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EXTENDING SERVICE DELIVERY (ESD) PARTICIPATORY ASSESSMENT

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ACRONYMS

AA	Associate Award
ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
A/ME	USAID Asia Bureau and Middle East Bureau
AMTSL	Active management of third stage of labor
ANC	Antenatal care
ANE	USAID Asia and the Near East Bureau (now Asia and Middle East Bureaus)
APROFAM	*La Asociación Pro Bienestar de la Familia de Guatemala* (IPPF affiliate)
BCC	Behavior change communication
BHS	Basic Health Services Project
BP	Best practice
BPPE	Best Practice Program Exchange
BSR	Business for Social Responsibility
CA	Cooperating agency/cooperative agreement
CAC	Community action cycle
CBD	Community-based distribution
CEmOC	Comprehensive emergency obstetric care
COTR	Contracting Officer's Technical Representative
CRTU	Contraceptive and Reproductive Health Technologies and Research Utilization
CSR	Corporate social responsibility
ESD	Extending Service Delivery Project
ESD/W	ESD's Washington office
FBO	Faith-based organization
FGC	Female genital cutting
FHI	Family Health International
Flex Fund	Flexible Fund
FP	Family planning
FS	Field support
GBC	Global Business Coalition
GBV	Gender-based violence
GH	Bureau for Global Health
GLP	Global Leadership Priorities (PRH)
GU/IRH	Georgetown University's Institute for Reproductive Health
HER	Health Enables Returns
HIM	Healthy Images of Manhood
HIV	Human immunodeficiency virus

HMIS	Health management information systems
HQ	Headquarters
HTSP	Healthy timing and spacing of pregnancy
IBP	Implementing best practices
ICMH	International Centre for Migration and Health
IDP	Internally displaced person
IEC	Information, education, and communication
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPPF	International Planned Parenthood Federation
IR	Intermediate result
IUD	Intrauterine device
LA	Long-acting
LAC	Latin America and Caribbean
LAM	Lactational amenorrhea method
LAPM	Long-acting and permanent methods
LWA	Leader with Associate
M&E	Monitoring and evaluation
MAQ	Maximizing Access and Quality
MCH	Maternal and child health
MDG	Millennium Development Goal
MEWATA	Medical Women Association of Tanzania
MNCH	Maternal, neonatal, and child health
MOH	Ministry of Health
MOST	Management and Organization Sustainability Tool
MSH	Management Sciences for Health
NEP	North Eastern Province (Kenya)
NGO	Nongovernmental organization
OVC	Orphans and vulnerable children
PAC	Post-abortion care
PAI	Performance Assessment Improvement
P/BP	Promising or best practice
PDQ	Partnership defined quality
PEPFAR	President's Emergency Plan for AIDS Relief
PHE	Peer health educator
PLWHA	People living with HIV/AIDS
PMP	Performance Monitoring Plan
PP	Postpartum
PPFP	Postpartum family planning

PRH	Population and Reproductive Health Office
QA	Quality assurance
RFA	Request for applications
RH	Reproductive health
RHRC	Reproductive Health Response in Conflict Consortium
RL	Religious leader
ROI	Return on investment
SC	Save the Children
SDI	Service Delivery Improvement Division (in GH/PRH)
SDM	Standard days method (contraceptive)
SOTA	State of the art
STTA	Short-term technical assistance
TA	Technical assistance
UNFPA	United Nations Population Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
UTT	Unilever Tea Tanzania
WHO	World Health Organization
WRA	White Ribbon Alliance

EXECUTIVE SUMMARY

OVERVIEW

This participatory assessment was commissioned by the United States Agency for International Development's (USAID) Bureau for Global Health (GH), Office of Population and Reproductive Health (PRH), Service Delivery Improvement Division (SDI), in order to (1) examine the Extending Service Delivery (ESD) Project's progress to date toward achieving planned results and lessons learned; (2) identify ways in which the project can maximize results and lessons learned during its remainder; (3) make recommendations regarding ESD activities that may warrant continued investment; and (4) identify gaps in the reproductive health (RH)/family planning (FP) activities covered by ESD that a follow-on project might want to address. ESD is a five-year, centrally-funded Leader with Associate (LWA) Cooperative Agreement (CA) that began on October 1, 2005, and will end on September 30, 2010.

ASSESSMENT METHODOLOGY

In March and April 2009, the assessment team, composed of two external consultants from the Global Health Technical Assistance Project and three USAID staff, conducted interviews with USAID and headquarters (HQ)-based stakeholders, and those based in countries where ESD is active (see Appendix G). The team, accompanied by ESD HQ-based staff, visited three country projects selected by USAID and ESD: Guinea, Kenya, and Tanzania. Information in this report was updated through June 2009.

