From **Kampala** to **Dakar...** and on to **Addis**

This report provides a summary of the six sessions led by the IBP Initiative at the 2011 International Conference on Family Planning held in Dakar, which followed a similar conference held in 2009 in Kampala. The IBP Initiative, a consortium of 37 international organizations, structured the sessions using small working groups with hands-on guidance. The report is designed to help programs have greater access to the resources and tools presented in the sessions with the goal of expanding access and availability of family planning – and prepare for the third international conference planned for Addis Ababa in 2013.

IBP Initiative

Scaling up evidence-based practices has been the mantra for the IBP Initiative since it began in 1999. The 2009 and 2011 international conferences sounded this message louder, adding to the evidence base and expanding the potential for scaling up successful practices. Like others, the IBP Initiative has heard the echoes from Kampala to Dakar and now calls for still more action to scale up practices that can expand access to family planning services for everyone who needs them.

In Kampala, IBP led a process to synthesize the research and programmatic evidence presented in two days of sessions into a summary report highlighting five actions for change. In Dakar, IBP developed a series of interactive sessions based on the five action areas and the USAID High Impact Practices initiative. In this series of interactive sessions in the Knowledge to Action track, participants shared lessons on using practical, tested programmatic tools to address ways to take knowledge to action – to implement successful approaches, promote partnerships, and scale up evidence-based practices.

Partnerships help to define the IBP consortium and proved to be pivotal in planning the IBP role in both Kampala and Dakar. Partners worked together to define the overall activities that IBP would host in both conferences. The IBP members reached out to the wider reproductive health community, including Ministry of Health officials, to provide the most valuable experience possible. IBP also hopes this report will help prepare the family planning community for the 2013 conference planned for Addis Ababa.

IBP Initiative
Scaling up what works in family planning/reproductive health

Taking **Knowledge** to **Action**

1. **Promote Investments in Family Planning: Advocacy for National Policies and Development Plans**
2. **Expand Access and Demand for a Broader Mix of Contraception: Focus on Long-Acting Methods**
3. **Supporting Contraceptive Security: Data Visibility and Coordination**
4. **Integration of Family Planning Services within and beyond the Health System**
5. **Engaging Men in Family Planning**
6. **High Impact Practices in Family Planning: From Global to Local**

Policymakers participated in the IBP sessions, including two Tanzania officials at the session discussing the country's new Costed Implementation Program.

Promote Investments in Family Planning: Advocacy for National Policies and Development Plans

Since the 2009 Kampala conference, family planning has become a higher priority as Ministries of Health in particular seek to address MDG 5 (maternal health, including family planning). A few countries have expanded advocacy beyond the health sector to Parliamentarians; to Ministries of Finance, Education, and Planning; and to other interagency activities. Through a collaborative process among many partners, Tanzania now has a line-item budget for family planning. Kenya held a national leaders conference among all sectors and developed a plan of action to integrate family planning into the national Vision 2030 goals. Rwanda built on existing political leadership for family planning and expanded advocacy into the youth and other sectors.

This IBP session in Dakar provided participants with an opportunity to learn how advocacy tools can help governments increase line-item budgets, gain commitments from planning/finance committees, and implement plans with costs identified and addressed. In the breakout sessions, participants gained a working knowledge of four advocacy tools that have been used successfully in advancing investment in family planning at the country level, summarized below along with the session lead organization.

ENGAGE, led by PRB. This session showed how PRB's multimedia presentations can be used as part of a nationwide communication plan to engage global leaders and country-level policymakers in issues related to population, family planning, and reproductive health. The session highlighted Trendalyzer—a program that converts traditional, two-dimensional graphs into interactive animations—and other software platforms such as Google Earth and Flash animation. Teams of local partners have used the tool to frame issues, identify key messages and recommendations, and implement policy-level communication strategies in Kenya, Pakistan, Ethiopia, Uganda, Burkina Faso, and Senegal. Overview: *http://www.prb.org/Journalists/Webcasts/2011/family-planning-poverty-reduction.aspx*

