.

Sources: This list was culled from documents from the International Planned Parenthood Federation, the U.S. Agency for International Development, the World Bank, the United Nations Population Fund, the International Projects Assistance Service, the International Women's Health Coalition, the Older Women's League, Population Action International, the Rockefeller Foundation, and the World Health Organization.

Justice (for insuring gender equality and addressing domestic violence), the Ministry of Planning, and the Ministry of Foreign Affairs. If one ministry has a coordinating role, how would it coordinate program components implemented by other ministries?

IV. Rationales for Integrated Services

An integrated approach represents the most commonly proposed strategy for implementing reproductive health services, although a broader range of services and improvements might also be achieved through enhanced single-purpose programs (e.g., expanded STD clinics and improved enforcement of laws against domestic violence), as well as through legal and policy reforms. Given the broad range of potential options, it is unlikely that many countries will introduce new vertical reproductive health programs unless such programs focused almost exclusively on medical activities and could be placed under the auspices of one ministry.

1. Definitions of integration

In family planning, the term “integration” has a long and controversial history. It has been used to describe the interaction between population and development, the incorporation of demographic variables into development plans, the addition of family planning activities to other service sectors or vice versa, the union of family planning and primary care or other health programs, the formation of umbrella coordinating committees, and the simultaneous introduction of different service packages (Korten, 1975; Ness, 1977; Morris and Lescohier, 1978; Hong, 1981; Files, 1982; Warwick, 1986; Simmons and Phillips, 1987; Mahmood, 1988; Hart et al., 1990; Mitchell et al., 1994). In family planning, “integration” has referred to various types of “administrative,” “service,” and “role” integration.

Administrative and service integration

Integration of various policy and program components may occur in varying degrees at the national, provincial, district, local, and other administrative levels, as shown in Figure 2 (page 10). Administrative and service integration are not mutually exclusive; attempts to integrate services without an effective administrative structure (integrated or not integrated at the various levels) may be counterproductive (Pratt et al., 1989; Simmons et al., 1990; Mitchell et al., 1994). The relationships between administrative and service integration are complex, and undertaking reproductive health service delivery requires an improved understanding of the conceptual and practical linkages between administration and service delivery to utilize effectively a limited pool of resources.

2. Two rationales for integration

While there are many ethical issues related to reproductive health — for example, can septic abortion treatment be provided without family planning, or can pills be provided without counseling on the risks of acquiring STDs and the potential need for dual method protection? — the authors focus on two rationales that have been offered for integrated service delivery of reproductive health services: Integrated services may better meet clients' needs, and integrated services may improve the efficiency and effectiveness of service delivery.

Better meeting clients' needs

The most fundamental rationale for integrated services is the likelihood that programs will be better able to help clients meet their reproductive needs (IPPF, 1981; Taylor et al., 1983b; Kunii, 1984; Rosen et al., 1989; Bruce, 1990; Simmons et al., 1990; Dixon-Mueller, 1994). While programs may separate services for administrative or financial reasons, from a client's perspective, it may be difficult to separate different reproductive health needs. The client may feel or actually be disadvantaged if offered an IUD without diagnosis and treatment of a reproductive tract infection, or if provided with antenatal and delivery care but no information on family planning or the signs and symptoms of reproductive health problems.

Some clients expect a broad array of reproductive health services when they have contact with a provider. Queen et al. (1991), for example, found that the clients from separate family planning and STD clinics in London assumed that providers would counsel them on all aspects of sexual health. Some clients, however, might not want all reproductive health services delivered at the same location. For example, family planning clients might consider it inappropriate to receive services at the same clinic attended by STD clients, or they might consider that they have to wait too long for family planning if family planning is offered together with MCH services.

A central premise of the reproductive health movement is the need to provide clients with high quality care by considering the client's perspective in the selection and delivery of services. The framework for family planning that outlines six elements of quality of care that programs should provide (Bruce, 1990) can be extended to other reproductive health services (Mora et al., 1993). More research is needed on the array of reproductive health care services clients would value most and the service delivery mechanisms through which they would like the services offered (e.g., through integrated or vertical programs). There are several links between reproductive health interventions and health outcomes. A framework developed by the Pan American Health Organization, FHI, and the International Projects Assistance Service (PAHO/FHI, 1993) outlines

Figure 2: Levels of Administrative and Service Integration for Reproductive Health

National/policy integration	Governments must decide whether reproductive health will be unified under a single umbrella organization at the national level. Policy-makers must also address mechanisms for integration and organizational arrangements to strengthen policy elements, set realistic time horizons for program implementation, and resolve differences between national goals and community needs.
Sectoral integration	Interactive linkages may be created among a variety of sectors, such as development, social welfare, and industry.
Interministerial integration	Roles are linked across agencies through joint activities of different reproductive health personnel. STD services might be subsumed under family planning in the Ministry of Health, or family planning and STD officials may be encouraged to interact. Officials must consider which ministry will assume responsibility for reproductive health services, such as those to address domestic violence, sex education, and the empowerment of women.
Subnational integration	Program planners must consider the extent to which administrative integration will occur at the provincial, district and local levels. Potential issues include staff interaction or consolidation, streamlining of records systems, and salary arrangements.
Local administrative integration	Local administrative integration might involve the reorganization of supervisory roles, client records systems, and program budgeting.
Service integration	Service integration might involve the linkage of several provider functions at the service delivery point and would require modification of worker roles, allocation of time and referral requirements.

Programs that serve similar populations and use similar service delivery strategies can be identified and linked through referral.

the linkages of desired health outcomes to three reproductive health components (Table 1, page 12). Empirical evidence supports this framework. Cuca and Pierce (1977a, 1977b) discussed results of 15 service experiments that integrated either maternal and child health and family planning, postpartum care and family planning, or postabortion care and family planning, or that used multipurpose workers. They found a synergistic relation between family planning and other health programs.

The challenge is not just to add services but to reach new populations. Family planning programs have traditionally focused on married women of reproductive age. Dixon-Mueller and Germain (1992) have proposed broadening definitions of “unmet need” for contraception to include additional groups: unmarried and married nonusers; users needing another method; users and nonusers needing a method to terminate unwanted pregnancies; and users and nonusers needing other reproductive health services. Men and adolescents generally have not been recipients of reproductive health services, nor have postmenopausal women. Integrated reproductive health services could fill the family planning needs of some of these underserved groups, as well as address other health concerns.

Improving efficiency and effectiveness of services

Integration of reproductive health services under some conditions — but not all — can improve the efficiency and effectiveness of the delivery system in relation to specified outcomes, such as increases in contraceptive prevalence or reductions in unintended pregnancies, maternal mortality, or incidence of sexually transmitted diseases. The terms “effectiveness” and “efficiency” could also be used to define outcomes regarding clients health — for example, the effectiveness of treatments and efficiency with which clients receive care (Finkle and Crane, 1976). Here we focus on effectiveness and efficiency as they relate to the service delivery system.

Greater efficiency could be achieved by requiring fewer worker-client contacts, minimizing duplication, sharing facilities, and training selected workers to perform multiple tasks. Some agree that service integration enhances program effectiveness, while others fear that service integration will cause one component to suffer at the expense of another. Walley et al. (1991) note in Ethiopia that despite an increase in visits of mothers and children to the multipurpose health worker (trained to provide growth monitoring/nutrition advice, immunizations, antenatal/postnatal care, family planning, and health education) certain services received more attention than others: Immunizations were offered regularly, growth monitoring was offered irregularly, and family planning and antenatal care were not offered but were provided when requested. On the other hand, integration of services can increase the interest and participation of a variety of service providers by enhancing their skills and level of responsibility (Files, 1982; Population Council, 1991).

Table 1: Linkages in Desired Outcomes of Reproductive Health Services			
Desired Outcome	Family Planning	Maternity Care	HIV/STD Services
Reduce unsafe abortion	X	X	
Reduce ectopic pregnancy	X		X
Reduce HIV/STDs among sexually active adults	X	X	X
Birth spacing	X	X	
Reduce cervical cancer	X		X
Reduce congenital syphilis		X	X
Reduce neonatal tetanus		X	
Reduce maternal complications	X	X	X
Reduce pelvic inflammatory disease	X	X	X
Reduce unwanted pregnancy	X	X	X
Reduce risk of nosocomial infection	X	X	X

Source: Adopted from PAHO/FHI, 1993

Grouping similar services may help influence the effectiveness of service integration. Degraff et al. (1986) found that the addition of oral rehydration therapy to the Matlab family planning and health services project had a significant negative effect on con-

contraceptive prevalence, whereas the addition of child care at the family welfare centers increased contraceptive prevalence. A study in Colombia, in which family planning employees of PROFAMILIA conducted AIDS outreach and prevention activities, showed that the new activities did not cause contraceptive sales to decline (Vernon et al., 1990).

