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ENVIRONMENTAL HEALTH ACTIVITY MID-TERM ASSESSMENT

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ACRONYMS

AED	Academy for Educational Development
CDC	Centers for Disease Control and Prevention
CLTS	Community-led total sanitation
CDM	Camp Dresser & McKee
DRC	Democratic Republic of Congo
EGAT	Bureau for Economic Growth, Agriculture and Trade
EH	Environmental health
EHA	Environmental health activity
EHP	Environmental Health Project
EPA	Environmental Protection Agency
GH	Bureau for Global Health
GH Tech	Global Health Technical Assistance Project
HIDN	Office of Health, Infectious Diseases, and Nutrition
HIF	Hygiene Improvement Framework
HIP	Hygiene Improvement Project
HWTS	International Network to Promote Household Water Treatment and Safe Storage
IAA	Interagency agreement
IAQ	Indoor air quality
IQC	Indefinite quantity contracts
MAARD	Modified acquisition and assistance request document
MCH	Maternal and child health
MDG	Millennium Development Goals
NGO	Nongovernmental organization
NTD	Neglected tropical diseases
OES	Bureau of Oceans and International Environmental and Scientific Affairs
OHA	Office of HIV/AIDS
PCIA	Partnership for Clean Indoor Air
PHE	Population, health, environment
POU	Point of use
POUZN	Point of Use Water Disinfection and Zinc Treatment
PPPHW	Global Public/Private Partnership for Handwashing
PSI	Population Services International

STTA	Short-term technical assistance
SWS	Safe water system
TEG	Water Technical Earmark Group
TPM	Team planning meeting
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VBC	Vector biology and control
WASH	Water supply, sanitation, and hygiene
WASH Project	Water and Sanitation for Health Project
WFP	Senator Paul Simon Water for the Poor Act
WSP	Water and Sanitation Program (World Bank)
WSSCC	Water Supply and Sanitation Collaborative Council

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EXECUTIVE SUMMARY

Over the past 30 years, the United States Agency for International Development's (USAID) environmental health (EH) programs have addressed global needs in the water supply, sanitation, and hygiene (WASH) sector. The nature of investment has changed significantly, originating with the Water and Sanitation for Health Project (WASH Project) that initially focused more on water and sanitation hardware or infrastructure. This evolved into the Environmental Health Project (EHP) that focused on a mix of water and sanitation hardware with software, promoting hygiene[1] behavior change associated with infrastructure for improved health outcomes; and then to the current mix of software investments—including the Hygiene Improvement Project (HIP), two Point-of-Use Water Disinfection and Zinc Treatment (POUZN) projects, the Interagency Agreement (IAA) with the Centers for Disease Control and Prevention (CDC) focusing on the Safe Water System (SWS), the EH indefinite quantity contract (EH IQC), and two global partnerships: the Global Public/Private Partnership for Handwashing (PPPHW) and the International Network to Promote Household Water Treatment and Safe Storage (HWTS). These initiatives focus mostly on three critical areas of hygiene: handwashing, household water treatment and safe storage, and effective access to and use of sanitation.

The shift in focus from hardware to software with the advent of the new environmental health activity (EHA) in 2004 attempted to align the EHA more closely with USAID's Bureau for Global Health (GH) objectives. It also changed the way it delivered assistance, from one central mechanism to multiple, smaller mechanisms. This report assesses the current portfolio of investments and makes recommendations for future directions of USAID's EHA.

The report also addresses the implications of the changes implemented in the first phase of the EHA for USAID's WASH programming in general and the perception of USAID in the WASH sector. The findings suggest that—largely because of fragmentation of WASH activities across the Agency—USAID's global reputation as a leader in WASH has diminished. Because USAID field missions have not received the comprehensive WASH support provided under previous GH technical assistance activities, the narrower focus of the current portfolio has drawn less interest and mission investment, diminishing the visibility of the activities at the country and international levels. In addition, international partners perceive USAID's WASH activities as imbalanced, with an overemphasis on behavior at the expense of infrastructure and institutional focuses. Though USAID's HIF—which proposes that realizing health impacts requires behavior change promotion, hardware, and enabling conditions for full success—has wide recognition, outsiders perceive USAID EHA's primarily software focus as a limited implementation of the framework that it designed.

Inside USAID, WASH infrastructure support has been largely assumed under the Bureau for Economic Growth, Agriculture and Trade (EGAT). Unfortunately, this shift has resulted in an imbalanced coordination effort. The informal "Agency Water Team" typically defaults to the EGAT Water Team and the agenda of EGAT (water resources, utility reform, and financing) often overshadows WASH software. Additionally, the Water Technical Earmark Group (TEG), created to ensure that proposed activities are consistent with the Senator Paul Simon Water for the Poor Act (WFP), is chaired by the U.S. State Department's Bureau of Oceans and International Environmental and Scientific Affairs (OES) and EGAT on behalf of USAID,

[1] According to the USAID Diarrhea Prevention Technical Reference Materials and the Joint Report on the Hygiene Improvement Framework, hygiene in the context of preventing childhood diarrhea focuses on improving three key practices: "proper hand washing with soap or another effective cleansing agent, such as ash or sand, safe disposal of feces, and treatment and safe storage of water in the household."

leading to a larger emphasis on water resources in WFP activities than some feel was intended by the authors of the Act.

A number of opportunities can be leveraged to re-establish USAID as a global leader and the EHA as a pillar in WASH programming designed for human health. The WFP offers the best chance because it situates WASH as a strategic agenda for the United States Government (USG). The Obama Administration's focus on maternal and child health (MCH) within the overall umbrella of the Global Health Initiative, as well as its climate change and food security initiatives, offer cross-sectoral areas with which to integrate.

To leverage the opportunities cited above, the following key recommendations are suggested under two major headings: those that relate to the Agency as whole and GH's role in WASH programming, and those that relate to the course of action for planned follow-on mechanisms to the current portfolio.

Within USAID, GH needs to:

- Strengthen the health perspective on the agency Water Team by advocating for GH to formally co-chair the USAID Water Team, helping to delineate and clarify Water Team activities as "Water for Human Health" and "Water Resources," and building a "Water for Health" strategy around the HIF.
- Advocate for the GH representative on the TEG to play a more central role on the TEG to ensure that WFP programming establishes and supports health outcomes.
- Re-emphasize the HIF by advocating its central role for all agency WASH activities, using it as basis to mobilize multi-sector and multi-partner funding to ensure its full implementation.

At the same time, any follow-on mechanism to the current EHA portfolio needs to:

1. Maintain and expand the comparative advantage in hygiene behavior change while also increasing its technical capacity to respond to USAID field mission and partners' technical needs relating to all aspects of the HIF.
2. Concentrate its limited project resources into one central mechanism under an EH brand.
3. As a complementary activity, focus its investment with CDC to a narrowly defined operational research agenda that serves the USAID EHA's purposes.
4. Continue and expand investments in strategic global partnerships.
5. Be configured to facilitate and continue cross-sectoral integration opportunities.

LIMITATIONS OF THIS REPORT

Four significant limitations to this report should be noted:

1. The assessment team was only able to travel to one country, Ethiopia, where USAID EH activities are ongoing. This trip only allowed the team direct exposure to one country implementing the HIP and no direct exposure to other investments such as POUZN, the EH IQCs, the CDC IAA, or either of the global partnerships. Phone interviews were conducted with other USAID missions, including those with these other investments.
2. Though the team interviewed 66 people from a wide array of perspectives, there is less discussion of integration of WASH into other health programs than of integration of WASH into USAID water infrastructure activities. This outcome represents a historical bias of the program and the reality that there is simply less institutional memory for EHA/health linkages than there is for EHA/water linkages.
3. The report relies on qualitative interviews with a wide range of development partners to USAID (the list of interviewees was approved by USAID). However, there is no substantial quantitative analysis of the results or impacts of investments.
4. At times, the report can appear to suggest that interviewees spoke with one unified voice. This was certainly not the case, especially relating to point-of-use (POU) interventions where there is wide disagreement over their impact, especially over the long term. However, the authors' recommendations attempted to reflect the broadest trend among interviewees. The authors also tried to represent both sides of an issue where possible in discussions.

I. BACKGROUND

Each year, nearly 9 million children under five years of age die—and nearly seven out of 10 of those deaths are in Africa and South and East Asia. Diarrhea and respiratory infections are the two leading killers of children. Both diarrhea and respiratory infections are closely linked to environmental risk factors. Contaminated water, lack of sanitation, and poor hygiene are the most important environmental causes of disease. Diarrhea is also closely linked with malnutrition, which contributes to more than one-third of child mortality and leads to long-term cognitive deficits, poorer performance in school, and lower adult economic productivity.

The primary goal of USAID's EHA is to reduce morbidity and mortality in children less than five years old, as well as mortality and morbidity associated with infectious diseases of major public health importance. Developing and implementing sustainable and scalable interventions that address improvements in key behaviors and environmental conditions is a strategic objective that helps reach this goal.

USAID's EHA directly addresses the leading risk factors for death due to diarrheal disease by focusing on the following key interventions:

- Improvement in drinking water quality at the POU,
- Increased use of sanitary facilities for human excreta disposal, and
- Increased and improved handwashing with soap.

After 25 years of providing a broad array of infrastructure and behavioral interventions across the WASH sector, in 2004, with the launch of USAID's EHA, the GH made a strategic decision to focus on the behavioral aspects of the three components noted above. The structure of assistance changed fundamentally, employing several focused implementing mechanisms rather than one central mechanism that had been utilized in the design of previous programs.

GLOBAL CONTEXT/KEY TRENDS

The Millennium Development Goals (MDGs) are a major influence on the policies and priorities of most international agencies and many governments. The goals—designed to be met by 2015—include a target of halving the proportion of people without sustainable access to safe drinking water and basic sanitation. Additionally, WASH interventions can contribute to the other seven MDGs, several of which target or contribute to reducing child mortality, an objective of USAID's GH. The total estimated spending required to meet the combined water and sanitation target is between $35 billion and $40 billion per year. Current levels of combined donor funding represent a relatively small proportion of the overall resources and effort needed to meet the internationally-agreed goals and targets.