MANDATE OF THE ESD PROJECT

The project mandate is to address the following:

- Prioritize underserved populations, defined as urban/rural marginalized persons, youth, refugees/internally displaced persons (IDPs), and women who are postpartum (PP) or receiving post-abortion care (PAC).
- Develop and test models that reach the target groups and improve integration of FP with maternal, neonatal, and child health (MNCH) and HIV/AIDS services.
- Develop models that contribute to the USAID/GH/PRH Global Leadership Priorities (GLPs) and technical priorities.
- Identify and disseminate state-of-the-art (SOTA) best practices (BPs).
- Apply multi-tiered, multisectoral approaches, include non-health sectors, and promote gender-based activities.[1]

ESD defined its overarching strategy as placing FP at the forefront of good health and social and economic development by mainstreaming evidence-based practices and using SOTA approaches. The project's proposed methodology involved strengthening and linking FP services and methods in facilities and the community, developing two-way referrals, and providing RH/FP services in workplaces.

[1] A "multi-tiered approach" refers to working at different levels (e.g., community, health center, hospital, regional, central levels). "Multisectoral strategies" address RH/FP through non-health sectors (e.g., education, agriculture, environmental, and social programs) as well as health sectors.

ESD COUNTRIES AND FUNDING TO DATE

As of May 31, 2009, ESD had received approximately $15.1 million in core funds, $15.2 million in field support (FS)-obligated funds, and $39.5 million obligated (of $82.5 million awarded) in Associate Award (AA) funds. Three additional AAs are in the pipeline (Angola, Guatemala, and Mozambique).

ESD currently works and has worked in 18 countries—Africa (Angola, Burundi, Ethiopia, Guinea, Kenya, Nigeria, and Tanzania), Asia and Near East (ANE) (now Asia/Middle East–A/ME) (Bangladesh, Egypt, India, Indonesia, Jordan, Nepal, Pakistan, and Yemen), and Latin America and the Caribbean (LAC) (Guatemala). ESD also previously supported work in refugee camps in Kenya and Southern Sudan.

ESD core funds have been used for testing models such as:

- Postpartum FP (PPFP) for urban slum women (with a focus on young women) (Nepal).
- Promoting RH/FP health services in plantations and factories and/or documenting return on investment (ROI) for corporate investment in RH/FP (Bangladesh, Egypt, Pakistan, and Tanzania).
- Healthy Timing and Spacing of Pregnancy (HTSP)/FP and reducing the number of child marriages in socially conservative areas (northern Nigeria and Yemen).
- Supporting Pathfinder and Intrahealth bilateral projects in expanding access to long-acting (LA) FP methods in rural regions, and integrating FP and HIV education and testing into obstetric fistula care (Ethiopia).
- Promoting provision of RH/FP/HTSP services by private midwives in conservative/remote areas and strengthening midwives associations' organizational and business skills (Yemen).
- Integrating FP into HIV/AIDS services (Kenya's North Eastern Province (NEP), Tanzania) and into maternal and child health (MCH) and integrated management of childhood illness (IMCI) services (now starting in Burundi).
- Using the Healthy Images of Manhood (HIM) strategy to increase male responsibility in RH/FP/HIV/AIDS services (Kenya NEP and Tanzania).
- Developing educational and training materials for the HTSP roll-out strategy, supporting local and regional HTSP Champions' Networks, updating national guidelines, and incorporating HTSP, lactational amenorrhea method (LAM), and standard days method (SDM) into best practices materials developed by other projects, making them relevant to ESD work.

Field Support (FS) and Associate Awards (AA) funds have been applied to the following activities (levels of effort and activities in each country vary depending on Mission requests and funding source):

- A/NE FS: Best Practices Technical Consultation in Bangkok (2007) to promote BPs in maternal, neonatal, child, and reproductive health and family planning (MNCH/RH/FP) (13 countries); grants and follow-up technical assistance (TA) for BP activities (six countries)
- A/NE FS: Changing social norms and promoting HTSP through religious leaders (RLs) (Bangladesh, Pakistan, Yemen)
- USAID/Yemen AA: Supporting MNCH/FP/HTSP services in remote regions in five governorates