Integrated service delivery can yield a lower cost per output than non-integrated programs (Gibbs, 1973; Rosen et al., 1989). Service integration can facilitate the use of existing health infrastructures and program staff, thus avoiding the costs of creating a new program infrastructure (Ness, 1981), as shown in the postpartum family planning programs and integrated maternity and family planning care in Honduras, Peru, and India (Faruquee, 1982a; Seward and Fong, 1983; Population Council, 1991). The assurance of a smooth flow of funds (Laing, 1981), the choice of populations served (Vernon, 1990), and the type of delivery strategy within the context of integrated programming (Rosenfield, 1984a) distinguish between programs that are cost-effective (depending on the program and outcomes of interest) and those that are not.

Depending upon choice of measures and analytical approach, however, two cost-effectiveness analyses of the same integrated service can vary markedly, depending on assumptions made in the analysis (Simmons et al., 1991). Furthermore, analyses rarely consider outcomes from the standpoint of longer-term client satisfaction or behavior:

- Did clients continue to use family planning effectively for birth spacing and limiting over a significant portion of their reproductive lifetimes?
- Did clients treated for STDs avoid contracting them again?
- Did clients who were taught good prenatal practices adhere to them in later pregnancies, and with what effect on morbidity as well as mortality?
- What costs did the client experience in utilizing the services that may not have been captured in measuring budgetary costs to the program?
- Were desired outcomes more likely with integrated or vertical reproductive health services?

New research using longitudinal and qualitative data can begin to examine these questions, which will become more salient as programs achieve expected short-term results on basic indicators, such as contraceptive prevalence or numbers of clients served.

V. Challenges to the Integration and Delivery of Reproductive Health Services

Establishing a structure for service integration can facilitate, but does not guarantee, implementation of reproductive health services, due to the complexity of reproductive health service packages, the existence of established vertical programs, and weak administrative capacity in some countries. This section draws on past experiences to address challenges facing integrated service interventions, looking first at the donor level, then at the national program environment, and finally, at the service delivery environment. We base these results on a review of more than 50 published and unpublished impact evaluations, operations research projects, demonstration projects, and other studies of national public-sector programs over the past 25 years. Many of these challenges are common to any service delivery program, but all are exacerbated in an integrated program setting.

Donor level environment

Effective donor collaboration will greatly facilitate the implementation of reproductive health service delivery. International agencies can influence national programs in various ways (World Bank, 1993; Mitchell et al., 1994). The expanding number of donors subjects recipients, as well as other donors, to increasing pressures of competing priorities. The orientation of the donor may result in an unbalanced evaluation of integrated services. Managers, for example, may worry about the response of a family planning donor to an integrated program that fails to raise contraceptive acceptance rates but improves maternal or child health. Finally, separate donor monitoring and reporting requirements can overburden in-country administrators with unnecessary duplication of reports.

Donors must address these concerns as well as those of resource sharing, assuming joint responsibility for successes and failures, and balancing local priorities with agency interests. One means to achieve this end could involve the establishment of a coordinating body with relevant ministries in recipient countries to ensure that donor inputs are complementary and that regular meetings between donors and governments occur. Donors may also form consortia to fund national programs or at least create informal groups to review progress and problems in reproductive health.

National program environment

National policies. Translating the broad goals of reproductive health into national policy through an implementation strategy requires political will and motivation by high-level government officials. There has been much debate about the content of expanded population policies that incorporate reproductive health (Dixon-Mueller, 1993a; Freedman and Isaacs, 1993; Berer, 1993; Bruce, 1994; Correa and Petchesky, 1994; Freedman, 1994;

Germain and Ordway, 1994; IWHC and CEPIA, 1994; IWHC and WHO, 1994; Zurayk et al., 1994). Cook (1993), for example, proposes a comprehensive view of public policy that incorporates women's rights, addresses reproductive health explicitly, and condemns all forms of discrimination.

Reproductive health policies will be most likely to succeed if the national policy development process includes a wide range of constituencies; for example, policy-makers, women's advocacy groups, grass-roots organizers, service providers, and client representatives, among others. Some policy-makers may resist addressing ideas such as women's empowerment and domestic violence. Lack of support from religious, political, or community groups can also frustrate policy efforts (Keller et al., 1974; Phillips et al., 1984a; CIAES, 1991). Since some of the proposed reproductive health interventions have not been widely tested, community ideas must be elicited. Broad-based participation in the design, planning, and management of reproductive health programs will facilitate the creation of sustainable programs.

An assessment of reproductive health care services currently available will provide a useful basis for policy discussions on service gaps. Many national programs have data from the Demographic and Health Surveys (DHS) and from studies such as the situation analysis of family planning service delivery points that can be used to inform decision-making. While quantitative techniques have been useful tools for setting targets, the goal of meeting clients' needs will benefit from increased use of qualitative research, particularly to discover which services clients themselves consider high priority components of reproductive health care.

Budgetary planning should accompany policy development, particularly if the policy will be implemented through an integrated program (World Bank, 1993). According to Mitchell et al. (1994:13), "when integration proceeds without changing the budgeting process, it does not work." Policy-makers, through balanced allocations, can implement mechanisms at the planning stages that de-emphasize capital-intensive projects, discourage competition for scarce resources, and encourage the formation of programmatic and sectoral linkages. Resource issues are discussed in more detail in Section VI.

Setting priorities and phasing implementation. In many countries, access to currently available services is limited. The relative deficiency of services in rural areas has long been a problem for integrated and non-integrated programs (Taylor and Berelson, 1971; Rosenfield, 1982; Simmons and Phillips, 1987; Thaddeus and Maine, 1994). For example, despite efforts to integrate mother and child health services in Ethiopia, health units have remained inaccessible to much of the population in the Wollo region (Walley et al., 1991). Village women, who must walk many kilometers over mountainous terrain to reach the clinic, tend to visit the clinic only for emergencies. Geographic access was also reported to be a problem in the rural Maternal and Child Health and Family Plan-

ning Project in Calabar, Nigeria (Weiss, 1982). Rosenfield (1982, 1984a) attributes the gaps in MCH and family planning in rural areas to the introduction of costly, highly technical, and physician-oriented urban strategies that drained national health budgets. Problems of access will be more critical as programs work to expand availability of other reproductive health services.

A limited program focusing on priority needs can have a greater impact on health outcomes and can achieve higher quality of care than a comprehensive program that becomes overextended (Rosenfield, 1984a; Ross, 1986; Maine, no date). Additional field support should accompany each new component so that new activities do not overburden workers and divert their energy from existing tasks (Phillips et al., 1984a). The UNFPA (1984) program report for Malawi, for example, suggests that as services are added (e.g., child spacing to MCH), program managers should assess the additional needs for supervisors and service personnel.

A delicate balance exists between the expansion of reproductive health services and the improvement of quality of care for every service component. Evidence from programs in Indonesia and Bangladesh demonstrates that the addition of new technologies does not necessarily expand choice; in fact, the removal of technologies that overburden a delivery system may improve quality of care (Simmons et al., 1990; Simmons et al., 1994). Likewise, introduction of new reproductive health services may tax an existing health care system. Reproductive health program planners and evaluators must remain cognizant of the costs to quality of care that will accrue if health providers are asked to assume new tasks without adequate resources, training, equipment, and other prerequisites. The introduction of one service that is desired by a community may foster the community's acceptance of additional service components. Phased implementation of service components would allow programs time to adjust the logistical and service delivery systems to accommodate program growth. Given the complex nature of proposed programs, national leaders and other constituents should provide explicit and realistic goals for the phase-in of new services and geographic program expansion.

Interministerial and intraministerial level issues. Even with consistent national policies, the organization of government ministries makes integration challenging (NCIH, 1982). When ministerial personnel, resources, and policies are organized vertically, a program subsumed under one ministry receives that ministry's focus. Fear of takeover and loss of status or career prospects create barriers to effective collaboration (Laing, 1981). Despite political support, integration under such circumstances can threaten established channels of command over scarce resources (Cuca and Pierce, 1977a; Simmons and Phillips, 1987).

Examples from Pakistan and Nepal in Figure 3 (below, page 17) illustrate that barriers to integration at the upper administrative levels of formerly centralized, vertical programs can strongly hinder program development.

Service delivery environment

Infrastructure and service referral. In the short-run, the feasibility of integrated health service delivery is contingent on the adequacy of the existing health infrastructure (Taylor and Berelson, 1971; Cuca and Pierce, 1977a, 1977b; WHO, 1992). In the long-run, advocates are proposing that investment be made to strengthen infrastructure. Referral systems represent a potential linkage where health infrastructures are particularly weak. Referral systems can be established vertically to provide higher levels of care (e.g., referral for female or male sterilization) or horizontally to link programs (e.g., family planning, STD and maternity care services).