In response to the 2.6 billion people lacking access to adequate sanitation, the General Assembly of the United Nations declared 2008 as the International Year of Sanitation. Given the historical dominance of water over sanitation and hygiene promotion in the sector, this heightened awareness appears to be resulting in increased funding and programming for sanitation and hygiene. This new emphasis and direction is expected to continue.

Increased urbanization also poses a critical issue for EH programs. According to WaterAid, over the next 30 years, urban populations in developing countries are expected to triple their size and account for 80% of the world's urban population. The majority of these people will live in impoverished slums without access to basic services. While health and child survival rates are better across the board in urban areas—when compared to rural areas—on average, they are often

as bad or worse for the urban poor than for their rural counterparts. Some of these differences are clearly evident, such as the heightened sanitation and hygiene concerns for urban populations living in cramped and dense housing.

There is a growing need to integrate environmental health programming into other global public health programs. For example, people with HIV/AIDS are at increased risk for diarrheal diseases resulting from poor water, sanitation, and hygiene conditions—and are far more likely to suffer severe and chronic complications if infected. In addition to the negative impact on life expectancy and quality of life that diarrheal illnesses cause in HIV-infected patients, they also add significantly to the burden on caregivers in clinics and at home, and put caregivers and other family members at risk for infection. EH activities—such as hygiene, sanitation promotion, and household-based water treatment and safe storage—can lower the risk of diarrhea for HIV-positive adults.

Other critical global issues that are inextricably linked to environmental health are climate change, food security, and disaster relief and mitigation. Climate change presents real risks to human health, and it is already causing more severe storms, unpredictable planting seasons, and melting glaciers. These changes will likely disrupt the reliability of water supply and sanitation systems, especially during extreme climate events. Adaptation to climate change will increasingly rely on close inter-sectoral cooperation for prevention, management, and recovery.

THE BUREAU FOR GLOBAL HEALTH (GH) GUIDING PRINCIPLES

The guiding principles behind USAID's EHA are those of USAID's GH: (1) to demonstrate global leadership, (2) to provide key inputs to research and innovation, (3) to provide support to USAID field missions and partners, and (4) to support crosscutting initiatives to achieve integrated programming.

EH PROGRAM HISTORY

USAID has supported EH activities for nearly 30 years. One of the first major USAID investments in EH occurred during the International Drinking Water Supply and Sanitation Decade (1981–1990), which aimed to provide safe water supply and sanitation for most of the world's population by 1990. USAID's WASH Project (1981–1994) formed a core part of the USG's response during this effort. The WASH Project provided technical support to USAID field missions in over 85 countries. During its 15 years of operation, the WASH Project slowly evolved from a focus mainly on hardware and infrastructure (e.g., pumps, pipes, and their operation and maintenance) to multidisciplinary approaches (public health, finance, economics, and institutional) that also targeted community participation and management as well as sustained behavior change.

The EHP, 1994–2004, was initially envisioned as a significant expansion in scope beyond the WASH and Vector Biology and Control (VBC) Projects, and included a broader array of EH topics (e.g., urban air pollution). During the project period, however, central strategic objectives directed EHP to address child health and, later, malaria objectives. Whereas previously, success of water, sanitation, and hygiene at USAID had been measured by the number of infrastructure projects completed, increasingly, emphasis was put on the measurement of health impacts and integration of EH activities within the GH. Over its 10 years, EHP included aspects of infrastructure and behavioral interventions, and funded nearly $107 million (one-fourth core funds) in 52 countries.

In 2004, USAID's EH programming continued its shift towards integration within the GH by choosing to emphasize behavioral change projects (software) over infrastructure (hardware) ones. The rationale for this shift was twofold: (1) As health funding became more stove-piped, less money was available for projects like EHP or WASH and so smaller investments were made, and

(2) It created a new management model where staff were no longer responsible for managing one dimension of a single project—instead, they became responsible for managing whole projects. After 25 years of investing in one central project for environmental health, USAID invested in a number of smaller projects: the HIP, two POUZN projects, the IAA with CDC focusing on the SWS, the EH IQC and two global partnerships—PPPHW and HWTS.

CHANGING ENVIRONMENT

The future of USAID Bureau for Global Health's EHA will likely be influenced by the Obama Administration's new health initiative announced in May 2009. The initiative proposes $63 billion over six years to address a range of global health challenges including $51 billion over six years to continue existing Presidential initiatives that fight HIV, tuberculosis, and malaria, and $12 billion to address other global health issues, such as MCH, family planning, and neglected tropical diseases (NTDs).

In 2005, Congress passed the WFP, which made the provision of safe water and sanitation in developing countries a key objective. The WFP also supports broader U.S. development objectives, from eradicating poverty to promoting girls' education. Each year, this earmark has increased: the 2008 Consolidated Appropriations Act required that at least $300 million be spent on the WFP. Prior to WFP, a large portion of the money spent on water supply and sanitation by USAID went towards disaster assistance, which falls outside the scope of the Act.

A new bill (H.R. 2030) introduced in April 2009, titled the ―Senator Paul Simon Water for the World Act of 2009," aims to build on the WFP. The new bill sets a specified number of people—100 million—to be served with safe water and sanitation by 2015. Additionally, the bill would create an Office of Water at USAID headed by a Director for Safe Water and Sanitation and a Special Coordinator for International Water at the State Department. Congress is currently considering this bill.

There are a number of new opportunities for EH activities to contribute to other USG programs that address food security, global climate change, and global health issues.

II. METHODOLOGY

The current assessment used the following methods: a team planning meeting (TPM), document review, survey development, in-person and phone interviews, a field visit to Ethiopia, and a qualitative analysis of survey results.

The TPM was held at GH Tech Offices from June 30 to July 1, 2009 and included team building exercises, briefings on the project, development of a workplan, and scheduling of the two-month activity. A list of documents was assembled for the team to review (see Appendix D).

A survey instrument was developed (see Appendix C) that broadly included the following five questions:

1. How effective have the investments made through USAID's EHA been?
2. What were the gaps not covered by USAID's EHA?
3. How well did USAID's EHA support other USG agencies and/or international partners?
4. How well did USAID's EHA support cross-sectoral work?
5. Over the next five years, what activities and mechanisms should USAID's EHA pursue?

The assessment team pre-tested the survey with three respondents before submitting the final draft to USAID's Chief of the Maternal and Child Health Division for approval. The team then used a combination of in-person interviews, telephone interviews, and one write-in survey. Interviews were conducted with both individuals and groups (see Appendix B for complete list of respondents). U.S.-based interviews included respondents with the following breakdown: 14 from USAID/Washington, four from USAID field missions (apart from Ethiopia), nine from international organizations, three from other USG agencies, 19 from U.S.-based implementing partners, and two from independent consultants. Ethiopia-based interviews included five from the USAID mission and 10 from implementing partners.

The results were analyzed to identify commonalities.

III. FINDINGS

The findings of this assessment are organized by the following categories: WASH at USAID, partnerships, cross-sectoral integration, support to USAID field missions, scale-up, gaps, and opportunities.

WATER, SANITATION, AND HYGIENE (WASH) AT USAID

USAID has lost its standing as a global leader in the WASH sector. Its effectiveness has suffered from: (1) a lack of focus within the Agency, (2) an imbalanced coordination effort, and (3) a pre-packaged (for scale) delivery assistance model[2] that replaced a service delivery one. The context around each of these reasons is described below.

WASH at USAID is not focused in one office or bureau—it does not have a WASH "lead." This reality derives from one central issue: formerly, the GH's EHA had one central mechanism—a "one-stop shop"— (WASH Project and EHP) that handled water and sanitation infrastructure and hygiene promotion programming for USAID. When USAID field missions, outside agencies, etc., needed water, sanitation, and hygiene assistance from USAID, they came to the EHA. Now, the EHA has evolved towards multiple mechanisms—and thus multiple awardees—that, in practice, focus mostly on hygiene promotion, and other parts of the agency (e.g., the EGAT) have assumed a majority of the water and sanitation infrastructure programming. When people need water, sanitation, and hygiene assistance from USAID now, they are confused about where to go.

While the division of hardware and software between offices or bureaus alone should not have reduced the Agency's standing (each office has its strengths), its combination with poor coordination has. There are four main WASH-related coordinating entities: the USG interagency water team, the TEG for the WFP earmark, the USAID water team, and the EGAT water team. The USG interagency water team will not be addressed specifically in this report. The USAID water team has weakened, in part defaulting to the EGAT water team, which broadens the WASH discussion to include not only water and sanitation infrastructure, but also water resources, utility reform and financing. Though the EH team participates in this coordination effort, it has only one voice that addresses WASH software. EGAT has multiple voices at the coordination table addressing principally water infrastructure and water resource issues. This reality results in water infrastructure and water resource issues dominating the USAID Water Team coordination agenda over hygiene, health, and software ones. This imbalanced agenda has resulted in USAID projects that appear less cohesive and that are perceived as poorly implementing the HIF, a widely accepted model, developed by the EHA and supported by USAID and key partners including the United Nations Children's Fund (UNICEF) and World Bank's Water and Sanitation Program (WSP), which offers that sustained health outcomes result when both software and hardware interventions (along with enabling environment) are addressed. With respect to the WFP, the TEG, responsible for budgeting and ensuring that proposed activities are consistent with the earmark, formally establishes EGAT and the State Department as its co-chairs, recognizing "representation" from other bureaus. Despite the emphasis of health implicit in WFP language, the EH team's voice is not as strong as EGAT's voice on this committee.

To further complicate the coordination challenge, the majority of WASH activities related to the Water for the Poor earmark are distributed among the same two bureaus at USAID—GH and EGAT—despite the fact that the principal thrust of the WFP activities are health-related. As well,

[2] The term "pre-packaged," as used here and elsewhere in this report, was used by numerous respondents in this study. It describes a perception that while previous USAID water, sanitation, and hygiene interventions have been demand-responsive, providing mostly short-term technical assistance, the current set of interventions were perceived as more prescribed, narrower, and limited.

the type of money that can be used for earmark attributions influences programming in missions. Non-health offices usually get Development Assistance money, whereas health offices typically get Child Survival/Health money, both of which are programmed separately. Multiple respondents stated that these divisions have led to poor intra-agency coordination of WASH activities and that a clear home and clear leadership in the agency was needed for WFP activities.