National Costed Implementation Program (CIP), led by FHI 360. This year-long process identified funds that would be needed for concrete operational goals in family planning, which were developed by planning teams involving multiple stakeholders. Tanzania health and finance officials attended the session and commented on how helpful the CIP was in developing clear budget goals for family planning, including the new line-item in the national budget. A monitoring process through the MOH is tracking how the plan is being implemented. Kenya has now drafted a CIP, and other countries have expressed interest. For more information: *http://www.fhi360.org/projects/progress-CIP*

Spectrum/FamPlan and GAP Tool, led by Futures Group/Health Policy Project. Spectrum is a computer modeling tool that analyzes existing information to determine the future consequences of population programs and policies. FamPlan can be used to plan service provision and calculate the cost and number of users of different methods by source; it was used in developing the Tanzania Costed Implementation Program. The Gather, Analyze & Plan (GAP) tool, which is Excel-based, can identify funding gaps in family planning service provision and commodities. For more information:

Spectrum: *http://www.healthpolicyproject.com/index.cfm?id=software*

FamPlan and RAPID: *http://www.healthpolicyproject.com/index.cfm?id=software&get=Spectrum*

GAP tool: *http://www.healthpolicyproject.com/index.cfm?id=software&groupID=33*

RAPID, led by Futures Group. One of the computer models in the SPECTRUM suite of policy models, RAPID can help in-country stakeholders manipulate data to analyze different scenarios and encourage policy dialogue about the effect of population factors on socioeconomic development. The RAPID model helped convince Parliamentarians in Rwanda to invest heavily in family planning, when they saw that reducing the total fertility rate to 2.3 by 2035 would lead to slower population growth, thereby reducing health costs by US $384 million. (See link above.)

Expand Access and Demand for a Broader Mix of Contraception: Focus on Long-Acting Methods

An outreach team supported by Marie Stopes International provides services in a rural area of Sierra Leone.

Since the Kampala meeting, improving access to a range of contraceptive choices, especially to underserved populations, has become a higher priority for many countries. The Kampala meeting underscored the challenges that many programs face in relying heavily on short-term contraceptive methods. Gradually, more leaders are acknowledging the importance of ensuring choice for long-acting and permanent methods both for long-term spacing and limiting the number of births.

The health systems in many countries may not be able to offer a comprehensive family planning method mix on a regular basis in static facilities due to human resource constraints, poor infrastructure, and other deficits in the healthcare system. More varied service delivery approaches are needed, especially to provide increased access to long-acting and permanent methods. Such approaches require increased provider training and time, access to appropriate supplies and commodities, facility infrastructure, and stakeholder support in the community, including raising awareness and addressing misconceptions about contraceptive methods.

In Dakar, EngenderHealth, Marie Stopes International (MSI), and Population Services International (PSI) addressed this issue of expanding choice in a "double session," utilizing two conference time slots to host a highly interactive and participatory workshop. The session provided an in-depth opportunity for participants to share experiences about three models shown to be effective in increasing access to contraceptive choices, especially long-acting and permanent methods. The session highlighted strategies that are being used to build partnerships with community groups and conveyed practical information for initiating, replicating, and scaling up these service delivery approaches.

Mobile outreach. Mobile services can bring information, services, and supplies to women and men in the communities where current family planning services are limited to short-term methods only. Partnerships involving private providers, non-governmental organizations, and government services can support mobile teams of trained providers for areas with limited family

planning services through periodic visits to a lower-level facility or through a mobile unit. Planning and partnerships are needed with public and private stakeholders, including attention to logistics and supplies, sustainability, and continuity of services. Counseling and follow-up with clients is important to ensure informed choice, post procedure care instructions, technical skills of providers, and infrastructure.

When high quality mobile services are fully implemented, studies have found that these models have the potential to increase uptake of long-acting and permanent methods and expand contraceptive choice among underserved population groups.