Figure 3: Inter- and Intraministerial Issues in Integration

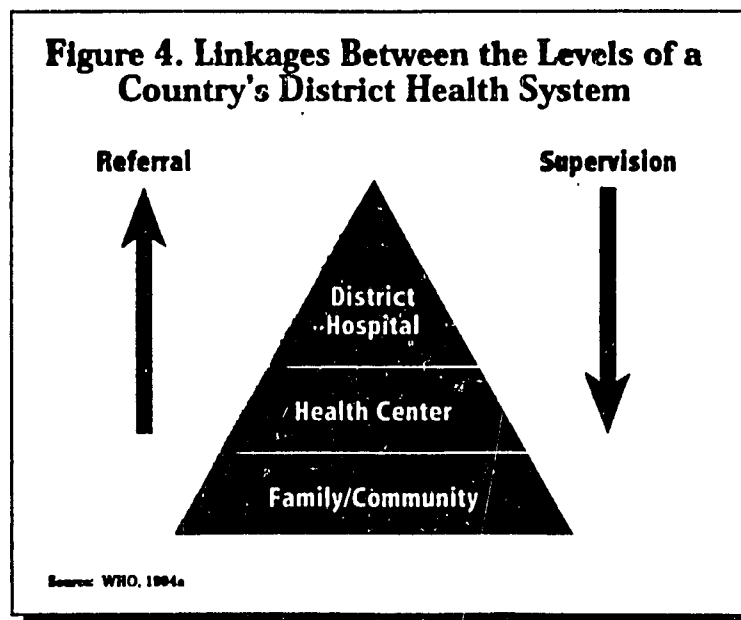
Nepal. Bureaucratic difficulties in the transition from vertical to integrated programming have occurred in the Nepal Integrated Rural Health/Family Planning Services Project (Pratt et al., 1989). The King's initial decision to integrate several vertical programs into the Ministry of Health and a later decision to decentralize the service package met with unanticipated resistance from senior staff of the vertical programs. The resistance to integration of vertical staff into the Ministry of Health was reportedly due to insufficient permanent posts, the failure of (skilled) contract employees to qualify for permanent posts, and the potential loss of status and authority. The division of authority at the highest administrative levels encouraged divided loyalties and inconsistent personnel changes throughout the administrative hierarchy. Vertical health posts continued to function in the absence of direction from senior employees of the health posts, who were constrained by poor supervision and concerns about their careers.

Pakistan. Frequent policy and program shifts have prevented the growth of the family planning program in Pakistan. Since the program's inception, responsibility for the program has shifted from the Ministry of Health, to the Ministry of Population and Development, to the Ministry of Population Welfare. Over the last 30 years, 22 federal-level program officials have been appointed (Rukanuddin and Hardee-Cleveland, 1992).

Referral between services and providers can be an effective intermediate or long-term strategy for improving coverage and quality of care without moving services to the same delivery point. First, components serving similar populations and using similar service delivery strategies can be identified and linked through referral (Cates, 1984; Vernon et al., 1993; Huntington and Aplogan, 1994). One or both of the programs should be functioning at the desired level of performance before linkage. Ladipo and Delano (1984) proposed the establishment of "health teams" consisting of a variety of providers with clearly defined roles. Their health teams parallel the Maternity Care Pyramid (Figure 4, below, page 18), which illustrates provider roles and linkages between the three levels of a country's district health system (MotherCare Project in WHO, 1994a).

The absence of functional facilities at the first and second referral levels, however, makes referral from the periphery an empty gesture (Simmons et al., 1990). Unfamiliarity among providers about the benefits of referral may require supervisory visits and discussion before the practice is adopted. Clinicians may require training to develop skills in merging discrete activities through referral, which can be accomplished with on-site supervision and short training programs for clinic staff and community workers.

Medical support, supplies and logistics. A continuous supply of drugs and equipment to all service delivery levels is essential to enhance reproductive health (NCIH, 1982; Rosenfield, 1984a; Thaddeus and Maine, 1994; WHO, 1994b). Yet many health posts lack basic equipment. Sixty-one percent of health posts in the Guatemalan highlands, for example, were without refrigerators for drug and vaccine storage, 44 percent lacked a work table, and 90 percent did not have educational materials (Annis, 1981 in Thaddeus and Maine, 1990).



Deficiencies in essential supplies have serious implications for several reproductive health components, especially STD diagnosis and treatment, maternity care, and management of abortion complications. Barriers to the regular provision of medical support and supplies, not only found in integrated programs (Laing, 1981; Ross, 1986; Burbach, 1987), include resource limitations, the lack of supplies at the central level, poor national or local systems of distribution, inadequate local storage capacity, untimely or inaccurate projections for needed supplies, irregular monitoring of supply use, and poor management of available resources. Simmons et al. (1990) show in Bangladesh that as a result of deficiencies in medical support and distribution of supplies, a field worker can identify a basic medical need, such as iron for anemia, but she must rely on hospital referral because there is no field distribution of iron tablets. Mitchell et al. (1994) have suggested that logistics systems should be integrated only when services are operating at similar levels of efficiency.

Updated service delivery guidelines. Work has been undertaken to analyze guidelines that would accomplish three goals: to reduce barriers hindering access to family planning, to broaden access to contraceptive methods, and to improve the quality of care with which contraceptives are provided (Shelton et al., 1992; Hardee, 1993; Angle, 1993; Technical Guidelines Working Group, 1994). Similar work will be required to ensure that guidelines exist for all reproductive health services offered in a country and that the guidelines are based on current scientific information. The guidelines must be disseminated to all service providers who offer reproductive health services.

Integrated records systems. Integration of reproductive health services will require changes in record-keeping and reporting. Experts have recommended the integration of records systems at the district level and below to avoid overburdening the program with separate reporting and evaluation systems if collaboration among agencies is involved (NCIH, 1982; UNFPA, 1984).

Delegation. Potential advantages of delegation of activities from higher to lower level staff include overcoming a shortage of trained workers, freeing physicians from routine tasks, conserving the specialist's time for emergencies, avoiding long delays in care caused by a centralized system, and promoting worker satisfaction. These advantages can affect program performance, as shown in the Katibougou family health project in Mali: "[A]s the responsibilities of the health workers expanded, more information and services became available at the village level" (Kak and Singer, 1993).

Barriers to effective delegation include resistance among medical professionals, delegation without adequate training, unclear job descriptions, and ineffective communication sparking team rivalries (UNFPA, 1984; Nasah, 1992; Shelton et al., 1992). Despite the potential pitfalls, local literate or illiterate health workers, given proper training and supervision, can successfully perform a variety of tasks normally reserved for more

highly trained professionals (Tom et al., 1984-5; Koblinsky et al., 1994). Delegation of some medical responsibilities (e.g., prescribing antibiotics) to paramedical workers may require legal and regulatory changes. In some cases, staff in local health centers carry out tasks they were not assigned, simply because they are the only staff available. They lack training, ironically, because the tasks fall outside of their job description. Ultimately, “[p]olicy decisions about the delegation of tasks need ... to be based upon ... the potential for reducing morbidity and mortality, the level of skills involved, the ability to maintain that level of skill, and the possibility of alternatives” (WHO, 1994b).

Adequacy and competence of personnel. Availability of trained personnel, worker density, worker competence, and the geographic distribution of workers have been issues of concern in integrated programs for decades (Taylor and Lapham, 1974; Laing, 1981; Ladipo and Delano, 1984; Thaddeus and Maine, 1994;). In general, Fathalla (in Khanna et al., 1992) notes that fewer than 20 percent of births in some developing countries are attended by trained personnel. The UNFPA (1991) notes, in a review of the integrated maternal and child health/family planning program in Botswana, that 140 health posts lacked enrolled nurses. As a result, family welfare educators were unable to carry out community-level activities and had to assume clinic nursing functions. High turnover due to job reassignment and the absence of temporary replacements also affected management capacity. Integrated reproductive health programs, having invested resources in training staff, will have to find ways to reduce staff turnover and make maximum use of existing staff.

The overburdening of workers and supervisors may be more pronounced as reproductive health services are expanded (Laing, 1981; Fong et al., 1982; NCIH, 1982; UNFPA, 1984; Burbach, 1987). Both the number of assigned tasks and the geographic area for which workers are responsible can contribute to the problem. Expecting field workers to complete an unmanageable number of tasks over a large geographic area can reduce workers' morale, motivation, and productive work time, and can ultimately hinder the quality of care of the program or of selective components. Some field workers in Bangladesh, for example, do not provide maternal and child health services because it adds to an already heavy work burden, and high worker/client ratios increase the difficulty of client contact (Simmons et al., 1990). Programs should assess how many tasks different levels of staff can learn and carry out.