Whereas the division of EH hardware and software, and the subsequent imbalanced coordination efforts, have reduced USAID's reputation as a global leader, its shift from a ~~"o~~ne-stop shop" service model to a pre-packaged project model has affected USAID field missions' willingness to contribute funds and invest ownership in these projects. The resultant lack of exposure has also reduced USAID's global leadership reputation. While the WASH Project and EHP allowed USAID to consistently and effectively respond to mission and partner needs with sound technical assistance, it did not reach large, ~~"a~~t scale" populations. The new EHA's focus on multiple, sound, scalable WASH software interventions (discussed below) attempted to address this shortcoming, but it has encountered many challenges. Though these projects offered promising approaches, they were not well-received. Respondents from field missions noted that these centrally-funded activities were often not ~~"i~~n synch" with USAID field mission priorities—many of which are made in collaboration with their respective national governments. Further, field mission respondents considered several of the central mechanisms (i.e., contracts and cooperative agreements) to be confusing, overlapping, and competing for services provided. Generally mission respondents did not like the idea of multiple mechanisms for WASH activities and felt that there was a general lack of awareness regarding the differences in central mechanisms.

REVIEW AND ANALYSIS OF ENVIRONMENTAL HEALTH ACTIVITY (EHA) INVESTMENTS

The current EH portfolio emphasizes hygiene behavior change and social marketing over infrastructure delivery. The table below lists each EHA and investments made. For POUZN, only POU investments—not zinc—are included. Below, each investment is analyzed in turn.

TABLE 3.1. INVESTMENTS MADE BY GH (I.E., CORE) OR MISSIONS (I.E., FIELD SUPPORT/MODIFIED ACQUISITION AND ASSISTANCE PROJECT DOCUMENTS [MAARDS]) INTO EH ACTIVITIES (FY 2004 TO FY 2009).

EH Activity	Type of Funding	Investments Made FY04 to FY09 (In Thousands)
HIP	• Core Funds • Field support/MAARDs • Total	$9,306 $7,680 **$16,986**
POUZN/AED	• Core Funds • Field support/MAARDs • Total	$950 $474 **$1,424**
POUZN/Abt/PSI	• Core Funds • Field support/MAARDs • Total	$3,223 $839 **$4,062**
CDC Interagency Agreement	• Core Funds • Field support/MAARDs • Total	$1,685 $0 **$1,685**

TABLE 3.1. INVESTMENTS MADE BY GH (I.E., CORE) OR MISSIONS (I.E., FIELD SUPPORT/MODIFIED ACQUISITION AND ASSISTANCE PROJECT DOCUMENTS [MAARDS]) INTO EH ACTIVITIES (FY 2004 TO FY 2009).		
EH Activity	**Type of Funding**	**Investments Made FY04 to FY09 (In Thousands)**
EH IQC (CDM Task Orders)	TO 1 (CDM) • Core Funds • Field support/MAARDs • Total TO 2 (CDM) • Core Funds • Field support/MAARDs • Total TO 3 • Core Funds • Field support/MAARDs • Total TO 4 • Core Funds • Field support/MAARDs • Total TO 5 • Core Funds • Field support/MAARDs • Total	 $0 $1,500 **$1,500** $1,702 $995 **$2,697** $0 $1,800 **$1,800** $0 $8,000 **$8,000** $0 $8,000 **$8,000**
EH IQC (Abt)	• Core Funds • Field support/MAARDs • Total	$0 $17,996 **$17,996**
International HWTS Network	• Core Funds • Field support/MAARDs • Total	$375 $0 **$375**
Global PPP for Handwashing	• Core Funds • Field support/MAARDs • Total	$600 $0 **$600**
Total	• Core Funds • Field support/MAARDs	**$17,841** **$47,284**

HIP

The HIP, implemented by Academy for Educational Development (AED), was designed to promote three critical hygiene behaviors—handwashing, safe excreta disposal, and household water treatment and safe storage—for improved health outcomes at scale. To date, HIP has obligated $9,306,671 of core funds. Scaled activities have been undertaken in Ethiopia and

Madagascar. Non-scaled project countries include Nepal, Peru, Uganda, Ghana, Mali, Niger, and India.

Though HIP has continued to establish USAID as a global leader in hygiene behavior change, it has encountered a number of challenges and successes:

In addition to staffing difficulties that persisted during the first two years of the project, HIP encountered three fundamental challenges. (1) Whereas HIP's predecessors (WASH Project and EHP) built a global reputation over 25 years by providing broad WASH technical services (both hardware and software) to international partners and USAID field missions on demand, HIP represented a substantial shift, offering a very limited, pre-packaged software project that did not respond directly to needs expressed by USAID field missions or partners. Consequently, HIP needed to sell itself to missions. Because missions were already streamlining activities (moving away from centrally-funded projects) and had not been included in the planning phases, many did not buy into the project and saw it as unrelated to mission activities. (2) HIP was designed as a "scaled" project (meant to reach large populations) and staff spent much of their first years defining what "scaled" meant and how to achieve it. (3) Although HIP was designed to work "at scale," the relatively small investments in the project did not reflect this mandate and were deemed insufficient by survey respondents.

Other constraints also persisted. (1) In places where, for a variety of reasons, HIP did not invest in full-time, dedicated staff on the ground at national level, partners have seen HIP as less collaborative, less available, and less engaged. With respect to full implementation of the HIF, HIP presented itself as a facilitation project focusing on software inputs while creating linkages with other components of the HIF (i.e., infrastructure and enabling environment) through partnerships. Without adequate HIP staffing, much of this work was perceived as falling on partners, contributing to disequilibrium in the partnerships. (2) The three health objectives promoted by HIP's mandate have proven limiting. In some places, other objectives have been requested by target populations (e.g., menstrual hygiene). (3) Hygiene improvement as a stand-alone theme did not have great resonance with missions given the many competing demands, and many suggested that a hardware component be added, even if it was a minor part of the program.

HIP successes provide four primary lessons. (1) Building itself on a partnership model, HIP leveraged in-country and international partners to co-implement projects and achieve sustained hygiene behavior change via full implementation of the HIF. (2) HIP realized that a scale approach required working within the context of the government's national health, hygiene, and sanitation strategy: in Ethiopia, HIP was able to take advantage of the country's well-developed health extension program, utilizing the cadre of community health workers and other development agents for implementation. (3) Cross-sectoral work is necessary to multiply the number of partnerships and avenues for behavior change, (e.g., significant work has been done with HIV/AIDS and hygiene in schools). (4) For a project to work at scale, national partners must be engaged to co-develop guidelines and tools that became part of the government program.

POUZN

Point-of-Use Water Disinfection and Zinc Treatment (POUZN) investments include two five-year task orders aiming to reduce diarrheal disease by scaling POUZN interventions and mainstreaming them into USAID field mission child survival activities. Though the POU and ZN parts have been largely independent, the current assessment only looked at POU. Two awardees implement the POU activities: Abt Associates/Population Services International (PSI) and AED.

The Abt/PSI model has primarily focused on mobilizing the private sector for the prevention and treatment of diarrhea through support and scale-up of POUZN, and disseminating communication messages to create awareness and demand for safe water treatment. Abt-PSI operates in Angola (water), Bangladesh (water), Benin (water and zinc), Democratic Republic of Congo [DRC]

(water), Haiti (water), Kenya (water), Madagascar (zinc), Malawi (water), Nepal (zinc), Pakistan (zinc), Rwanda (water) and Senegal (water). At the time of this report, $5,743,000 of core funds had been obligated to POU/Abt/PSI.

The AED model identified an existing private sector operation selling different POU methods: chlorine liquid, chlorine tablets, and filters. It then adapted this pre-existing model to other segments of the population (especially poorer segments of the population), with an accompanying communications program. AED operates in Uttar Pradesh, India. Its strategic approach is to offer a choice of methods to the consumer, increasing the likelihood of a sustained practice of water treatment. As of April 2009, $700,000 was obligated to AED for POU interventions and another $2.6 million was allocated for zinc treatment.

AED and Abt/PSI have met a number of challenges in implementing these projects. (1) Ultimately, the biggest challenge with POU is that poor consumers must consistently re-supply consumable products such as chlorine and repeat the treatment-related behaviors, which can include multiple steps in the case of turbid water. For many targeted populations, the need to constantly re-supply chlorine to treat water becomes a behavioral barrier to usage. (2) There is little long-term data on the sustainability of these interventions promoting consumable household water treatment products. Though both projects have initial data forthcoming, the projects are still too new to have longer-term conclusions. (3) Implementing partners saw the two mechanisms as competing and felt their effectiveness was compromised by sharing available funding. (4) USAID field missions[3] have not widely adopted POU as part of their child survival strategies. (5) Support for this intervention is not universal. Critics of POU argue that this particular intervention suffers from issues related to sustainability (described above) and that POU interventions involving commercial products may not offer additional advantages over safe water handling and storage.

POU's successes suggest several lessons. (1) Providing choice (i.e., multiple options) to consumers is important. (2) Models aiming to achieve scale need to leverage outside, pre-established (e.g., non-governmental organizations (NGOs) and/or private sector) partners to achieve their objectives. (3) Sustainability can be best achieved by leveraging existing private sector interventions (i.e., building local capacity) rather than subsidizing the introduction of new ones (i.e., funding the introduction of POU in countries where it has not yet proven successful).

Respondents perceived that the AED model could more easily ―work itself out of a job" because of a design that essentially aims to improve the reach and efficiency of pre-existing POU programs. In contrast, respondents perceived that the Abt-PSI model, which introduces a new POU program into countries where it did not exist previously, did not have as clear an exit strategy.[4] In these countries, it was unclear how much time and resources are needed in order to fully establish a self-sustaining POU program.