For more information go to: *http://www.mariestopes.org/data-research/resources/increasing-family-planning-access-and-choice*; and

http://www.respond-project.org/pages/files/4_result_areas/Result_1_Global_Learning/LA_PM_CoP/Mobile-services-meeting-report-final.pdf

Dedicated providers. Projects have expanded the use of dedicated providers to offer long-acting methods on particular days at static health clinics. In a PSI project in Mali, for example, after education sessions that present a range of contraceptive options, PSI-employed midwives have successfully provided implants and IUDs for women attending immunization clinics. The model is most cost effective in an urban setting, where transport costs are minimal and a large number of clients are accessing the public facility. This model enables a private provider who is well trained to partner with a public facility in offering a broader range of contraceptive methods. Training public sector staff at the host clinics is an important component in service continuation along with addressing long-term sustainability.

Special service days. Special service days are concentrated services at a recognized location preceded by days of intensive demand creation activities. Demand creation consists largely of outreach by community mobilizers to educate women on their family planning options and link them with local providers. By providing services to large numbers of clients in a single day, providers are able to create economies of scale and offer implants and intrauterine devices, which take more time to provide than short acting methods. PSI employs special service days in its private sector network clinics as an extension of provider training and supervision in numerous countries, including Cameroon, Togo, and Kenya. Generating large numbers of clients in a single event helps newly trained providers gain competency in delivering long-acting and reversible methods while under the supervision of an experienced trainer, and also ensures that supervisors can periodically observe ongoing service delivery and offer coaching and supportive supervision to participating providers.

Supporting Contraceptive Security: Data Visibility and Coordination

Many presentations in Kampala noted that contraceptive stock-outs occur frequently and supply systems are not reliable. This can be due to forecasting problems, inadequate supply systems, limited funding, and other factors. Contraceptive supply chains are global, with visibility of data about supplies needed for decision-making, as well as trust and collaboration among partners. The people leading this session in Dakar have been working at the global and national levels to improve information systems, procurement planning, and monitoring reports. Participants received an overview of the Reproductive Health Supplies Coalition (RHSC), a global partnership of public, private, and non-governmental organizations, including the session leaders; participants were encouraged to join the RHSC and become more active, if already a member (for more information, see: *http://www.rhsupplies.org/*).

This session showed participants how new tools are being used at the local, national, and global levels to improve reliable supply systems for contraceptives and related commodities. In addition, efforts to improve confidence in sharing information from the district to the national level have been successful. This focus on "data visibility" for the broader good – rather than fearing that reporting of low stocks will result in blame – has been an increasingly successful focus since Kampala. Participants learned how greater data visibility among partners can help and worked with practical tools that can be applied in their settings. They worked with case studies in three stations, rotating among them for more exposure in using several tools.

Logistics Data Enhances Coordination for Country Contraceptive Security. This station focused on how to improve data visibility and to use tools at the country level. Participants learned how a national logistics management information system (LMIS) enhances visibility of demand and stock levels for contraceptives. These data help inform the national Reproductive Health Commodity Security (RHCS) committee's decision-making process. In Ethiopia, the Logistics and Family Planning Technical Working Group (national equivalent of the RHCS) has worked to strengthen the LMIS by supporting the establishment of an Integrated Pharmaceuticals Logistics System (IPLS). Contraceptives are now part of this system which helps to remove the vertical programming of commodities and to automate the process to improve efficiency, accuracy and response times. For more information, see: *http://www.rhsupplies.org/index.php?id=3212*; *http://deliver.jsi.com/dhome/*; and *http://deliver.jsi.com/dlvr_content/resources/allpubs/logisticsbriefs/ET_NewsVol4.pdf*

Procurement Planning and Monitoring Report (PPMR). At the global level, data on contraceptive supplies for approximately 15 countries are reported to the Coordinated Assistance for Reproductive Health Supplies (CARHs) group using the PPMR as a tracking tool. This group brings together key commodity suppliers to review data and take action to ensure contraceptive availability in multiple countries, including adjusting shipping schedules, making emergency shipments, and scheduling transfers between programs, if needed. In Togo, for example, USAID and UNFPA jointly responded to shortages of four commodities by agreeing to assume responsibility for delivering whichever of the four they could get into the country first, including Depo-Provera, Jadelle, and male condoms. A similar example in Liberia averted a shortage of Jadelle. For more information, go to: *http://www.rhsupplies.org/resources-tools.html* (the PPMR tool will be available soon).