Staff training. Adequacy of staff training has been cited repeatedly as an issue for integrated services. Several characteristics of training personnel in integrated programs repeatedly appeared in the literature. All levels of workers should be trained in accountability and quality of care, including technical competence, sensitivity to the needs of clients, continuity of care, commitment to informed choice, and listening to clients (Dixon-Mueller, 1993a). Phased training, where health workers are taught new skills after they are competent in other skills, is recommended. Refresher training can main-

tain a positive rapport among staff and the interest of providers and supervisors in the quality and intensity of work (Bhatia et al., 1980; NCIH, 1982; Rosenfield, 1984a; UNFPA, 1984; Pratt et al., 1989; WHO, 1994b). Training of supervisors is critical, as well. If supervisors are not trained in the new skills of their staff, they will not be able to adequately supervise the new activities. They will also be less likely to encourage staff to use their newly acquired skills.

An expanded package of reproductive health services, however, is likely to complicate the retraining of supervisors and service providers. In addition to having more topics to teach, programs will have to organize either on-site training in potentially remote areas or interrupt the availability of services to retrain staff away from the service delivery point.

Supervision. Supervision will play a key role in ensuring that workers are able to perform their expanded duties. Workers need to understand their new roles in reproductive health programs to enable them to perform their new jobs effectively and to discourage them from reverting to their former practices. Barriers to adequate supervision have included deficiencies in supervisory training, inadequate transportation, unclear definition of supervisory responsibilities, inadequate materials and checklists, and the absence of a reporting system at the peripheral level (UNFPA, 1984). Weak supervision in Danfa, Ghana, contributed to lowered activity of the field staff and loss of new skills (Ross, 1986). Such barriers can also affect the nature of the supervisor-supervisee relationship. Fong et al. (1982), found in South Korea that the frequency of interaction between workers and the clinic chief explained 50 percent of the variance in clinic-level performance. In the public sector in Bangladesh, the bureaucratic hierarchical nature of public-sector programs hampered supportive, problem-solving supervision (Simmons et al., 1990:219).

Supervisors can encourage positive staff interaction. In Malaysia, collective problem-solving had a positive impact on program performance (Fong et al., 1982). Building effective working relationships at the local level, paying attention to norms of service, and effective external interaction are program characteristics under the direct control of managers. Under supportive conditions, supervisors should be able to conduct regular site visits, observe worker activities directly, train workers, and facilitate effective programming (Rosenfield, 1984a; UNFPA, 1984; Pratt et al., 1989; Mitchell et al., 1994; WHO, 1994b).

Evaluating integrated programs

Assessing whether the intervention works. In the long-run, experimentation with various combinations of reproductive health services can help programs develop their optimal package of services. Demonstration projects can test the feasibility of integrating reproductive health services (NCIH, 1982; Germain and Antrobus, 1989). For example, current demonstration projects in Bangladesh and Navrongo, Ghana, could be used to

study the interventions that have emerged in recent discussions of reproductive health and from the 1994 ICPD. Certain national characteristics can be incorporated in the design of a demonstration project to ensure its replicability and applicability. In Bangladesh, the Matlab Extension Project has transferred innovations far beyond the original service area (Phillips et al., 1984c:62).

One critique of demonstration projects is that issues and policy-makers change during the course of an extensive demonstration project, which may hinder the use of the findings in the end. Another concern is whether the findings will be replicable beyond the demonstration project, which often benefits from well-trained staff and abundant financial resources. The high costs of demonstration projects and impact evaluation also must be balanced with the benefits of learning whether or not an intervention can work.

Program evaluation. Future evaluations of reproductive health programs will benefit from the development of conceptual frameworks and indicators that apply to various national and local contexts, that incorporate a broader range of outcomes — including longitudinal and community-level outcomes — and that consider the views of stakeholders in reproductive health outcomes, most notably clients.

Tsui (1994) conceptualizes the demand-side, supply-side, life-cycle, behavioral-epidemiological, and donor views of reproductive health through a framework for understanding the common implementation features of different combinations of reproductive health components.

Mora et al. (1993) have developed a framework for evaluating quality of care in reproductive health that focuses on the integration of maternal health, STDs, and family planning, and outlines three levels of care (community, clinic and hospital). They have provided an array of indicators useful for evaluating program components by type of service delivery point.

FHI's Women's Studies Project has designed a framework to assess the impact of family planning and reproductive health programs on a number of aspects of women's lives, including individual psychological and physical factors, women's household and family roles, and their community and social roles (FHI, 1994). Because the Project is designed to collect information on women's perceptions of family planning services, a logical extension might be use of the framework to guide evaluation of reproductive health programs and to understand the impact of these new activities on the lives of women.

Evaluations will require use of multiple indicators of success based on expanded target populations. A USAID working group has identified more than 180 indicators to measure various components of reproductive health (Bertrand and Stewart, 1995). Definitions of positive impact may vary among different constituencies for projects (for ex-

ample, donors, policy-makers, health care advocates, and clients may all perceive different indicators of success). Jain and Bruce (1993) suggest the use of a modified HARI index (Helping Individuals Achieve their Reproductive Intentions), which is 100 if the program is completely successful and 0 if the program fails to prevent unwanted pregnancy and unnecessary morbidity. The HARI index allows clients to define the reproductive health needs to be met and implies the logical intervening steps of quality of care. A challenge to the use of a modified HARI index is the current difficulty of measuring reproductive health morbidity in the developing world. Murray and Chen (1992) have developed a conceptual framework for measuring morbidity that includes both perceptions of the client and observations of the health worker. Family Health International currently is undertaking a five-country study and preliminary results show that the incidence of maternal morbidity is higher than previously estimated — 240 to 330 maternal morbidities to each maternal death compared to 15 to 100, as previously estimated (Finger, 1994).

VI. Costs and Funding for Reproductive Health Services

Proposed packages of reproductive health services are ambitious, as is the task of implementing integrated services. Two further issues for consideration are the expected costs of reproductive health services and sources of funding.

Current cost estimates

Table 2 (page 24) shows UNFPA (1994) cost estimates for basic population and reproductive health programs. By the year 2000, basic reproductive health programs in developing countries (and countries in transition) will cost an estimated U.S. \$17 billion annually from all sources. Figures for the “reproductive health” component in Table 2 are based on experiences with maternal health programs. For a more complete account of the components of the cost estimate, see UNFPA, 1994. It is important to remember that these are global estimates rather than an aggregate of country estimates.

Data and methodology limitations. Current cost estimates are limited by the dearth of reliable information from national programs. Poor information on the extent and distribution of reproductive morbidity and mortality, which varies from country to country, increases the difficulty of assessing unmet need for routine and emergency reproductive health care and, thus, the costs of these services (Tinker and Koblinsky, 1993). Finally, the infrequent disaggregation of population expenditures by service component and discrepancies between the type of data available and the data necessary for cost analyses complicates the estimation process (HCPDS, 1994; World Bank, 1994). Janowitz and Bratt (1992) have proposed several ways to improve the

Program Component	Year			
	2000	2005	2010	2015
Family planning	10.2	11.5	12.6	13.8
Reproductive health	5.0	5.4	5.7	6.1
HIV/STD prevention	1.3	1.4	1.5	1.5
Data/policy analysis	0.6	0.3	0.7	0.3
Total	17.0	18.5	20.5	21.7

Source: UNFPA (1994). Note: 1993 U.S. dollars in billions. Figures are rounded.

comparability of cost estimates and support the development of a clear understanding of essential program characteristics, as well as the development and adoption of a standard costing approach by donors and programs.

Applicability of global estimates. A single cost estimate for world reproductive health programming disguises national diversity in resource needs (Tinker and Koblinsky, 1993; HCPDS, 1994). The applicability of current estimates is necessarily limited by analytical assumptions. One assumption concerns the quality of care. UNFPA (1994) estimates are based on the assumption that improvements in quality of care will occur with proposed resource inputs, improved technical efficiency, and economies of scale. Another analysis is based on the assumption of "constant quality" across service components and packages (Cowley and Bobadilla, 1994). While this assumption overcomes the obstacle of inadequate availability of quality of service data, it overlooks real variability in the quality of services by program setting. A key problem is lack of knowledge of the relationships between inputs and outputs in reproductive health care.

Current estimates (Cowley and Bobadilla, 1994) also assume a certain level of administrative and technical efficiency that may be unrealistic. Cost analysts have suggested that efforts to understand local resource flows may be more meaningful than global cost estimation of reproductive health (HCPDS Workshop Minutes, 1994). The costs of program outputs will vary by country. Until contextual factors are considered, cost estimates will not be applicable to country program settings.

Funding for expanded reproductive health programs

According to Fathalla (in Khanna et al., 1992:27), “[t]he world has the resources to implement the necessary strategies to improve reproductive health. It is a question of rational allocation and effective utilization and of redressing imbalances in priorities.” The UNFPA (1994) reports that, on average, 75 percent of resources for population activities (ranging from 20 percent in some countries to 100 percent in others) have been provided by developing countries themselves. However, increasing constraints on developing countries caused by growing populations, declining economies in some countries, and increasing demand for services may compel external funding sources to assume a greater share of the cost if services are to be maintained and strengthened (ICPD, 1994; UNFPA, 1994). Several experts have suggested ways to expand and increase the efficiency of internal and external resource flows. Donors are expected to assume one-third of the costs of new reproductive health programs (UNFPA, 1994). The ICPD Programme of Action (1994) notes that low-income developing countries will require a greater share of external assistance.