CDC Agreement

Since FY 2004, USAID has invested nearly $1.7 million into the CDC IAA intending to maximize CDC investments for safe drinking water and hygiene promotion activities in developing countries. While CDC's SWS includes components relating to household water treatment, safe water storage, and behavior change techniques, many respondents associated this agreement, almost uniquely, with POU project design and research. Though respondents recognized CDC as a critical and cost-effective research partner for USAID, in this case they

[3] When the project was awarded in September 2005, Abt POUZN had no POU buy-ins. They currently have buy-ins for POU programs from four countries: Benin, Kenya, Malawi, and Rwanda.

[4] Though respondents were unaware of Abt POUZN's exit strategy, the Abt POUZN program does have a clear exit strategy. The two main components of that strategy are ―product cost recover and reaching a sufficient scale such that significant investment in demand is no longer required."

generally perceived it as inherently biased in researching the effectiveness of the SWS/POU interventions it designed.

EH IQCs

The EH IQCs are broad-based umbrella mechanisms intended to allow USAID to respond to environmental health needs, including software. The three IQCs were awarded to the following prime contractors: Camp Dresser & McKee (CDM), the Research Triangle Institute, and Abt Associates. To date, several task orders have covered a wide range of interventions including: pollution prevention, rural WASH, secondary city sewerage systems, water treatment plants, tropical diseases, and knowledge management.

The EH IQCs were designed to respond to many of the issues that WASH and EHP addressed, covering all things under the EH umbrella. However, distinct from WASH and EHP, core funding was not attached to this mechanism, except for a knowledge management function designed solely for core support. Respondents felt it has been underused and diluted for several reasons. (1) With USAID's increasingly earmarked budget and the EHA's decision to invest in software, investments that apply the whole HIF have declined. (2) Because USAID's EHA utilized a mix of mechanisms with multiple implementing partners, including this one, which counts three awardees that can bid on each task order, the technical capacity of any one organization has been compromised as expertise has spread across these multiple organizations. (3) Because the EHA portfolio invests in multiple mechanisms, the funding available for the EH IQCs is limited.

Numerous respondents, however, identified with this EH mechanism for several reasons. (1) The EH name carries the torch of WASH Project and EHP, and signifies success and reliability globally. (2) Over 80% of EH respondents identified USAID EHA's Knowledge Management effort as the most useful and recognizable tool provided by the EHA portfolio. Respondents felt the type of information, the breadth of information, and the responsiveness of the mechanism to information requests were superb. (3) The EH IQCs are designed to respond to mission needs. (4) More than any other, this mechanism provides the best opportunity to assist USAID missions in programming Water for the Poor earmarked funds.

Global Partnerships

USAID's EHA currently invests in two global partnerships, the PPPHW and the HWTS. Respondents generally saw these investments as positive. Though large-scale outcomes have yet to be achieved in either, both efforts are generally seen to bring USAID's EHA to the international table in a leadership role. Considering the general critique that USAID often "goes it alone" and does not contribute to international collaborative efforts, these minimal investments are positive. It is important to note that USAID builds its international reputation through investing in these partnerships, not because of the amount of money they invest, but because it puts them at the table. Many respondents felt that additional, strategic investments of this sort can be positive for USAID.

Rotary International

USAID's EHA, in collaboration with EGAT, recently invested in a Global Development Alliance with Rotary International with support contracted through the EH IQC Task Order. Though this investment was not reviewed as part of this assessment, the co-funding mechanism may provide a model to address the widely-expressed criticism that WASH is too scattered across the Agency.

PARTNERSHIPS

EH activities aim to address environmental risk factors that affect health outcomes and are crosscutting by definition and therefore require a great deal of coordination and collaboration to achieve results, be relevant, and have a broad impact on development. To best understand the

critical nature of partnerships to EH, it helps to consider that it combines two disparate and discrete worlds: health, which focuses more on WASH software, and infrastructure, which focuses more on WASH hardware. When we consider that positive health outcomes result when the HIF is fully implemented, joining these worlds through partnerships becomes essential.

USG Partnerships

In general, USAID's EH team was recognized and complimented for their open attitude toward and successful support for various partnerships within USAID and the USG. The EH team engages in formal and informal coordination and collaboration mechanisms with offices and partners inside USAID, the CDC, the Department of State, the Environmental Protection Agency (EPA), the Department of State, and the National Institutes of Health.

The EH team's representation on the USAID Water Team facilitates the sharing of knowledge and expertise to the intra-agency dialogue on water, influencing programming around the WFP earmark, and providing training and technical assistance to team activities. Respondents felt that within the Water Team, each bureau's interests relating to WASH (i.e., GH's household-level, software WASH focus versus EGAT's urban, infrastructure and water resources focus) are clear. However, several respondents noted that these roles and responsibilities are not well understood by USAID staff outside the Water Team. This leads to confusion in programming and possibly missed opportunities for internally leveraged activities (e.g., joint GH/EGAT funded activities). Additionally, though EGAT covers infrastructure, it has never had a clear mandate to undertake WASH for health, even after the EHA divested its WASH infrastructure.

Several respondents noted that coordination within GH between the EH team and the Office of HIV/AIDS (OHA) has resulted in improved dialogue and technical exchange. Outside of the HIV/AIDS activities, however, the EH team has been less visible when integrating with other health activities, and consequently is often not seen by the Water Team as representative of GH.

The EH team's involvement in the interagency working group for coordination of the Partnership for Clean Indoor Air (PCIA), which includes other USG agencies such as EPA, was seen as positive.

External Partnerships

While support of international partnership networks (the PPPHW and the HWTS) was noted as a strength for the EHA, and the EH team is very well connected with the larger WASH community, the EHA continually struggles against the perception of USAID as a government agency that does not partner very well—often marked by USAID's inability to contribute to pooled funding and its lack of participation in sector-wide approaches.

Inconsistency also hampers external partnerships for USAID's EHA. One reason for this perception of inconsistency is the multiple implementing partners and mechanisms, which sometimes result in different people and/or different organizations representing USAID at international fora. During the WASH Project and EHP, this reality did not have the same influence because in USAID's absence, there was only one partner sitting at many tables. With the current configuration of the EHA, there are over six partners, all representing USAID at different meetings. This leads to confusion about who USAID is and a lack of coherence about the message it sends out to the world.

CROSS-SECTORAL INTEGRATION

As noted previously, the EHA's biggest challenge in cross-sectoral integration is joining the multiple sectors that it spans, including health, infrastructure, and water resources. This challenge is not USAID's alone, and in fact, most international respondents commended USAID as the best government agency at linking health and water. However, much work remains on this front.

Additional integration opportunities exist in education, economic growth, and democracy and governance.

While several smaller projects have been undertaken with the Population, Health, Environment (PHE) portfolio, the most successful cross-sectoral integration to date has been with HIV/AIDS. As discussed above, HIP has begun significant activities with HIV/AIDS in the field; and in Washington, the EH team has collaborated successfully with OHA. Other promising integration efforts by HIP in the field include the introduction of WASH in schools.

The successes mentioned here offer examples of good cross-sectoral integration, yet they were insufficient. Respondents recommended additional cross-sectoral programming in the following areas: other health issues (e.g., nutrition, immunizations, family planning, and MCH), infrastructure, environment, global climate change, economic development, and women's development.

SUPPORT TO USAID MISSIONS

USAID field missions' respondents recognized the strong technical assistance provided by the EH team and regularly utilize this specialized (software) assistance. However, the strong relationship between the EH team and colleagues in USAID field missions has not been matched with large-scale mission investments in and utilization of the EHA's portfolio.

The current EHA portfolio is not perceived to respond to USAID mission needs. Three reasons were identified for this. (1) The current EHA investments appear pre-packaged and inflexible, whereas the former WASH Project and EHP provided short-term technical assistance (STTA) to field missions based on need; these new projects offer activities with pre-defined objectives. (2) The current projects all appear limited, primarily because they offer software interventions when often a broader, more multi-faceted approach to WASH is needed. In the case of HIP, several mission staff observed that the limited scope of the activity would necessitate an additional procurement action paralleling HIP activities in order to meet host country infrastructure objectives. Some mission respondents also lamented the lack of a —one-stop shop" for WFP programming support. (3) Though these projects are sound and have important objectives (e.g., implementation at scale), they were not presented to missions appropriately. The initial successes could have been different if the EHA had invested time and resources to sit with mission staff, to evaluate five-year plans and host country government priorities, and then to co-strategize how these projects could support those plans and priorities. Instead, missions felt these projects were marketed to them for sale, and ultimately, were launched in a somewhat top-down fashion.

SCALE-UP

The current USAID EHA departed significantly from the former WASH Project/EHP efforts with respect to scale. Whereas the previous models provided STTA and developed small-scale programs that sought best practices to then transmit to larger audiences, the current programming targets scaled outcomes from the onset. This approach necessitated a new model, one that leveraged additional resources to fully implement the HIF and to reach scaled populations:

1. Because USAID's EHA targeted primarily behavioral aspects, international partnerships were necessary to fully implement the HIF. In the case of HIP- Ethiopia, behavior change activities are partnering with the WSP sanitation infrastructure inputs and in parallel with large World Bank investments in water supply. Jointly, WSP and HIP work on the enabling environment.

2. Because donor-funded projects do not have the human resources to reach scaled populations, in-country partnerships are necessary for implementation. In the case of HIP-Ethiopia, Ministry of Health district and community health workers have been leveraged to reach large-

scale populations. In the case of POU, reaching scaled populations required a combination of donor-supported inputs with private-sector ones.

According to respondents, the biggest challenge for the EHA's "scaled projects" has been resources. USAID invested insufficient resources to implement these activities well.

While it is still early to claim success in this "scaled" approach, a number of lessons, including those noted above, have been learned and are being shared. As the sector strives towards achieving the MDGs, it is clear that "scaled" approaches are necessary and that partnerships will be critical pieces of successful models. Because of its experience via HIP and POUZN, USAID's EHA has an opportunity to contribute significantly to this partnership dialogue. And, by engaging these partnerships early on in new projects and leveraging them to implement the HIF for better health outcomes, USAID's EHA can further link WASH and health to reach large, scaled populations.