- USAID Mission FS and AA: Providing residential TA to support government FP programs (Guinea), as well as providing FP/MNCH (Burundi), MCH and HIV/AIDS (Kenya Northeastern Province (NEP), and FP (Angola)
- USAID/Guatemala FS: Providing short-term technical assistance (STTA) to bilateral projects ALIANZAS and APROFAM[2] to revitalize FP in their corporate social responsibility (CSR) initiatives (2007); providing STTA to the Ministry of Health (MOH) to update National RH/FP Guidelines and promote HTSP among health professional organizations (2008), STTA to evaluate APROFAM (completed April 2009), and STTA to conduct gaps assessment for USAID health (including FP) activities (completed July 2009)
- USAID/Ethiopia FS: Providing STTA to bridge two bilateral contracts (2007)
- East Africa FS: Providing STTA to strengthen FP and promote reduction of gender-based violence (GBV) and FP outreach education in Kenya refugee camps (2007)

MAIN FINDINGS

The assessment team identified strong evidence of progress toward project objectives, as well as areas that could improve end-of-project results if strengthened during the final year.

ESD was praised by many U.S. and field-based informants for its ability to restart the FP discussion in locations where it had stagnated, for its flexibility and responsiveness to requests from USAID and others; for its ability to get services up and running rapidly in populations considered difficult to work with (nomads, refugees, post-conflict, and very conservative populations in Burundi, Kenya, Nigeria, and Yemen (now also planned with Angola and the Democratic Republic of Congo (DRC)); and for meeting USAID Mission needs for long and short-term technical assistance.

ESD achievements related to Intermediate Result (IR) #1: Global leadership demonstrated in RH/FP policy, advocacy, and services

ESD is acknowledged as having shown global leadership in two areas:

1. A roll-out strategy for promoting evidence-based HTSP, which is credited with breaking barriers to acceptance of FP in countries or regions where it had previously been rejected or had stagnated.
2. A model for best practices dissemination and scale-up that was developed at the technical consultative meeting in Bangkok in 2007. The model includes presentations and workshops on promising and best practices (P/BPs) for MNCH/RH/FP, supports teams developing proposals for introduction/expansion of these P/BPs into their countries, and provides small grants and follow-up TA to funded projects. There is evidence that funded follow-up introduction and scale-up of P/BPs continues in participating countries. The BP strategies modeled on the Bangkok meeting have been or are being implemented in nine countries (see Appendix I).

Examples of potential global leadership that are promising but require further evidence include integrated and multisectoral models that:

- Target religious leaders and men for dissemination of HTSP information and greater involvement in promoting RH/FP.

[2] International Planned Parenthood Federation (IPPF) affiliate.

- Increase RH/FP among employees of factories and plantations through nongovernmental organization (NGO)-corporate partnerships and document corporate return of investment through reduced worker turnover and training costs.
- Integrate FP into community PP care.
- Integrate FP services into HIV/AIDS services.
- Help private professional groups (e.g., midwives, female gynecologists) to expand FP services and promote HTSP.

Models being implemented with ESD support include the following (details about each model and its components are available in the report):

1. Integrating FP with MNCH/RH services (Angola, Burundi, Guinea, Kenya NEP, Yemen (Guatemala under discussion)).
2. Integrating FP with HIV/AIDS services (Kenya NEP, Tanzania: Unilever Tea Tanzania (UTT)).
3. Integrating FP with community-based PP care (Egypt, Nepal, Nigeria; new—Bangladesh and India).
4. Integrating FP with PAC (Jordan, Kenya, Tanzania).
5. Multisectoral integration of HTSP/FP using different models (Bangladesh, Egypt, Indonesia, India, Kenya NEP, Nepal, Northern Nigeria, Pakistan, Tanzania, Yemen).
6. Expanding availability of FP through private providers among professional organizations (private-sector midwives) (Yemen).

The above examples may not be comprehensive; more complete information is provided in Appendix O.

FP services and contraceptive supplies have become more widely available and reliable in some programs (Guinea, Kenya NEP). ESD provided the following evidence of increased FP uptake in projects where ESD has supported FP activities and/or has targeted risk groups for HTSP/FP education and referral:

- Guinea: Contraceptive use in the previously severely underserved forest region increased from a 2% baseline (August 2007) to 9% (December 2008), and also increased in Upper Guinea from 13% (March 2007) to 22% (December 2008).
- Nepal: Among the target population of PP women, 60% (n=391) were using LAM at one month postpartum. At six months PP, 79% (n=316) were using an FP method; at 12 months PP, 84% (n=257); and at 18 months PP, 80% (n=154) were continuing to use an FP method. Twelve private-sector Yemeni midwives newly trained and supported by ESD to provide FP services reported that they applied modern FP methods during 641 visits in the first half of 2009, including 72 IUD insertions. ESD reports that most of these were PP women.