The United Nations estimates that two-thirds of the costs for reproductive health care need to be met by the countries themselves (ICPD, 1994). However, declines in central government allocations for health and declines in real growth of the gross domestic product (GDP) in many developing countries have resulted in a deterioration in health sector expenditures. Yet, the intersectoral allocations of central governments in developing countries provide avenues for change (Nigam and Parker, 1994). The main focus on intersectoral restructuring could be on improved efficiency, effectiveness, and cost recovery (Lewis, 1986; Ross and Isaacs, 1988; Lande and Geller, 1991; Tinker and Koblinsky, 1993). Governments will have to examine new modes of resource mobilization, such as involving the private sector, selective use of user fees, social marketing, and cost-sharing (ICPD, 1994; World Bank, 1993). In low-income countries, governments may consider investing in more cost-effective health activities, shifting health spending from tertiary care centers to the district health infrastructure, and encouraging increased community financing of essential health care. In middle-income countries, governments could phase out subsidies for higher socioeconomic groups and encourage payment methods that control costs.

VII. Summary and Policy Actions

Countries have a unique opportunity to capitalize on the historic consensus reached at the 1994 ICPD: to expand beyond family planning to broader and more client-centered approaches to reproductive health care. Taking advantage of the excitement and momentum created in Cairo, countries must now translate broad goals into specific service delivery programs to meet the reproductive health needs of women and men worldwide. While the 1994 ICPD has set the agenda, many tasks remain. Policy-makers, program planners, reproductive health advocates, and donors, among others, must first set national goals for reproductive health and translate them into policies. Countries then need to decide on the package of services to be offered, in light of services currently available, to reach the goals for improving reproductive health. Next, countries must determine funding requirements and sources of funding, both national and international. Finally, they need to plan an implementation strategy, including integration of services or service linkages, organizational responsibilities and a timeline for phasing in the services, given financial and infrastructure constraints. Programs will need to monitor the implementation of reproductive health services and to be flexible about making appropriate shifts in programs.

This review of the literature on the components of reproductive health has synthesized past experience with integrated service delivery, primarily in national family planning and maternal and child health programs. At a minimum, country-level reproductive health programs are very likely to include family planning, maternity care, STD/HIV services and some type of abortion-related care. The extent to which countries can offer any of the other related services will depend on epidemiological trends, services currently offered, resource availability, and need. Past experiences with integrated programs provide valuable insights and information useful for future expansion of services. The authors hope the process of policy formation and the design, implementation, and evaluation of reproductive health programs will benefit from previous lessons learned at the policy and service delivery levels. Careful planning, coupled with consideration of clients' needs, is necessary to expand services and to increase women and men's access to quality reproductive health care.

VIII. References

Angle, MA, Curtis KM, Zea JW, Meows KJ, Mesa P. *Improving Family Planning Service Quality by Reducing Medical Barriers and Increasing Access to Family Planning Services and Quality of Care through the Development of National Family Planning Policies: Examples from Sub-Saharan Africa*. Paper presented at the American Public Health Association Annual Meeting, 1993.

Berer M. Population and family planning policies: Women-centered perspectives. *Reproductive Health Matters* 1993; (1): 4-12.

Bertrand J, Stewart K. *Overview of the Reproductive Health Indicators and the Process for their Development*. Paper presented at the Population Association of America Meetings, San Francisco, 1995.

Bhatia S, Mosley WH, Faruqee ASG, Chakraborty J. 1980. The Matlab family planning-health services project. *Studies in Family Planning* 1980; 11(6): 202-12.

Bruce J. Fundamental elements of the quality of care: a simple framework. *Studies in Family Planning* 1990; (21):61-9.

Bruce J. Population policy must encompass more than family planning services. *Beyond the Numbers: A Reader on Population, Consumption, and the Environment*. Ed. Laurie Ann Mazar. Washington DC: Island Press, 1994, 150-57.

Burbach C. PVO perspectives on integrating family planning into primary health care. *Family Planning with Primary Healthcare*. Ed. F. Curtiss Swezy and Cynthia P. Green. Washington, DC: National Council for International Health, 1987. 36-99.

CIAES. *Qualitative Research on Knowledge, Attitudes, and Practices Related to Women's Reproductive Health: Cochabamba, Bolivia*. Working Paper No. 9. Arlington: MotherCare Project, 1991.

Chen L. U.S. policies on population resources: issues and suggestions on the road to Cairo. [Unpublished]. 1994.

Chesler E. Stop coercing women. *The New York Times Magazine* 6 Feb. 1994: 30-32.

Cohen SA, Richards CL. The Cairo consensus: population, development and women. *Family Planning Perspectives* 1994 (26):272-77.

Cook R. International law and women's health. *Gender, Women, and Health in the Americas*. Ed. Elsa Gomez Gomez. Washington, DC: PAHO, 1993. 244-51.

- Correa S, Petchesky R. Reproductive and sexual rights in feminist perspective. *Population Policies Reconsidered: Health, Development, and Human Rights*. Ed. Gita Sen, Adrienne Germain, and Lincoln Chen. Cambridge: Harvard University Press, 1994. 1-17.
- Cowley P, Bobadilla JL. *Costing the Mother-Baby Package*. Washington, DC: World Bank, 1994.
- Cuca R, Pierce CS. *Experiments in Family Planning: Lessons from the Developing World*. Baltimore: Johns Hopkins University Press, 1977a.
- Cuca R, Pierce CS. Experimentation in family planning delivery systems: an overview. *Studies in Family Planning* 1977b; 8(12): 302-310.
- DeGraff DS, Phillips JF, Simmons R, Chakreorty J. Integrating health services into an MCH-FP program in Matlab, Bangladesh: an analytical update. *Studies in Family Planning* 1986; (17): 228-34.
- Dixon-Mueller R. *Population Policy and Women's Rights: Transforming Reproductive Choice*. Westport: Praeger, 1993a.
- Dixon-Mueller R. "The sexuality connection in reproductive health. *Studies in Family Planning* 1993b; (24): 269-82.
- Dixon-Mueller P. Women's rights and reproductive choice: rethinking the connections. *Beyond the Numbers: A Reader on Population, Consumption, and the Environment*. Ed. Laurie Ann Mazur. Washington, DC: Island Press, 1994. 227-41.
- Dixon-Mueller R, Germain A. Stalking the elusive 'unmet need' for family planning. *Studies in Family Planning* 1992; (23): 330-35.
- El Tom AR, Matthews MH, Wessley S, Mubarak N, Lauro D. Introducing integrated health services in a traditional society: the Sudan community-based family health project. *International Quarterly of Community Health Education* 1984-85; 5(3): 187-202.
- Faruqee R. *Analyzing the Impact of Health Services: Narangwal and Other Experiences*. Population and Human Resources Division Discussion Paper No. 81-6. Washington, DC: World Bank, 1981.
- Faruqee R. *Integrating Family Planning with Health Services: Does It Help?* World Bank Staff Working Paper No. 515. Washington, DC: World Bank, Development Research Department, 1982a.
- Faruqee R. *Analyzing the Impact of Health Services: Project Experience from India, Ghana, and Thailand*. World Bank Staff Working Papers No. 546. Washington, DC: World Bank, 1982b.

- Faruqee R. 1983. Family planning and health: the Narangwal experiment. *Finance and Development* 1983; 20(2): 43-6.
- Faruqee R, Johnson E. *Health, Nutrition, and Family Planning: A Survey of Experiments and Special Projects in India*. Population and Human Resources Division Discussion Paper No. 81-14. Washington, DC: World Bank, 1981.
- Fathalla MF. From family planning to reproductive health. *Beyond the Numbers: a Reader on Population, Consumption, and the Environment*. Ed. Laurie Ann Mazur. Washington, DC: Island Press, 1994a. 143-49.
- Fathalla MF. Fertility control technology: a women-centered approach to research. *Population Policies Reconsidered: Health, Development, and Human Rights*. Ed. Gita Sen, Adrienne Germain, and Lincoln Chen. Cambridge: Harvard University Press, 1994b. 223-34.
- Faundes A, Hardy E, Pinotti JA. Commentary on women's reproductive health: means or end? *International Journal of Gynecology and Obstetrics* 1989; 3 (supp): 115-18.
- FHI. *Conceptual Framework: The Impact of Family Planning on Women's Lives*. Durham, NC: Family Health International, 1994.
- Files LA. A reexamination of integrated population activities. *Studies in Family Planning* 1982; (13)10: 297-302.
- Finger W. Maternal morbidities affect tens of millions. *Network* 1994; 14(3): 8-11.
- Finkle J, Crane B. The World Health Organization and the population issues: organizational values in the United Nations. *Population and Development Review* 1976; 2(3-4); 367-94.
- Fisek NH. An integrated health/family planning program in Etimesgut district, Turkey. *Studies in Family Planning* 1974; 5(7): 210-20.
- Fong CO, Kim KW, Ness GD. Integration and family planning programme performance: an interpretive summary of research projects in Malaysia and the Republic of Korea on the determinants and impact of integration in family planning programmes. *Population Research Leads* 1982; 12: 1-25.
- Freedman LP. Law and reproductive health. *Beyond the Numbers: A Reader on Population, Consumption, and the Environment*. Ed. Laurie Ann Mazur. Washington, DC: Island Press, 1994. 199-205.
- Freedman LP, Maine D. Women's mortality: a legacy of neglect. *The Health of Women: a Global Perspective*. Ed. Marge Koblinsky, Judith Timyan and Jill Gay. Boulder: Westview Press, 1993.
- Freedman LP, Isaacs SL. Human rights and reproductive choice. *Studies in Family Planning* 1993; (24): 18-30.