GAP ANALYSIS

One of the principal questions asked of respondents during the assessment related to gaps: i.e., in what technical and programmatic areas is USAID's EHA programming deficient or absent. The following paragraphs summarize the major findings:

Full Implementation of the Hygiene Improvement Framework (HIF)

USAID's HIF is recognized by USAID staff and international development partners as a simple, credible, and constructive model for achieving public health impact from environmental health programs and activities. As mentioned previously, the framework integrates actions and activities related to hardware access (water and sanitation infrastructure), hygiene promotion (water and sanitation software), and enabling conditions in order to have an effective and sustained impact.

Many survey respondents noted that USAID's EHA programming is out of balance with respect to the HIF. The current EH portfolio strongly emphasizes hygiene promotion but provides very little technical support and investment in related hardware. Survey respondents also observed gaps in addressing the enabling environment at a national level. While USAID EH partners broadly acknowledge the rationale emphasizing hygiene promotion, most survey respondents noted that failure to fully implement the HIF has diminished USAID's leadership in the WASH sector.

Several international partners reported that USAID representation at international meetings and working groups can appear one-dimensional and lacks the depth of programming expertise and experience that many were accustomed to under the WASH Project and EHP. USAID mission partner comments resonated with this observation by recognizing the specific value offered by the USAID EH team but lamenting the lack of a "one-stop-shop" to meet broader hardware and policy programming needs.

Technical Gaps

Most survey respondents acknowledged the need to focus USAID's EHA, especially in light of limited budget resources. However, several additional technical focus areas were identified in discussion and review of the EH portfolio:

1. Sanitation programming was broadly identified as a gap. Despite recent efforts to engage with this intervention, the EHA is seen as a latecomer and still in process of defining its role. This gap reflects a historical view of WASH investments by USAID–as well as other donors that has largely focused on water supply, and more recently, hygiene promotion. However, increased international attention and the status of MDG sanitation targets globally highlight the need to more fully address sanitation programming from both an infrastructure and a

behavioral perspective. Survey respondents commended USAID's Sanitation Working Group as an important step toward increased dialogue and focus on sanitation issues and programming.

2. While respondents identified solid waste management as an important gap in USAID's EHA programming, they deemed it a lower priority than specific WASH interventions. Further, they felt USAID lacks technical expertise in this area, which is largely covered by other donors and development partners. The specific issue of medical waste management was also identified as a gap in USAID EH programming. EHA could play a role in addressing this issue as it relates to USAID health programs in order to support compliance with Agency environmental guidelines. It was noted that USAID does have some experience with medical waste incineration (Jordan).

3. Several respondents noted that the EHA is not necessarily the best means for addressing indoor air quality (IAQ) because of the cross-sectoral and cross-agency nature of the issue, which involves components of health, energy, climate change, and biodiversity. Further, they noted that the direct relationship between IAQ interventions and improved health outcomes is not well characterized. Despite these constraints, most respondents felt that USAID's EHA can and should remain engaged in this area at some level. For example, several noted that participation in the PCIA allows USAID's EHA to not only contribute technical leadership in this area, but also to glean lessons from this widely-viewed partnership success and transfer these lessons to its other partnership engagements. Additionally, some indicators suggest that resources for IAQ interventions may grow and that being at the IAQ table during this process may prove advantageous for USAID's EHA.

Operational Research

Numerous respondents indentified operational research as a gap in USAID's EHA. Within USAID, the EH team is viewed as a technical leader on numerous WASH issues (household water treatment and safe storage, hygiene promotion, etc.). Similarly, outside partners view USAID's EHA briefs and reports with respect and appreciation. However, despite these strengths within the USAID EH team, numerous respondents felt that USAID's EHA invests money in projects without guiding the research agenda. The resultant disconnect between what USAID's EHA funds and why is not always clear.

Some issues identified for operational research included:

- Long-term effects of behavior change interventions: Is promoting one message at a time (e.g., handwashing) more effective than promoting all three of the key hygiene behaviors?
- Ecological sanitation: What is the cost/benefit of ecosan? How can ecosan leverage other programs (e.g., agriculture, food security, and nutrition)?
- Commercial POU products: What is the correlation between sales of household chlorination products and usage of those products? How effective is safe water handling/storage versus commercial POU products for improving health outcomes?
- Community-led total sanitation (CLTS): How much of a community must be open defecation free to achieve improved health outcomes? Can improvements to sanitation be sustained if latrines are poorly constructed, as is the case in many CLTS programs?

Many respondents at field missions noted the need for rigorous screening of information related to WASH products and approaches to help them develop appropriate and effective programs.

Monitoring and Evaluation

In the current assessment, monitoring and evaluation of EH activities, impacts, and outcomes were widely recognized as a gap by survey respondents. Specifically, respondents called for better indicators to help accurately describe the impact and effectiveness of USAID investments in POU and hygiene improvement. However, this call for better indicators must be taken with an understanding of the extraordinary difficulty of measuring true impacts. It also has to take into account the resource requirements for better monitoring.

USAID, and donors writ large, have historically measured outputs over impacts. Over the last 15 years, as USAID's EHA has integrated into GH, this tendency has been reflected in a shift from measuring infrastructure-related outputs to measuring behavior-related outputs (e.g., liters of drinking water treated). Respondents did note progress on development of impact indicators, specifically work done through HIP, but more work in this area is still needed.

A number of respondents noted that monitoring and evaluation of USAID's EHA was too often conducted by implementing partners who have a vested interest in demonstrating program success.

OPPORTUNITIES

There exist a number of real opportunities over the next five years for the EHA—and USAID more broadly—to re-establish global leadership in the WASH sector, to strengthen their WASH technical approach, to better support field activities, and to expand cross-sectoral activities.

Combined with the MDGs, the WFP—which calls for the USG to bring safe access to water and sanitation for the world's poor—offers the EHA a real opportunity to re-establish a central role for health in the WASH sector within USAID. Though the WFP requires significant infrastructure development, it also signifies important health outcomes. It provides the opportunity for USAID's EHA to influence better coordination between health and water infrastructure/resources within the Agency, to promote better implementation of the HIF, and to restore the EH brand that built USAID's reputation as a global leader in WASH for over 25 years.

A number of opportunities also exist for USAID's EHA to strengthen its technical capacity, better feeding into research initiatives and providing global innovation. USAID can take advantage of this opportunity by concentrating its resources into a central mechanism that allows for one partner organization to house broader technical capacity and/or by increasing in-house technical capacity. Similarly, it can optimize its technical interventions by: (1) setting its own operational research agenda, (2) improving project designs to maximize its comparative advantage in hygiene behavior change and to allow greater project flexibility, (3) promulgating the "at scale" lessons it learns, (4) and/or further developing sanitation programming.

Given the lessons learned over the past five years, USAID's EHA can improve its support to field missions by collaborating with them during the project planning phases. It can begin to re-establish its leadership role by becoming more recognizable through better branding: i.e., linking what it offers under a moniker that missions and partners recognize and can relate to. Opportunities to undertake this task include: (1) continuing and expanding investments in international partnerships, (2) providing (or improving accessibility to) the full range of WASH technical services (both software and hardware) to missions and partners, and (3) developing country prioritization strategies for the rollout of its pre-packaged, scaled projects.

The Obama administration's new focus on MCH, eradication of NTDs, climate change, and food security offer USAID's EHA new avenues for cross-sectoral initiatives that achieve integrated programming. For example, the issue of water resource availability due to climate change may provide the EHA with an opportunity to link watershed restoration programs with improved

access to water, sanitation, and hygiene. Similarly, a new MCH emphasis may also allow the EHA to better implement WASH interventions related to specific MCH objectives. Several models exist (e.g., DRC) where decentralized health structures have integrated water and sanitation software and hardware underneath regional and/or district hospitals.

IV. RECOMMENDATIONS AND PROGRAMMATIC MODELS

RECOMMENDATIONS

Exploiting the opportunities noted above is a challenge of relationship building, of finding the right implementation model to capitalize on the options, and of encouraging investment from different funding sources. The following recommendations are organized to correspond to the opportunities outlined above, though many of these recommendations correspond to more than one of the opportunities listed. Some of the recommendations are already being pursued in one form or another. The assessment team outlines them here as areas that need to be highlighted and reinforced.

A. Establish the EHA (and health) as a critical pillar in WASH to rebuild USAID's global leadership position.

   1. *Emphasize the HIF for WFP implementation*. USAID's EHA should establish the HIF as the core of its WFP activities. This outcome may require: (a) advocacy by the EH team across the Agency, (b) pooled funding of initiatives where multiple offices provide different pieces of the HIF, and/or (c) establishment of protocols for WFP projects requiring software and hardware sign-offs.

   2. *Strengthen the health perspective on the Agency Water Team* by: (a) advocating for the EH team to co-chair the Water Team and the TEG, (b) clarifying Water Team activities as they relate to the water earmark, and (c) building a "WASH for Health" strategy on the HIF explicitly for WFP activities.

   3. *Re-create the environmental health brand.* USAID's EHA should leverage the successful branding of the WASH Project and EHP to re-position USAID as a leader in the field. The brand "Environmental Health" resonated with many respondents.

B. Improve USAID EHA's technical capacity.

   1. *Maintain comparative advantage in hygiene behavior change.* USAID's EHA should maintain its global leadership and comparative advantage in hygiene behavior change. In part, this requires broadening the scope of hygiene behaviors it addresses. In addition to promoting the three key health objectives, it should allow for flexibility to deal with other issues that may arise within the communities with whom USAID works.

   2. *Concentrate limited resources.* USAID's EHA should concentrate resources through limiting the number of mechanisms in which it invests. A smaller portfolio will allow partners to build up a qualified cadre of experts to support the broad array of needs in environmental health. Via an integrated, single mechanism, core investments can be made and supported for a hygiene behavior change intervention in the context of broader environmental health needs—e.g., water and sanitation infrastructure, or smaller projects related to medical waste and/or IAQ.