4 Integration of Family Planning Services within and beyond the Health System

Using Data for Improved Contraceptive Security. The Reproductive Health Interchange (RHI) is an easily accessible, live repository for harmonized global information on contraceptive orders and shipments. The website is used by countries, donors, and advocates to manage commodities, conduct analysis, and plan. The site allows users to review data as well as produce user-friendly reports to facilitate decision-making. For example, one sub-Saharan country official in the absence of regular coordination meetings on commodities among in-country partners used the RHI to find out what other partners have ordered and to compare and verify information in their database on past quantities and planned shipments, to confirm that the data were correct. The website allows a country to track details of incoming shipments such as quantities, value, and dates of shipment. For more information, contact: *rhi-supply@unfpa.org* or go to: *http://rhi.rhsupplies.org/rhi/index.do?locale=en_US*

The Kampala conference emphasized the importance of linking family planning with development. One way to do that is to link family planning services with related health fields and more broadly to sectors that influence development. Attention to integrating family planning with other services is not new, but support is increasing. Countries are requiring health providers to link such services as antenatal care and child immunization with family planning. Also, the private sector is joining with government, linking environmental, agricultural, microfinance, and workplace projects with health ministries and providers. While such efforts have yielded some promising results, evidence on implementation and scale up requires additional thought and sharing of lessons learned.

The Dakar session highlighted successes, challenges, and next steps moving forward to increase family planning integration into both health and non-health sectors. The session included separate breakout discussions where resource people shared examples of successful efforts, identified gaps in the evidence, and identified new strategic partnerships and next steps in these efforts.

Common themes in the health sector break-out sessions included: lack of knowledge about family planning among health care providers focusing on another service (e.g., immunization or HIV), challenges with vertical or "silo" delivery systems, opportunity for multiple contact points, and health systems constraints including confidential space for family planning counseling and stock-outs of contraceptives.

Common themes in the sessions on non-health sectors included: the need to encourage funders to support integrated programs, the importance of community input, opportunities to reach underserved populations, the fact that people lead integrated lives that are not in vertical programs, and the importance of designing these projects from the beginning to be self-sustaining beyond donor funding. Other more specific issues, country examples, and resources by subtopic are below.

Maternal and Newborn Health (MNH). A case example presented focused on Nigeria, where family planning was included as part of a MNH program. There was an initial focus on preventing maternal and newborn mortality, which was prioritized by both the community and providers. The addition of a postpartum family planning component provided a clear linkage with MNH

at the facility level. At the community level, household visits by female community health workers were successful at promoting both MNH services and postpartum messages on healthy timing and spacing of pregnancy. Engaging men in MNH/FP, through special activities with volunteer male motivators, was also a successful part of the approach.

Child Immunization. Uganda, Senegal, India, and other countries increasingly are asking community based workers to provide both child immunization and some types of family planning services. Research on this integrated approach is limited, but programmatic examples are growing. More evidence is needed on which models work best to increase family planning uptake and at the least do no harm to immunization levels, which are usually already high. Common themes emerging from the evidence include limited knowledge about LAM and return to fertility, and the fact that the normal approach of group counseling poses challenges. A map of current integration projects is available at: *http://maps.google.com/maps/ms?ie=UTF8&hl=en&msa=0&msid=111608260631877414017.00048a1a6f767ff8ac026&ll=45.58329,49.570313&spn=99.503838,180&z=2*

HIV/AIDS. Integrating family planning with HIV can help meet the needs of people living with and at risk of HIV. Research shows that preventing unintended pregnancy reduces HIV transmission and that clients of HIV services have high levels of unmet need for family planning. Effective models of integrated services are emerging, and a supportive global policy environment has been established. Field-based integration efforts are expanding, and an increasing array of guidance documents and tools are available to help translate policy support into practice. For resources on family planning and HIV integration designed for policy makers, program managers, and service providers, go to: *http://www.k4health.org/toolkits/fphivintegration*