- Freedman R, Berelson B. The record of family planning programs. *Studies in Family Planning* 1976; 7(1): 1-40.
- Gadalla S, Nosseir N, McCarthy J, Shah F. *Fertility, Contraceptive Use, and Use of Oral Rehydration Salts in Rural Beni-Suef Governorate, Egypt*. Papers on Population. Baltimore: Johns Hopkins University, Hopkins Population Center, 1983.
- Gadalla S, Nosseir N, Richardson P, McCarthy J. *Comprehensive Report of the Integrated Social Service Delivery System Project in Menoufia Governorate, Egypt*. Papers on Population. Baltimore: Johns Hopkins University, Hopkins Population Center, 1983.
- Gadalla, S, Nosseir N, Shah F, McCarthy J. *Comparison of Baseline and Round III Surveys in 12 villages in Menoufia Governorate, Egypt: An Evaluation of Family Planning and Health Interventions*. Papers on Population. Baltimore: Johns Hopkins University, Hopkins Population Center, 1984a.
- Gadalla S, Nosseir N, Shah F, McCarthy J. *Population and Health in Rural Menoufia Governorate, Egypt: Results of a Survey of 24 Villages*. Papers on Population. Baltimore: Johns Hopkins University, Hopkins Population Center, 1984b.
- Gadalla S, Nosseir N, Shah F, McCarthy J. *Integrated Social Services Delivery System Project in Menoufia, Egypt: Results of the Third Round of a Socio-demographic Survey*. Papers on Population. Baltimore: Johns Hopkins University, Hopkins Population Center, 1984c.
- Gadalla S, Rashad A, McCarthy J, Shah F. *Integrated Social Service Delivery System Project in Menoufia Governorate, Egypt: Results of the First and Second Rounds of a Socio-demographic Survey*. Papers on Population. Baltimore: Johns Hopkins University, Hopkins Population Center, 1982.
- Gallen ME, Rinehart W. *Operations Research: Lessons for Policy and Programs*. Population Reports, Series J, Family Planning Programs. Baltimore: Johns Hopkins University, Population Information Program, 1986. 813-52.
- Germain A, Antrobus P. New partnerships in reproductive healthcare. *Populi* 1989; 16: 18-30.
- Germain A, Ordway J. Population policy and women's health: balancing the scales. *Beyond the Numbers: A Reader on Population, Consumption, and the Environment*. Ed. Laurie Ann Mazur. Washington DC: Island Press, 1994. 135-39.
- Gibbs CE. 1973. Family planning — a matter of health. *Obstetrics and Gynecology* 1973; (41): 621-23.
- Graham WJ. Reproductive health in developing countries: measurement, determinants, and consequences: overview. *International Population Conference*. Liege (Belgium): IUSSP, 1993. 571-77.

- Graham WJ, Campbell OM. Maternal health and the measurement trap. *Social Science and Medicine* 1992; 35(8): 967-77.
- Hardee K. Six quality of care elements and medical barriers that inhibit them. *Network* 1993; (3): 11.
- Hart RH, Belsey MA, Tarimo E. 1990. *Integrating Maternal and Child Health Services with Primary Health Care: Practical Considerations*. Geneva: WHO, 1990.
- Harvard Center for Population and Development Studies. *Estimating Resource Needs for Population Activities after Cairo*. Report of a workshop. Ed. Tahmina Rahman. Cambridge: Harvard Center for Population and Development Studies, 1994.
- Heise L. Violence against women: the missing agenda. *The Health of Women: A Global Perspective*. Ed. Marge Koblinsky, Judith Timyan, and Jill Gay. Boulder: Westview Press, 1993.
- Hong S. 1981. Review of the concepts of integrated programmes and community participation. *United Nations Economic and Social Commission for Asia and the Pacific Regional Seminar on Evaluation of Schemes and Strategies for Integrated Family Planning Programmes with Special Reference to Increased Involvement of Local Institutions*. Asian Population Studies Series No. 51; I ST/ESCAP/161. New York: United Nations, 1981. 42-44.
- Hossain M. Policy issues in integrated approaches to family planning: an analytical framework. *United Nations Economic and Social Commission for Asia and the Pacific Regional Seminar on Evaluation of Schemes and Strategies for Integrated Family Planning Programmes with Special Reference to Increased Involvement of Local Institutions*. Asian Population Studies Series No 51; I ST/ESCAP/161. New York: United Nations, 1981. 54-56.
- Hull VJ. The role of local institutions in integrated family planning programs: steps toward community participation. *United Nations Economic and Social Commission for Asia and the Pacific Regional Seminar on Evaluation of Schemes and Strategies for Integrated Family Planning Programmes with Special Reference to Increased Involvement of Local Institutions*. Asian Population Studies Series No 51; I ST/ESCAP/161. New York: United Nations, 1981. 47-49.
- Huntington D, Aplogan A. The integration of family planning and childhood immunization services in Togo. *Studies in Family Planning* 1994; 25(3): 176-83.
- International Conference on Population and Development. *Programme of Action of the International Conference on Population and Development*. New York: United Nations, 1994.
- International Program Assistance Services. Personal communication. 1994.
- International Planned Parenthood Federation. *Integrated Programs in IPPF*. London: IPPF, 1981.
- International Women's Health Coalition and CEPIA. *Reproductive Health and Justice: International Women's Health Conference for Cairo '94*. New York: IWHC, 1994.

- International Women's Health Coalition and World Health Organization. *Creating Common Ground*. Geneva: WHO, 1991.
- Jain A, Bruce J. *Implications of Reproductive Health for Objectives and Efficacy of Family Planning Programs*. Programs Division Working Papers No. 8. New York: The Population Council, 1993.
- Jain A, Bruce J. 1994. A reproductive health approach to the objectives and assessment of family planning programs. *Population Policies Reconsidered: Health, Development, and Human Rights*. Ed. Gita Sen, Adrienne Germain, and Lincoln Chen. Cambridge: Harvard University Press, 1994. 192-208.
- Janowitz B, Bratt J. Costs of family planning services: a critique of the literature. *International Family Planning Perspectives* 1992; (18): 137-144.
- Kak LP, Signer MB. *The Introduction of Community-based Family Planning Services in Rural Mali: The Katibougou Family Health Project*. Working Paper Number 2. Washington, DC: Center for Development and Population Activities, 1993.
- Keller A, de Rodriguez AR, Correu S. The Mexican experience with postpartum/postabortion programs, 1970-1972. *Studies in Family Planning* 1974; (5): 195-200.
- Khanna J, Van Look PFA, Griffin PD. *Reproductive Health: A Key to a Brighter Future*. Geneva: WHO, 1992.
- Kielmann AA, DeSweemer C, Chernichovsky D, Uberoi IS, Masih N, Taylor CF, Parker RL, Reinke WE, Kakar DM, Sarma RS. 1983. *Child and Maternal Health Services in Rural India: The Narangwal Experiment. Volume 1. Integrated Nutrition and Health Care*. Baltimore: Johns Hopkins University Press, 1983.
- Kiereini EM. The role of nurses in reproductive health. *Reproductive Health In Africa*. Baltimore: Johns Hopkins Program for International Education in Reproductive Health, 1984.
- Koblinsky MA, Campbell O, Harlow S. Mother and more: a broader perspective on women's health. *The Health of Women: A Global Perspective*. Ed. Marge Koblinsky, Judith Timnyan, and Jill Gay. Boulder: Westview Press, 1993. 33-62.
- Koblinsky MA, Timnyan J, Gay J, eds. *The Health of Women: A Global Perspective*. Boulder: Westview Press, 1993.
- Koblinsky MA, Tinker A, Daly P. Programming for safe motherhood: a guide to action. *Health Policy and Planning* 1994; 9(3): 252-66.
- Korten DC. *Integrated Approaches to Family Planning Services Delivery*. Cambridge: Harvard Institute for International Development, 1975.