   3. *Increase technical capacity.* USAID's EHA should increase technical capacity to support partners and USAID field mission requests for WASH needs related to all three components of the HIF. This means increasing technical capacity at headquarters, either with permanent staff members or a roster (e.g., HQ could hire someone to manage a roster of technical specialists). This also means building technical capacity through a single, centralized mechanism outlined below. Recommended technical expertise includes: behavior change, marketing, sanitation, drinking water supply, infrastructure, population/health/environment/climate change, solid (medical) waste, economic

development, and IAQ. Additionally, USAID's EHA can advocate for regional WASH specialists via the Water Team.

4. *Develop research strategy.* USAID's EHA should establish an operational research agenda driven by USAID (not partners) that can utilize the CDC IAA and/or other mechanisms to answer the questions that are most relevant to missions' EH programs.

5. *Improve monitoring and evaluation.* USAID's EHA should improve monitoring and evaluation of intervention programs, perhaps linking it to operational research efforts. Many important programmatic questions related to cost effectiveness, scalability, and sustainability remain unanswered. This effort may also include development of proxy indicators that do not measure health outcomes, which are not always possible or economically feasible to measure.

6. *Increase sanitation emphasis.* USAID's EHA should highlight sanitation efforts. Because of its comparative advantage in behaviors, this work may involve support of operational research or promulgation of various strategies such as CLTS and/or sanitation marketing. It may also involve expanding its sanitation working group into an international network or creating a separate, parallel global partnership for sanitation. Given that USAID has partnerships on the other two key hygiene behaviors, a third partnership on sanitation would improve the USAID reputation internationally in parallel to its stated interventions.

7. *Expand knowledge management.* USAID's EHA should continue its leadership in knowledge management under a broader EH umbrella. In parallel, it should develop an EH knowledge-sharing platform for USAID missions and headquarters which allows sharing of best practices, success stories, posting of new projects and opportunities, and monitoring of agency EH activities.

C. Support Field missions and partners.

1. *Develop two pillars for EHA WASH assistance.* USAID's EHA should continue its global leadership in hygiene behavior change with scaled project experiences that, among other things, tie in closely with health programming. In parallel, it should invest in broader technical resources that partners and USAID field missions can access via a "one stop shop" WASH service model, especially given the increased need to program WFP money.

2. *Continue to build and invest in partnerships.* For its hygiene behavior change programming, USAID's EHA should leverage other resources via partnerships, especially in implementation of the HIF. In addition, to maximize limited resources needed to scale interventions, USAID behavior change programs should leverage existing partners (e.g., via global development alliances and informal partnerships) to produce public health products (e.g., chlorine packets or household water filters). For its global reputation, USAID's EHA should continue investments in global partnerships, and should evaluate and engage in new global partnerships, such as the Water Supply and Sanitation Collaborative Council WSSCC), the Joint Monitoring Program, the Global Framework for Action, and/or the International Scientific Forum on Home Hygiene. As noted above, investing in expansion of the sanitation working group into an international partnership may be worth pursuing. Investments in PCIA may also prove fruitful. Many respondents suggested that the number and quality of partnerships USAID's EHA invests in is more important than the total amount of money invested.

3. *Assert stronger leadership.* USAID's EHA and the USAID EH staff overseeing the activity need to assert more technical leadership both within the USG's water programming and with its international partnerships—either with more permanent staff members or a roster of consultants. As discussed previously, HQ staff or consultants representing USAID should be at the table with international partners, not other organizations.

4. *Develop country prioritization methodology.* Before introducing pre-packaged projects, USAID's EHA should prioritize countries. This process should include an analysis of a USAID mission's five-year strategy and buy-in from the mission, as well as the target country's human resource and other infrastructure that can support scaled work.

5. *Promulgate scaled experiences.* USAID's EHA should document its experience in scaled projects and share them at international forums.

D. Leverage Cross-sectoral Opportunities

1. *Develop a cross-sectoral strategic plan.* USAID's EHA should develop a cross-sectoral strategic plan related to WASH that outlines which sectors warrant the best partnerships and most efforts. In aligning with new Obama administration priorities, they may include climate change, MCH, family planning, and NTD eradication efforts.

PROGRAMMATIC MODELS

Given the findings and recommendations above, the assessment team proposes the following technical tracks for assistance:

First, USAID's EHA should further develop its global leadership in hygiene behavior change through a project that implements the full HIF and builds on a partnership model with USAID missions, WSP, UNICEF, and other partners. Major changes in this project include prioritizing countries by studying national health structures and five-year USAID mission plans, bringing USAID mission staff into the planning phase of the project and also hiring a permanent staff member in country. Additionally, the project should expand upon the scope and flexibility of HIP to allow for additional health objectives and additional activities.

Second, USAID's EHA should reinvigorate its technical capacity to support a broad array of EH interventions, including both software and hardware aspects. This broad technical capacity will provide support to missions and partners on demand. Its scope should include a roster of consultants that can respond to a broad range of environmental health issues (see recommendation B: 3 above), but that focuses on WASH. This technical capacity should be developed in a twofold manner via a broad umbrella mechanism as well as in-house at USAID.

To pursue the above tracks, the assessment team proposes the following investments:

1. One broad EH mechanism that includes discrete tasks and develops a resource cadre of staff and expert consultants to provide assistance across the environmental health field.

2. The largest activity here would be a hygiene behavior-change project.

3. Other activities could include POU interventions, infrastructure, IAQ, etc.

4. Global partnerships that include continued support of the PPPHW and HWTS but also allow for investment in other partnerships such as those noted in recommendation C: 2 above.

5. A mechanism (including CDC's IAA) for operational research under which USAID's EHA defines the research questions. Example research projects are listed in the *Operational Research* sub-section of the Gap Analysis section.

6. Pooled USAID funds to implement "WASH for Health" strategy and ensure the HIF are central to all Water for the Poor programming.

V. CONCLUSIONS

For over 25 years, USAID's EHA responded to requests for WASH assistance. Due to internal decisions to integrate this activity more closely within the GH and a change in how assistance was delivered, WASH programming shifted during this time from an infrastructure-base under the WASH Project to a mix of infrastructure and hygiene promotion/software under EHP, to its most current version that emphasizes multiple mechanisms (HIP, POUZN, SWS, EH, etc.) delivering hygiene promotion/software. For a number of reasons, both internal and external, this shift has reduced USAID's reputation in the global WASH arena. However, the pieces that built its reputation over those 25 years are still present: the HIF; its stated goals of global leadership, technical innovation, field support, and cross-sectoral integration; and the numerous partners that helped build that reputation.

While regaining the same leadership position is perhaps not possible, there are opportunities to re-establish a different leadership role that will potentially have more profound health impacts. USAID's EHA can: (1) re-establish a critical coordination role in the agency by co-chairing the Agency Water Team and playing a more central role in the TEG for the WFP earmark, (2) encourage implementation of its HIF for sustainable health outcomes, and (3) leverage the WFP's health focus to accomplish these tasks. In essence, it needs to continue GH's direction of integrating WASH activities into health programming, but at the same time build a central role for health activities (e.g., hygiene promotion) into WASH programming.

Accomplishing these goals is not a simple task, but lessons have been learned over the past five years that can lead to success. Bringing the array of software investments back under one mechanism and award—and re-establishing some level of broad technical assistance that can respond to field demands—will be critical and challenging. At the same time, continuing global leadership in hygiene behavior change through building institutional partnerships is essential, especially considering the necessity of HIF implementation. Lastly, engaging directly in coordinating agency programming related to "WASH for Human Health," and thus, Water for the Poor investments, will push the current program back into its rightful place as a global leader in water, sanitation, and hygiene.

APPENDIX A. SCOPE OF WORK

Environmental Health Activity 936-3122
MID-TERM EVALUATION
SCOPE OF WORK

I. USAID ENVIRONMENTAL HEALTH ACTIVITY MID-TERM EVALUATION

Activity: Conduct a mid-term evaluation of the Environmental Health Activity portfolio to determine the effectiveness of the procurements for a new design and adjustments to the portfolio as necessary.

II. PERFORMANCE PERIOD: NOVEMBER 2004–MAY 2009

III. FUNDING SOURCE: USAID/GH/MCH

IV. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT

The primary objective of this evaluation is to determine the performance of the Environmental Health (EH) Activity and how it is contributing to the GH objectives. The performance review should evaluate successes, constraints, failures, impact, and lessons learned of the hygiene improvement aspect of the EH Activity. The mid-term evaluation should also provide recommendations for future design for the remaining five years of the activity (2009–2014).

This evaluation will assess the portfolio of contracts and grants awarded through the EH Activity. This includes the following:

- Hygiene Improvement IQC # GHS-I-00-04-00024-00, Order No. 1: Hygiene Improvement Project.
- PSP IQC Contract # GPO-I-05-04-00007, Order No. 5: Social Marketing Plus for Diarrheal Disease Control: Point-of-use Water Disinfection and Zinc Treatment (POUZN/Abt-PSI).
- PSP IQC Contract # GPO-I-02-04-00012, Order No. 2: Social Marketing Plus for Diarrheal Disease Control: Point-of-use Water Disinfection and Zinc Treatment (POUZN/AED).
- Centers for Disease Control and Prevention IAA Agreement II # GHN-T-00-06-00001: Safe Water System (SWS)/Centers for Disease Control and Prevention
- Global Public/Private Partnership for Handwashing (PPP Handwashing)
- WHO International Network to Promote Household Water Treatment and Safe Storage (HWTS).
- Environmental Health IQC, Order # GHA-I-02-04-00006: Knowledge management; water supply, sanitation and hygiene technical assistance; and population-health environment programming (CDM).

V. BACKGROUND

The Environmental Health Activity is housed in the Bureau for Global Health's Office of Health, Infectious Diseases and Nutrition (GH/HIDN). This is a mid-term evaluation of a 10-year activity

focused on implementation and scale-up of proven environmental health interventions to prevent morbidity and mortality from infectious diseases, primarily in young children, but also among vulnerable adult populations. The Environmental Health (EH) activity commenced in mid–2004 and will end in 2014.