Environment. A growing number of Population, Health, and Environment (PHE) projects now exists, linking issues related to limited resources to population growth. A map of such projects is available, with other information including a listserv for sharing lessons learned. Go to: *http://www.prb.org/about/internationalprograms/projects-programs/phe.aspx*

Workforce Development. Linkages between Ministries of Health, Labor, and Education are needed. Studies have shown that factories investing in workers' health get a five to one return on investment. Both urban and rural workforces need linkages with family planning services. Family planning integration into private sector workplaces is most successful when it is offered as part of a comprehensive health package to workers.

Microfinance/Savings and Loan. Projects in many Asian countries and some parts of Africa have incorporated some broad health information into their education programs. More evidence is needed to see if projects that include family planning lead to higher uptake of contraception, and if so, to guide the replication of the types of projects that have such impact. Voluntary savings and loan projects also offer an opportunity for integrated family planning services, but research is needed on the impact of adding a family planning component. A gender gap analysis found that women take loans to solve health issues. Integration in this sector provides an opportunity to engage men in health issues. A video describing one microfinance/family planning project is available at: *http://www.youtube.com/watch?v=JrvQznNBXX8&feature=youtu.be*

Engaging Men in Family Planning

Numerous studies have shown that engaging men in family planning (FP) increases FP use overall and contributes to correct and continued use of FP methods. At Kampala, issues related to men and FP received some attention, both in presentations and even with a couple in a plenary, where a Ugandan man with little education said through a translator that he wished he had had a chance to know about FP.

Nonetheless, FP programs continue to focus on married women for the most part in terms of services, provider training, and outreach without regard to the complexities of FP-related decisions that involve men, families, and larger community norms. Male methods of FP are limited and are not widely used in many contexts. To increase access to and use of FP while ensuring gender-equitable outreach and services, guidance is needed to help programs engage men through strategies that are low cost and feasible for routine implementation.

The Dakar session provided an overview of how projects have approached male involvement, with sample materials, strategies and programmatic approaches. The Institute for Reproductive Health (IRH) introduced the issue and IPPF facilitated a lively group discussion to ensure that all participants had the opportunity to raise concerns, share experiences, and learn about a variety of programs.

The session included six breakout sessions that highlighted programmatic examples of recent successes in engaging men and couples in family planning. Program examples were largely from Africa, and mostly from settings with very low contraceptive prevalence and a long history of programs that target women with FP messages and services with little attention to men. These sessions addressed such questions as:

- Why would managers, providers, outreach workers, and others want to engage men?
- Who are the key stakeholders who could influence others to engage men in FP? What support do these stakeholders need?
- How can I support these stakeholders? What can I do to plan for/implement a successful strategy?

The interactive breakout sessions were led by the following organizations:

- Save the Children highlighted innovative approaches to engaging men at the community level and facilitating their support for and ability to communicate positively about FP as part of a larger focus on gender equity.
- Plan International/Senegal described development programs that involve men and women and have the potential to facilitate FP communication and use.
- EngenderHealth shared experiences with involving men in the use of long-acting and permanent methods (LAPMs).
- The Universal Access to Female Condoms Joint Programme, an advocacy group, uses popular media to focus on male and female sexuality and "safe sex" as a shared responsibility. For example, this YouTube video is an innovative promotion for using the female condom: *http://www.youtube.com/watch?v=65kYjCyTedA*
- Jhpiego demonstrated the value of involving men from pre-natal care through post-natal adoption and use of FP as a means of focusing more broadly on reproductive health and family health issues.
- IRH led a discussion of interventions that involve counseling information and tools to encourage couple communication, empower women, and promote changes in gender norms.

Discussions during the plenary and break-out sessions contributed to consensus and commitment around three cross-cutting themes.