Kunii C. How integration of family planning and maternal and child health should be initiated and developed. *JOICFP Review* 1984; (7): 15-19.

Ladipo OA, Delano GE. Team approach to reproductive health. *Reproductive Health in Africa*. Ed. JKG Mati, OA Ladipo, Ronald T. Burkman, Ronald H. Magarick and Douglas Huber. Baltimore: Johns Hopkins Program for International Education in Gynecology and Obstetrics, 1984. 32-42.

Laing J. 1981. Methods for evaluation of integrated programmes. *United Nations Economic and Social Commission for Asia and the Pacific Regional Seminar on Evaluation of Schemes and Strategies for Integrated Family Planning Programmes with Special Reference to Increased Involvement of Local Institutions*. Asian Population Studies Series No 51; I ST/ESCAP/161. New York: United Nations, 1981. 52-54.

Lande RE, Geller JS. *Paying for Family Planning*. Population Reports, Series J, No. 39. Baltimore: Johns Hopkins University, Population Information Program, 1991.

Lewis MA. Do contraceptive prices affect demand? *Studies in Family Planning* 1986; (17): 126-35.

Maguire E. *Changing Paradigms and Lessons for the Public Sector in Population and Reproductive Health*. Paper presented at the 21st Annual NCIH International Health Conference. Arlington, VA. 26-29 June, 1994.

Mahmoed A. Self-help through an integrated project: the Majene case. *JOICFP Review* 1988; (15): 18-23.

Maine D. *Safe Motherhood Programs: Options and Issues*. New York: Columbia University, Center for Population and Family Health, n.d.

Mauldin WP. Family planning programs and fertility declines in developing countries. *Family Planning Perspectives* 1975; 7(1): 32-38.

Mitchell M, et al., Ed. Managing integrated services. *The Family Planning Manager* 1994; (3): 1-22.

Mora G, Betts C, Gay J, Hardee K, Chambers V, Fox L. *Quality of Care in Women's Reproductive Health: A Framework for Latin America and the Caribbean*. Washington, DC: Pan American Health Organization, 1993. [Draft].

Morris R, Lescohier IH. Service integration: real versus illusory solutions to welfare dilemmas. *The Management of Human Services*. Ed. RC Sarri and Y Hasenfeld. New York: Columbia University Press, 1978.

Murray CJL, Chen LC. 1992. Understanding morbidity change. *Population and Development Review* 1992; (18): 481-503.

- Nasah BT. General principles in delegation of maternity functions to community based health workers. *International Journal of Gynecology and Obstetrics* 1992; 38(supp): S23-S27.
- National Council for International Health. *Approaches to Integrated Programs: Health, Family Planning, and Development*. Washington, DC: NCIH, 1982.
- Ness GD. *Organizational Aspects of Integrating Family Planning with Development Programs in the ESCAP Region*. Asian Population Studies Series No. 36. Bangkok: ESCAP, 1977.
- Ness GD. Existing patterns of integrated programmes—their strengths and weaknesses. *United Nations Economic and Social Commission for Asia and the Pacific Regional Seminar on Evaluation of Schemes and Strategies for Integrated Family Planning Programmes with Special Reference to Increased Involvement of Local Institutions*. Asian Population Studies Series No. 51; ST/ESCAP/161. New York, United Nations, 1981. 44-45.
- Nigam A, Parker D. Resources for human development. How much is needed? How much is available? Florence: UNICEF, 1994. [Draft].
- Office of Population. *Mission Statement: Family Planning, Reproductive Health, and Other Related Activities*. Washington, DC: U.S. Agency for International Development, 1994.
- Older Women's League. *Campaign for Women's Health: A Model Benefits Package for Women in Health Care Reform*. Washington, DC: OWL, 1994.
- Pai Panandiker VA. Strategies for increased involvement of non-governmental organizations, local governments and institutions for promoting greater community participation. *United Nations Economic and Social Commission for Asia and the Pacific Regional Seminar on Evaluation of Schemes and Strategies for Integrated Family Planning Programmes with Special Reference to Increased Involvement of Local Institutions*. Asian Population Studies Series No 51; 1 ST/ESCAP/161. New York: United Nations, 1981. 49-51.
- Pan American Health Organization and Family Health International. *Quality of Care in Reproductive Health: Developing an Integrated Framework. Final Report of a Workshop*. Durham, NC: FHI, 1994.
- Parker RL, Sarma RS. Efficiency and equity of project services. *Child and Maternal Health Services in Rural India: the Narangwal Experiment. Volume 2. Integrated Family Planning and Health Care*. Ed. CE Taylor, RL Parker, RS Sarma, WA Reinke, R Faruquee. Baltimore: Johns Hopkins University Press, 1983. 191-213.
- Phillips JF, Simmons R, Chakraborty J, Chowdhury AI. Integrating health services into an MCH-FP program: lessons from Matlab, Bangladesh. *Studies in Family Planning* 1984a; (15):153-61.

Phillips JF, Simmons R, Chakraborty J, Chowdhury AI. *Integrating Health Service Components into a Comprehensive Family Planning and Basic MCH Programme: Lessons from the Matlab Family Planning Health Services Project*. Paper presented at the NCIH 11th Annual International Health Conference, Arlington, VA. 11-13 June 1984b.

Phillips JF, Simmons R, Simmons GB, Yunus M. Transferring health and family planning service innovations to the public sector: an experiment in organization development in Bangladesh. *Studies in Family Planning* 1984c; 15(2): 62-73.

Population Action International. Personal communication. 1994.

Population Council. Lessons learned: September 15, 1984 - September 14, 1990. INOPAL I. Final technical report: operations research to improve family planning and maternal-child health service delivery systems in Latin America and the Caribbean. *Operations Research Findings, Impacts, and Lessons Learned in Project Development*. Vol. 1. New York: The Population Council, 1991.

Population Reference Bureau. *Women's Concerns about Global Population Issues*. Washington, DC: Population Reference Bureau, 1993.

Pratt R, Acharya S, Lubis F, Pillsbury B, Rana M, Shipp P, Pandey MR. *Evaluation of the USAID/NEPAL Integrated Rural Health / Family Planning Services Project. No. 367-0135*. Population Technical Assistance Project. Report No. 88-004-075. Arlington, VA: Dual and Associates, 1989.

Queen HF, Ward H, Smith C, Woodroffe C. Women's health: potential for better coordination of services. *Genitourinary Medicine* 1991; (67): 215-19.

Randall C. The obstetrician-gynecologist and reproductive health. *American Journal of Obstetrics and Gynecology* 1977; (129): 715-22.

Rockefeller Foundation. *Improving the Quality and Reach of Reproductive Health Service Delivery: A Strategy Paper*. New York: Rockefeller Foundation, 1994.

Rosen JE, Foreit JR, Salvador L, De Vargas T, Sevilla F. *Integration and Home Visiting: Necessary Ingredients for Acceptance of Family Planning Services in Indigenous Communities? Results from an Experiment in Ecuador*. Paper presented at the 117th Annual Meeting of the American Public Health Association, Chicago, 1989.

Rosenfield A. Integrated maternal-child health and family planning services. *Gynecology and Obstetrics*. Ed. John W. Sciarra. Philadelphia: Harper and Row, 1982. 1-7.

Rosenfield A. *The Integration of Health, Nutrition, and Family Planning Services*. New York: Center for Population and Family Health, 1984.

- Rosenfield A, McNamara R. *Community-oriented Health, Nutrition and Family Planning Services: Overview and Lessons from Operations Research*. CPFH Working Paper No. 21. New York: Columbia University, Center for Population and Family Health, 1985.
- Ross JA. *Family Planning Pilot Projects in Africa: Review and Synthesis*. CPFH Working Paper No. 24. New York: Columbia University, Center for Population and Family Health, 1986.
- Ross JA, Isaacs SL. Costs, payments, and incentives in family planning programs: a review for developing countries. *Studies in Family Planning* 1986; 19(5): 270-83.
- Rukanuddin AR, Hardee-Cleaveland K. Can family planning succeed in Pakistan? *International Family Planning Perspectives* 1992; (18): 109-21.
- Sai FT, Nassim J. *The Need for a Reproductive Health Framework*. Paper presented at the Christopher Tietze International Symposium on Women's Health in the Third World. Rio de Janeiro. 29-30 Oct. 1988.
- Sai FT, Nassim J. The need for a reproductive health approach. *International Journal of Gynecology and Obstetrics* 1989 (Suppl 3): 103-13.
- Sarma RS, Faruqee R. 1980. Achievements in family planning use. *Integration of Family Planning and Health Services: The Narangwal Experience*. Ed. CE Taylor, RS Sarma, RL Parker, WA Reinke, R Faruqee. Washington, DC: World Bank, 1980.
- Sarma RS, Faruqee R. The use of family planning. *Child and Maternal Health Services in Rural India: the Narangwal Experiment. Volume 2. Integrated Family Planning and Health Care*. Ed. CE Taylor, RL Parker, RS Sarma, WA Reinke, R Faruqee. Baltimore: Johns Hopkins University Press, 1983, 59-84.
- Satia JK. Issues in integrated approaches to family planning programs. *United Nations Economic and Social Commission for Asia and the Pacific Regional Seminar on Evaluation of Schemes and Strategies for Integrated Family Planning Programmes with Special Reference to Increased Involvement of Local Institutions*. Asian Population Studies Series No 51; 1 ST/ESCAP/161. New York: United Nations, 1981. 45-47.
- Sciarrà JJ. 1993. Transactions of the sixteenth annual meeting of the Central Association of Obstetrics and Gynecology. *American Journal of Obstetrics and Gynecology* 1993; (168): 1649-53.
- Seward SB, Fong CO. *Integrated Family Planning Programs: Rationale, Concepts and Methodology for Evaluation*. Paper presented at Research on the Regulation of Human Fertility: An International Symposium Organized by the Karolinska Institute and the University of Uppsala, Stockholm. 7-9 Feb. 1983.
- Shelton J, Angle M, Jacobson F. Medical barriers to access to family planning. *The Lancet* 1992. 340: 1339-1335.