The goal of the EH activity is to reduce mortality and morbidity in children under five years of age, as well as mortality and morbidity associated with infectious diseases of major public health importance. The EH strategic objective aims to contribute to this goal by sustainable scale-up of priority interventions that reduce exposure to agents of disease, and to hazards that exacerbate disease by focusing on improvements in key behaviors and environmental conditions. Through the EH activity, USAID committed to focusing on the following:

1. **Hygiene Improvement** (HI): achieve measurable improvement in key hygiene conditions at a scale sufficient to attain significant public health impact in USAID-assisted countries, with inputs under the EH activity directly linked to the country-level outcomes (70% of EH activity).
    - Prevention of diarrhea through hygiene, sanitation, and water supply improvement. Example projects include: safe storage and treatment of water at point-of-use, optimal handwashing, and sanitary disposal of human feces.
2. **Indoor Air Quality Improvement** (IAQI): develop program approaches to improving indoor air quality in the rural and urban households still reliant on biomass fuels and basic stoves to meet their energy needs for cooking and heating (15% of EH activity).
    - Prevention of childhood pneumonia through reduction of exposure to indoor smoke.
3. **Innovative Program Approaches in Special Settings:** advance programming approaches in other specialized areas related to the EH strategic objective (15% of EH activity).
    - Environmental health threats faced by the urban poor (e.g., access to appropriate water, sanitation, and hygiene systems), and
    - Integrated programming of health, population, and environment interventions, especially in regions of threatened biodiversity.

The EH activities described above are designed to ultimately achieve large-scale public health impact. However, it is important to emphasize that they are at different stages of development, with some—such as interventions to address indoor air quality—still at the early stages, and others— like social marketing of POU products—largely a mature intervention to be expanded by field programs. Of the three EH activities described, hygiene improvement—receiving the majority of EH effort over the last several years—will likely continue to be a major focus. Thus, the bulk of the mid-term evaluation should address hygiene improvement activities (handwashing promotion, water quality and quantity, and sanitation). Investments in interventions to improve indoor air quality have been relatively low during the timeframe 2004–2009. Over the last five years, small investments have been made in a few countries to better describe urban health challenges and pilot appropriate responses. Pilot activities have been undertaken as part of MCH programs in India and Ghana, and under the Child Survival Grants (e.g., Bangladesh, Haiti and Indonesia). Population, health, and environment work has been reduced within the EH portfolio and is now by and large addressed by the Office of Population and Reproductive Health. The evaluation team is not expected to do a detailed evaluation of indoor air quality, urban health, or population, health, and environment activities, but should provide a general review about the role of these issues as part of the EH portfolio and as a future direction.

VI. SCOPE OF WORK

The evaluation team is expected to perform a mid-term evaluation of the USAID Environmental Health Activity. The evaluation should pose and answer the following questions using the broader categories as a framework for inquiry.

Global Leadership

1. Determine the benefits and constraints of EH Activity support and participation in the following international partnerships:
    a. Global Public/Private Partnership for Handwashing (PPP Handwashing),
    b. WHO International Network to Promote Household Water Treatment and Safe Storage (HWTS), and,
    c. Water Supply and Sanitation Collaborative Council (WSSCC).
2. Determine the benefits and constraints of EH Activity support to Safe Water System (SWS)/Centers for Disease Control and Prevention Interagency Agreement.
3. Evaluate the comprehensiveness of the current design and organization of the EH portfolio in contributing to the Hygiene Improvement Framework.
4. Determine how EH Activity contributes to a global strategy to impact national-level water and sanitation and hygiene indicators.

Research and Innovation

1. Evaluate how effectively the EH Activity has incorporated new research findings using the GH/HIDN research to use continuum. Determine how this has worked and how it can be improved.

Support to the Field

1. Evaluate to what extent the contracts and grants have contributed to the local capacity to implement water, sanitation, and hygiene programs, including the sustainability of the projects.
2. Determine the contribution of USAID field missions to core mechanisms, reasons for presence/absence of field support or participation in core-funded projects, and any changes in field support over the past five years.
3. Evaluate how the GH/MCH/EH Team has provided technical support to the field missions in designing, implementing, and monitoring EH interventions and programs.

Crosscutting

1. Evaluate to what extent the contracts and grants have met the technical and programmatic objectives, including the examination of deliverables and the quality of technical expertise.
2. Determine the effectiveness of the current design and organization of the EH Activity (one project vs. several), including cost-effectiveness of the modes of implementation.
3. Evaluate the quality and organization of support at USAID/W for the EH Activity portfolio.
4. Determine how the EH Activity has interfaced with other GH activities and offices, including successes and constraints.

5. Determine if progress was made on achieving the EH results pathways for GH.
6. Determine the possible scale-up of the activities, or introduction of new activities, both administratively and technically.
7. Evaluate the strategic management of knowledge and information related to environmental health activities.

VII. METHODOLOGY

The evaluators should consider a range of possible methods and approaches for collecting and analyzing the information which is required to assess the evaluation objectives. Data collection methodologies will be discussed with—and approved by—the USAID EH team prior to the start of the assessment.

Document Review

- USAID/W will provide the team with background documents such as proposals, strategies, and mid-term and final evaluations. The evaluator will review these documents in preparation for the initial team planning meeting.

Planning Meeting

- A two-day team planning meeting will be held in Washington, D.C. before the evaluation begins. This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will:

- review and finalize the assignment time line;
- develop data collection methods, instruments, tools, and guidelines;
- review and clarify any logistical and administrative procedures for the assignment; and
- develop a preliminary draft outline of the team's report.

Interviews and Site Visit

- Conduct a thorough review of EH Activity projects, including conducting in-person and phone interviews and one site visit to Ethiopia. From this information the evaluator will analyze his/her findings.
- The evaluator will make appointments and conduct phone and site visit interviews.
- With the assistance of HIDN/MCH, the evaluator will make logistical preparations prior to the in-country visit to Ethiopia.

VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

Team Leader: The team leader will be responsible for the overall organization of the work as well as the overarching management and administration aspects of the SOW. The team leader will facilitate preparation of the executive summary and the full report, assure that the draft and final products are prepared in accordance with the scope of work, and that the required revisions for the final report are incorporated. The team leader should be an expert in environmental health.

Public Health Specialist: The public health specialist will work with the team leader on all aspects of the evaluation, including preparation, interviews, and drafting the final report. S/he should be an expert in international public health and have experience in environmental health.

EH Specialist: A member of the Environmental Health team may be provided by GH/HIDN to participate on the evaluation team. This person is an expert in environmental health.

Level of Effort for each team member:

Task	Team Members	Estimated LOE (Days)
Background reading	Team Leader Public Health Specialist	2 2
Planning Meeting	Team Leader Public Health Specialist EH Specialist*	2 2 2
Interviews/Meetings (DC)	Team Leader Public Health Specialist EH Specialist	9 9 9
Travel to Ethiopia	Team Leader Public Health Specialist EH Specialist	2 2 2
Field Interviews	Team Leader Public Health Specialist EH Specialist	5 5 5
Drafting Report	Team Leader Public Health Specialist	5 5
Debriefings with USAID & Presentation	Team Leader Public Health Specialist	2 2
Report Finalization	Team Leader	5
TOTAL LOEs	**Team Leader** **Public Health Specialist** **EH Specialist**	**30 days est.** **25 days est.** **18 days est.**

*An EH Specialist from GH/HIDN office may be provided to participate on the evaluation team.

IX. LOGISTICS

USAID/GH/MCH Team point of contact will be responsible for the following technical and logistical support:

- Provide background documents, and
- Provide contact information for list of interviewees in Section XII.

The evaluation team leader and specialists will be responsible for the following technical and logistical support:

- Arrange the schedule of interviews with grantees and partners, and
- Provide support and editing services for the preparation of the final versions of the deliverables.

X. DELIVERABLES AND PRODUCTS

1. **Planning Meeting: November**

   Evaluators will participate in a two-day team planning meeting in Washington at the beginning of the project as stated in Section VII.

2. **Interviews and Site Visits: November**

   Team members will conduct interviews and a site visit in accordance with the guidelines set forth in Section VII and the tools and methods established during the planning meeting.

3. **USAID/W Debriefing & Presentation**

   The team will present the major findings to a USAID/W audience through a PowerPoint presentation at the conclusion of the interviews and site visit. This debriefing will include a discussion of past achievements and issues, as well as any recommendations the team has for future programming.

4. **Draft Report: December/January**

   A complete draft report—not to exceed 30 pages (not including annexes) and which will include a clear executive summary—will be submitted to USAID/W no later than two weeks after the end of interviews. This report will include a summary of findings including feedback on performance and implementation, recommendations, analysis of the grants and contracts, and recommendations for improved implementation. USAID/W will have two weeks to provide comments and suggestions to the evaluator that will be addressed in the final report.

5. **Final Report: January**

   After comments have been provided to the team, the final executive summary and full report will be prepared incorporating the comments received from the review of the draft. The team will submit the final but unedited report for USAID approval no later than one week after USAID has provided comments on the draft.