1. Engaging men through maternal health services, providing (or referring for) male methods, and counseling strategies to strengthen women's ability to engage their partners in supporting and using FP offer low-cost means of increasing men's positive FP attitudes and behaviors.
2. Popular media play an important role in fostering positive FP attitudes and behaviors and can be used successfully to encourage men to use FP to benefit their wives, children, and themselves.
3. Efforts to engage men in FP that have sustainable results are often rooted in changes in gender norms that occur at the community level.

High Impact Practices in Family Planning: From Global to Local

Providing family planning services through community health workers is one of the proven high impact practices.

In order to better facilitate the use and scale up of evidence-based practices in family planning, USAID Mission staff and partners highlighted the need to develop a list of high impact practices in family planning programs. While not meant to constitute or replace a country family planning strategy, a specific list of high impact interventions was identified as critical to help focus intervention efforts given the many challenges in implementing family planning programs, including competing health priorities, scaling up best practices, and varying technical expertise in family planning. In 2009, USAID and partners collaboratively led an effort to review evidence and identify "High Impact Practices" (HIPs) for Family Planning Programs.

In addition to developing an initial list of HIPs, this effort initiated a systematic process to review evidence, identify and prioritize high impact interventions, and support issues around implementation at the country level.

The evolving list currently includes practices around "Creating an Enabling Environment" and "Service Delivery." Creating an Enabling Environment practices can help facilitate the broader implementation of HIPs at a country level. These HIPS, which are related to health systems, are correlated with improved health behaviors and/or outcomes, including lower rates of unintended pregnancy, reduced fertility rates, or improvements in one of the primary proximate determinants of fertility.

The Service Delivery HIPs are divided into "proven" and "promising" practices based on the current level of evidence and magnitude of impact on family planning outcomes such as contraceptive use and continuation. Proven practices are those where sufficient evidence exists to recommend widespread implementation. Promising practices refers to those where good evidence exists but additional evidence is needed to fully document implementation experience and impact. These interventions may be promoted widely, provided that there is careful evaluation both in terms of impact and process.

Monitoring of coverage, quality, cost, and capacity for implementation research was considered. The list also reflects whether the practices are replicable, scalable, and sustainable. All practices contribute to ensuring informed choice and volunteerism, and should have potential application in a wide range of settings.

The box shows both types of HIP practices. More information on the HIPs and the HIP process including several HIP evidence briefs is available at *http://hips.k4health.org/about-hips*.

Supporting HIPs at Country Level

The session in Dakar focused on strategies and materials that USAID and partners have developed to support country programs in implementing various HIPs. Supportive materials and strategies include evidence briefs that synthesize the body of evidence under individual HIPs, tools to monitor scale up and institutionalization of HIPs, algorithms to help decision-making around the use of the HIPs, mapping technology to identify areas for scale up, collaboration and south to south exchange, and strategies to provide technical assistance to successfully implement HIPs.

The main themes of discussion around the HIPs at the country level were:

1. Taking **country context** into account when developing and programing HIPs. USAID and partners have been working on decision-making tools and algorithms to help contextualize the HIPs for country settings.
2. Soliciting **buy-in from a wide range of partners** to ensure harmonized and evidence-based programming. This includes both USAID and non-USAID constituencies such as other donors, country level partners, academic institutes, and civil society organizations.
3. **Balancing** the need to provide prescriptive guidance on implementing HIPs without impeding the flexibility and creativity that allows for successful programming in local environments.

Next steps include engaging a wider range of partners and donors in the HIP process and continuing work on developing materials to support country implementation of HIPs.

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Create an Enabling Environment HIPs

- Galvanize **commitment** to family planning through advocacy and policy development.
- Develop, implement, and monitor **supportive government policies**.
- Support **financing** for family planning services and supplies at the national and local levels.
- Invest in **contraceptive security** by developing an effective supply chain, supportive policies and regulations, financing, coordination and planning, and commitment.
- Ensure **contraceptive choice** by making a wide range of family planning methods available.
- Implement **a systematic, evidence-based SBCC** strategy that includes communication through multiple channels.
- Develop in-country capacity to **lead and manage** family planning programs.
- Advocate keeping **girls in school**.