de Sherbinin A, Ashford L, Gelbard A. *What I Hear When You Say "Population": Interpretation of Key Population Terms*. Paper Presented at the Annual Meeting of the National Council for International Health. 29 June 1994.

Simmons GB, Balk D, Faiz KK. Cost-effectiveness analysis of family planning programs in rural Bangladesh: evidence from Matlab. *Studies in Family Planning* 1991; 22: 83-101.

Simmons R, Koenig MA, Huque AA. 1990. Maternal-child health and family planning: user perspectives and service constraints in rural Bangladesh. *Studies in Family Planning* 1990; 21(4): 187-96.

Simmons RS, Ashraf A. 1978. Implementing family planning in a ministry of health: organizational barriers at the state and district levels. *Studies in Family Planning* 1978; (9)2-3: 22-34.

Simmons R, Phillips JE. The integration of family planning with health and development. *Organizing for Effective Family Planning Programs*. Ed. RJ Lapham, GB Simmons. Washington, DC: National Academy Press, 1987. 185-211.

Simmons R, Phillips JF, Rahman M. Strengthening government health and family planning programs: findings from an action research project in rural Bangladesh. *Studies in Family Planning* 1984; 15: 212-21.

Simmons R, Fajans P, Lubis F. Contraceptive introduction and the management of choice: the role of Cyclofem in Indonesia. *Contraception* 1994; 49: 509-25.

Sinding SW, Ross JR. Seeking common ground. unmet need and demographic goals. *International Family Planning Perspectives* 1994; 20: 23-32.

Sivin J. 1971. Fertility decline and contraceptive use in the international postpartum family planning program. *Studies in Family Planning* 1971; 2(12): 248-56.

Taylor CE, Newman JS, Kelly NU. 1976. Interactions between health and population. *Studies in Family Planning* 1976; 7(4): 94-100.

Taylor CE, Parker RL, Sarma RS, Reinke WS, Faruquee R. eds. *Child and Maternal Health Services in Rural India: The Narangwal Experiment. Volume 2. Integrated Family Planning and Health Care*. Baltimore: Johns Hopkins University Press, 1983.

Taylor CE, Reinke WA, Faruquee R, Parker RL, Sarma RS. Main research findings on policy issues. *Child and Maternal Health Services in Rural India: The Narangwal Experiment. Volume 2. Integrated Family Planning and Health Care*. Ed. CE Taylor, RL Parker, RS Sarma, WA Reinke, R Faruquee. Baltimore: Johns Hopkins University Press, 1983. 33-56.

- Taylor C, Sarma RS, Parker R, Reinke W, Faruqee R. *Benefits of Integrating Family Planning with Health Services: the Narangwal Experiment*. Population and Human Resources Division Discussion Paper No. 81-62. Washington, DC: World Bank, 1981.
- Taylor CE, Sarma RS, Parker RL, Reinke WA, Faruqee R. *Integration of Family Planning and Health Services: The Narangwal Experience*. Washington, DC: World Bank, 1980.
- Taylor HC, Berelson B. 1971. Comprehensive family planning based on maternal/child health services: a feasibility study for a world program. *Studies in Family Planning* 1971; 2: 22-54.
- Taylor HC Jr., Lapham RJ. A program for family planning based on maternal/child health services. *Studies in Family Planning* 1974; 5: 71-82.
- Technical Guidelines Working Group. *Recommendations for Updating Selected Service Practices in Contraceptive Use: Results of a Technical Meeting. Volume I: Combined Oral Contraceptives, Progestin-Only Injectables, NORPLANT Implants, Copper-bearing Intrauterine Devices*. Chapel Hill: INTRAH, 1994.
- Thaddeus S, Maine D. *Too Far to Walk: Maternal Mortality in Context*. New York: Columbia University, Prevention of Maternal Mortality Program, Center for Population and Family Health, 1990.
- Thaddeus S, Maine D. Too far to walk: maternal mortality in context. *Social Science and Medicine* 1994; 38(8): 1091-1110.
- Tinker A, Daly P, Green C, Saxenian H, Lakshminarayanan R, Gill K. 1994. *Women's Health and Nutrition: Making a Difference*. Discussion Paper Number 256. Washington, DC: World Bank, 1994.
- Tinker A, Koblinsky MA. *Making Motherhood Safe*. World Bank Discussion Papers No. 202. Washington, DC: World Bank, 1993.
- Tsui AO. *A Conceptual Framework for the Evaluation of Reproductive Health*. Chapel Hill: The Carolina Population Center, 1994.
- Tuladhar JM, Stoeckel J. The relative impacts of vertical and integrated FP/MCH programs in rural Nepal. *Studies in Family Planning* 1982; 13(10): 275-86.
- United Nations Fund for Population Activities. *General Lessons Learned from Evaluations of MCH/FP Projects in Botswana, Malawi, Swaziland and Zambia*. New York: UNFPA, 1984.
- United Nations Fund for Population Activities. *Botswana: Program Review and Strategy Development Report*. New York: UNFPA, 1991.

United Nations Fund for Population Activities. *Background Note on the Resource Requirements for Population Programs in the Years 2000-2015*. New York: UNFPA, Technical and Evaluation Division, 1994.

Vernon R, Lopez-Canales JR, Carcamo JA, Balindo J. The impact of a perinatal reproductive health program in Honduras. *International Family Planning Perspectives* 1993; 19: 103-09.

Vernon R, Ojeda G, Murad R. Incorporating AIDS prevention activities into a family planning organization in Colombia. *Studies in Family Planning* 1990; 21(6): 335-43.

Walley JD, McDonald M. Integration of mother and child health services in Ethiopia. *Tropical Doctor* 1991; 21: 32-35.

Warwick, DP. The Indonesian family planning program: government influence and client choice. *Population and Development Review* 1986; 12(3): 453-90.

Wasserheit JN. 1989. The significance and scope of reproductive tract infections among Third World women. *International Journal of Gynecology and Obstetrics* 1989; (Supp) 3: 145-68.

Weiss EM. *The Calabar. Rural Maternal and Child Health/Family Planning Project: Evaluation and Research Component*. International Programs Working Paper No. 16. New York, Population Council, 1982.

Williamson NE. The Bohol project and its impact. *Studies in Family Planning* 1979; 10(6-7): 195-210.

Winikoff B. Women's health: an alternative perspective for choosing interventions. *Studies in Family Planning* 1988; 19: 197-214.

World Bank. *World Development Report 1993*. New York: Oxford University Press, 1993.

World Health Organization, Global Programme on AIDS and Programme of Maternal and Child Health Including Family Planning. *AIDS Prevention: Guidelines for MCH/FP Programme Managers, Vol. I: AIDS and Family Planning*. Geneva: WHO, 1990b.

World Health Organization, Global Programme on AIDS and Programme of Maternal and Child Health including Family Planning. *AIDS Prevention: Guidelines for MCH/FP Programme Managers, Vol. II: AIDS and Maternal and Child Health*. Geneva: WHO, 1990c.

World Health Organization. *Women's Health Across Age and Frontier*. Geneva: WHO, 1992.

World Health Organization. *Creating Common Ground in Asia*. Geneva: WHO, 1994a.

World Health Organization. *Care of Mother and Baby at the Health Center: A Practical Guide*. Geneva: WHO, 1994b.

Wulf D, Wolff J, Miller J. Cairo and beyond: addressing the critical management challenges. *The Family Planning Manager* 1994; 3(4): 1-26.

Zurayk H, Younis N, Khattab H. *Rethinking Family Planning Policy in Light of Reproductive Health Research*. Paper prepared for the Population Council Symposium on Family, Gender, and Population Policy: International Debates and Middle Eastern Realities. 1994.