XI. RELATIONSHIPS AND RESPONSIBILITIES

USAID Points of Contact:

John Borrazzo, MCH Division Chief
USAID/GH/HIDN/MCH
Ronald Reagan Building 3.7–017
1300 Pennsylvania Ave, N.W.
Washington DC 20523–3700
Telephone: 202–712–4816
Email: jborrazzo@usaid.gov

Other technical contacts:

Merri Weinger, COTR, Hygiene Improvement
Ronald Reagan Building 3.7–026
202–712–5102
Email: mweinger@usaid.gov

APPENDIX B. PERSONS CONTACTED

EAST TIMOR

U.S. Agency for International Development

Peter Cloutier, International Development Intern Executive Officer

ETHIOPIA

Amhara Ministry of Health Bureau EH Team

Ato Mengisayehu, Environmental Health Officer

Girma Wondale, Cluster Leader

Amhara Regional Education Bureau

Ato Fanta, Deputy Head

Amhara Regional Health Bureau

Tilahun Yimaldu, Deputy Head

Carter Center

Ato Mulat, Regional Coordinator

HIV/AIDS Community of Practice Partners

Almaz Abebe, Outreach Coordinator

Thewodros Kassahun, Branch Manager

Etagin Desaleye, Branch Manager

Degie Zerihun, Dawn of Hope Manager

Organization for Social Services for AIDS

Amare Bedada, General Manager

United Nations Children's Fund (UNICEF)

Daniel Galen, WASH Advisor

Ato Takele, WASH Advisor

U.S. Agency for International Development

Meri Sinnitt, Director of the Office of Health, AIDS, Population and Nutrition (HAPN)

Abeje Zegeye, Deputy of HIV Programs, HAPN

Steven Neri, Technical Advisor

Kassahun Deneke, Strategic Information Advisor, HAPN

Fentie, Mequanent, WASH Advisor, HAPN

Water and Sanitation Program (WSP) - World Bank

Andreas Knapp, Water and Sanitation Specialist

Kebede Faris, Water and Sanitation Specialist

INDIA

U.S. Agency for International Development

Sanjeev Upadhay, Advisor in Urban Health and Infectious Diseases

MADAGASCAR

U.S. Agency for International Development

Faramalala Raharisolo, WASH Program Assistant

SENEGAL

U.S. Agency for International Development

Aaron Brownell, Program Officer

SWITZERLAND

World Health Organization

Yves Chartier, Public Health Engineer

Water Supply and Sanitation Collaborative Council (WSSCC)

Jon Lane, Executive Director

UK

Aguaconsult Ltd.

Harold Lockwood, Consultant

UNITED STATES OF AMERICA

Abt Associates Inc.

Rodolfo Camacho, Director, EH IQC

Susan Mitchell, Project Director, POUZN/Abt-PSI

Vicki MacDonald, Program Manager, POUZN

Academy for Educational Development

Camille Saade, Project Director, POUZN/AED

Julia Rosenbaum, Deputy Director, Hygiene Improvement Project

Orlando Hernandez, Senior Evaluation Officer

Sandy Callier, Project Director, Hygiene Improvement Project

Associates in Rural Development

Chris McGahey, Water Resources/Environmental Health Specialist

Scott Tobias, WASH Specialist

Camp Dresser McKee

J. Ellis Turner, Chief Officer Technical Representative, EH IQC

John Gavin, Resource Manager

Dan Campbell, Knowledge Management Specialist

Catholic Relief Services

Dennis Warner, WASH Senior Technical Advisor

Centers for Disease Control and Prevention (CDC)

Eric Mintz, Chief of the Diarrheal Disease, Epidemiology Section

Independent Consultant

Craig Hafner, Water and Sanitation Consultant

Manoff

Elizabeth Younger, Senior Advisor

PATH

Glenn Austin, Director, Safe Water Project

Population Services International

Megan Wilson, Program Manager, Child Survival

Research Triangle Institute

Eugene Brantly, Environmental Health Program Manager

Training Resources Group

Fred Rosensweig, Senior Consultant

Save the Children

Massee Bateman, Director, Saving Newborn Lives Program

United Nations Children's Fund (UNICEF)

Therese Dooly, Senior Advisor, Hygiene & Sanitation

U.S. Agency for International Development (USAID)

Anthony Kolb, Urban Health Advisor

Carl Mitchell, Africa Water Group Leader

Dan Deely, Water Resources Advisor

Elizabeth Fox, Deputy Director, Office of Health, Infectious Disease and Nutrition

Heather D'Agnes, Population, Health and Environment Advisor

Irene Koek, Chief of the Division of Infectious Disease

Jim Franckiewicz, Water Team Leader

John Borrazzo, Chief of the Division of Maternal and Child Health

Malia Boggs, Micronutrients Program Advisor

Mary Harvey, Africa Bureau Health Officer

Merri Weinger, Program Manager, Hygiene Improvement Project

Neal Brandes, Health Research Advisor

Rochelle Rainey, Environmental Health Advisor

U.S. Environmental Protection Agency (EPA)

Jacob Moss, Senior Advisor, EPA Office of Air and Radiation

U.S. State Department

Dano Wilusz, Foreign Affairs Officer

World Bank

Pete Kolsky, Senior Water & Sanitation Specialist

Water and Sanitation Program (WSP) – World Bank

Eddy Perez, Senior Water & Sanitation Specialist

APPENDIX C. SURVEY INSTRUMENT

Respondent Name:_____

Organization:_____

Position:_____

Phone Number:_____

Interviewer:_____

Date:_____

The current survey is being conducted as part of a mid-term assessment of USAID's Environmental Health activity examining achievements and results to date to inform future programming. Initiated in 2004 and scheduled to continue through 2014, the EH activity expects to:

- Demonstrate global leadership,
- Provide key/critical inputs to research and innovation,
- Provide support to USAID field missions and partners, and
- Support crosscutting initiatives to achieve integrated programming.

The overall goal of the activity is to reduce mortality and morbidity in children under five years of age, as well as mortality and morbidity associated with infectious diseases of major public health importance. USAID aims to contribute to this goal through sustainable scale-up of **improvements in key behaviors and environmental conditions**. Thus far, the activity's major investments have included [provide as much detail as necessary to familiarize the respondent with each IQC]:

- HIP/AED (Hygiene Improvement Project) is a USAID-funded project that has a strong focus on behavior change at scale as it relates to three key hygiene practices:
  - Safe feces disposal,
  - Handwashing with soap, and
  - Safe storage and treatment of water at point-of-use (POU).
- POUZN/AED (Point-of-Use Water Disinfection and Zinc Treatment) – Social Marketing – focuses on a public-private partnership model for engaging manufacturers. This approach aims to strengthen the infrastructure of local commercial companies, manufacturers, distributors, and retailers to conduct sustainable production and marketing of products specifically targeting low-income and rural communities.
- POUZN/Abt-PSI (Point-of-Use Water Disinfection and Zinc Treatment) – Social Marketing for diarrheal disease control – builds on existing USAID-supported social marketing activities at the country level. The project has the capacity to develop commercial partnerships for product development, marketing, and distribution.
- CDC Interagency Agreement for ―Safe Water System" provides support to the CDC to carry out the Safe Water System (SWS) – a water quality intervention that employs

simple, robust, and inexpensive technologies and behavior change appropriate for the developing world. The objective is to make water safe through disinfection and safe storage at the point of use.

- EH IQC – is a world-wide mechanism to provide technical assistance across a broad array of environmental health interventions (water supply, sanitation, hygiene, vector control, indoor air pollution, and population-health-environment). One of the major components of the IQC is knowledge management and knowledge sharing through the EHP knowledge manager, Dan Campbell, and the EHP website.

As well, USAID/W provides support to two global partnerships:

- The Global Public/Private Partnership for Handwashing is a coalition of international stakeholders whose focus is to prevent diarrhea and respiratory infections and to make handwashing with soap a common practice in homes, schools, and communities worldwide

- The International Network to Promote Household Water Treatment and Safe Storage (WHO) aims to contribute to a significant reduction in waterborne disease by promoting household water treatment and safe storage as a key component of water, sanitation and hygiene programs. The Network engages in advocacy, communication, research and implementation to achieve this.

All of your responses will be confidential and you are free to not answer questions if you choose.

1. With which of these USAID investments do you have experience and/or knowledge?

   Considering USAID's expectations to provide global leadership, provide key inputs to research and innovation, provide support to USAID field missions and partners, and support crosscutting initiatives for integrated programming, what do you think about these investments in terms of effectiveness or impact? What are USAID's strengths? What are USAID's weaknesses?

2. What do you think are the gaps in USAID's Environmental Health Activity? In which of the following areas do you think USAID is weak? Please explain.

   [Go through each of the items below and, at a minimum, have them answer yes or no on the gap question]

   a. BALANCE of Community-level infrastructure (Hardware)/ Hygiene Promotion (Software)/ Enabling Environment (i.e., hygiene improvement framework)

   b. Research: How effective has USAID been at integrating research into its research to use continuum? How can this be improved? What areas can USAID EH research?

   c. Integration within health: How can USAID EH improve and with which other health activities?

   d. Monitoring and Evaluation

   e. Water Supply

   f. Sanitation

   g. Urban Issues

h. Indoor Air Quality

i. Women's Health

j. Solid Waste (Medical Waste)

k. HIV/AIDS (only ask this to Merri Weinger, Jon Palen, and Gloria Steele)

l. NTDs (only ask this to Irene Koek and Richard Greene)

3. How well does USAID's EH portfolio support other USG and/or international agency activities? How well do we collaborate with partners? What value do we bring to them? How can we do this better?

   Do you think that investing in global partnerships (PPPHW/HWTS) is fruitful for USAID? Why or why not? Are there any specific partnerships that USAID should become involved with?

4. How well does the EH portfolio support other (USAID) sectors? What sectors do we support well? What sectors do we need to support better? How can we do this better?

   Probe for:

   Infrastructure Development,

   Environment,

   Economic Development,

   Climate Change,

   Food Security/Nutrition, and

   Women's Development.

5. Over the next five years, what do you see as the most critical interventions in Environmental Health? What role can USAID's EH program play over the next five years? What are we missing? Considering MDGs and new presidential initiatives, how can USAID best support scaling up of EH interventions?

USAID Field Mission Specific Questions:

6. How well does USAID EH Headquarters support field activities?

   6a. What USAID EH headquarters support provides most value to the field?

   6b. What should it stop doing?

7. What enables or disables USAID field missions to contribute to core-funded activities?

8. What actions by HQ will lead to field missions being more engaged with core-funded projects?

   Probe with:

   Policy, guidance;

Better models for budget – e.g., innovative Water for the Poor assistance, integration across sectors, etc.;

Technical assistance and support;

Technical development;

Knowledge management; and

Partnership support.

9. What EH activities would you like to see from HQ in the future?

APPENDIX D. REFERENCES

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For more information, please visit
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