HIPs in Service Delivery

Proven

- Train, equip, and support **community health workers (CHWs)** to provide a wide range of family planning methods. In addition to pills and condoms, CHWs can safely and effectively provide emergency contraceptive pills, injectables, the Standard Days Method (SDM), and the Lactational Amenorrhea Method (LAM). They also can refer clients for long-acting and permanent methods (LAPMs).
- Provide family planning counseling and services at the same time and location where women receive **treatment for complications** related to spontaneous and induced **abortion**.
- Support distribution of a wide range of contraceptive methods through **social marketing**. In addition to condoms and pills, social marketing programs can safely and effectively distribute emergency contraceptives, injectables, Cyclebeads® for SDM, and IUDs.

Promising

- Offer a wide range of family planning methods through **mobile outreach services**.
- Train and support **pharmacists and drug-shop keepers** to provide a wide range of contraceptive methods. In addition to pills and condoms, pharmacists often play a key role in providing injectables, emergency contraceptive pills, and Cyclebeads® for SDM.
- Offer family planning services to postpartum women (up to 12 months after birth), such as screening women during routine child **immunization contacts**.

Family Planning for Health and Development: Selected Resources

Elements of Family Planning Success. This toolkit includes materials organized by the 10 essential elements of family planning success, the process used to identify these elements, and more. *http://www.k4health.org/toolkits/fpsuccess*

ExpandNet. This network promotes ways to scale up health services innovations. *http://www.expandnet.net/*

Global Health E-Learning Center. This Web site offers free access to 53 online courses, many of them related to family planning. *http://www.globalhealthlearning.org*

IBP Initiative. The IBP Web site provides reproductive information through links to the sites of the IBP partners and many other sites, including the IBP Knowledge Gateway; this gateway supports a virtual reproductive health network with online forums, communities of practice, and more. *http://www.ibpinitiative.org*

To join the IBP Knowledge Gateway, go to *http://knowledge-gateway.org/*

International Conference on Family Planning. This is the official site of the 2011 conference in Dakar, Senegal, and includes the presentations and much more. *http://www.fpconference2011.org*

United Nations (UN) and the Millennium Development Goals (MDGs). This Web site describes the roles played by UN agencies in promoting the MDGs, including work by UNFPA on MDGs 3, 5, and 6. *http://www.un.org/millenniumgoals/*

United Nations Population Fund (UNFPA). This section of the UNFPA site links to global documents related to ensuring that every pregnancy is wanted. *http://www.unfpa.org/rh/planning.htm*

U.S. Agency for International Development (USAID). This is USAID's home page for family planning, with links to many resources, including the agency's Population, Health and Environment (PHE) programs. *http://transition.usaid.gov/our_work/global_health/pop/*

World Health Organization (WHO). This section of the WHO Web site links to many sexual and reproductive health publications, such as WHO's *Medical Eligibility Criteria for Contraceptive Use*. *http://www.who.int/reproductivehealth/publications/en/*

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IBP Initiative

Scaling up what works in family planning/reproductive health

The International Conference on Family Planning, held in Dakar, Senegal, 29 November - 2 December 2011, was sponsored by the Bill and Melinda Gates Institute for Population and Reproductive Health at the Bloomberg School of Public Health and by the Ministry of Health and Prevention in Senegal, and co-sponsored by more than 30 international organizations. The Implementing Best Practices (IBP) Initiative led a track of interactive sessions at the conference focusing on "taking knowledge to action." The IBP Initiative is intending to play a similar role at the 2013 conference to be held in Addis Ababa, Ethiopia. The IBP Initiative is a partnership of 37 international organizations supported by the World Health Organization, Department of Reproductive Health and Research (WHO/RHR), in collaboration with the U.S. Agency for International Development and the United Nations Population Fund. IBP partners contributed to the planning and implementation of the separate track of the IBP sessions. FHI 360/ PROGRESS led the development of this report, working with the IBP Secretariat at WHO/RHR and with Management Sciences for Health, which currently serves as the IBP Chair.

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