Other data furnished by ESD require more context in order to interpret, but they do provide evidence of ongoing FP service utilization. For example:

- FP services at UTT (Tanzania) facilities show steadily increasing numbers of clients (the average number of new FP clients was 11 per month in January–June 2007, as compared to 16 per month in January–June 2009). Data also show that in January–June 2009 there were 16 implant insertions and three sterilizations. Due to the very high prevalence of HIV, ESD strongly supported the use of condoms through 25 trained peer health educators (PHEs), who in 17 months have distributed 122,492 male and 5,321 female condoms.

- FP services, not previously offered in the UTT HIV services, show uptakes in FP by HIV clients (17 new FP clients and 70 repeat visits in January–June 2009).
- Average monthly FP clinic visits in Dadaab, Kenya refugee camps increased from 151 (January–March 2007) to 341 (April–August 2007), which has been attributed by NGO service providers to the work of ESD-trained community FP educators. ESD also trained peer educators in HIM and GBV over the same period, but further follow-up was not possible.
- SDM is being tested in one Kenya NEP District where HTSP is being introduced through religious leaders. The team was told that SDM is being accepted in this conservative area where most acceptors are new to FP use.

IR #2: Knowledge generated, organized, and communicated in response to field needs

Activities include the following:

- Facilitating the update or development of national-level policies, guidelines, and training materials for RH/FP, focusing on counseling clients on FP as a component of antenatal care (ANC), MCH, PP, PAC, HIV/AIDS, and child health services, and advocating the addition of HTSP, lactational amenorrhea method (LAM), and standard days method (SDM).
- Documenting P/BPs previously implemented by other organizations/projects (AMKENI/Kenya and TAHSEEN/Egypt); developing information briefs, including a Promising and Best Practices Series.
- Reviewing models, data collection, and analyses to strengthen evidence for HTSP; presenting ESD-identified P/BPs at international and national meetings; supporting South-to-South learning (e.g., A/ME BPs technical consultation); and sponsoring study tours, small grants to support local advocacy and information exchanges, and innovative virtual technologies.

Examples of PRH-funded training materials developed by ESD include:

- Postpartum Family Planning for Healthy Pregnancy Outcomes: A training manual for providers on community-based PP services, which includes counseling on HTSP and appropriate PPFP methods.
- Healthy Images of Manhood (HIM) Facilitators' Training Manual to Improve Men's Role in Health Programs for UTT, updated to include modules on HTSP/FP.
- Training Curriculum for Mobilizing and Building the Capacity of Muslim Leaders as Champions of RH and FP, updated to include community development and leadership.
- HTSP Trainers' Reference Guide, toolkit, and training materials for multi-tiered, multisectoral integration of HTSP.
- Youth-friendly PAC guidelines, including counseling cue cards developed for Kenya.
- RH/FP Training Manual for Refugee Community Health Workers (adapted from existing materials to include HTSP).

More information on activities and documents developed for information-sharing is provided in Appendices J–N.

Examples of materials and their originators identified by ESD as P/BPs and used in activities include the following:

Corporate Social Responsibility Toolkit (CATALYST); Community Action Cycle (CAC) (Save the Children Fund); Balanced Counseling Guide (Population Council); Family Planning Checklists (Family Health International); World Health Organization (WHO) Providers' Family Planning Pocket Guide; Positive Deviation/Hearth (Save the Children); Performance Assessment Improvement (PAI) and Health Watch Framework (Management Sciences for Health); Refugee Health Materials (Reproductive Health Response in Conflict Consortium (RHRC)); Management and Organization Sustainability Tool (MOST) (Management Sciences for Health (MSH)); Business Planning for Health (MSH); Virtual Leadership Development Program (Fostering Change) (MSH); FP Compliance Training (Tiahrt and Mexico City Policy); Improved Collaborative Approach for Scaling Up Best Practices (University Research Corporation (URC)). A full list of P/BPs identified by ESD is provided in Appendix H.

There is evidence that the Bangkok best practices model for organizing and communicating P/BPs, information supporting the evidence base for HTSP, and documentation of ROI for corporations have been effectively communicated and are being adopted by others. Additionally, interviewees appreciated ESD having sponsored visits to BP meetings. However, when asked about their familiarity with ESD-developed briefs and materials, most interviewees were only familiar with those related to their own project or country and those related to HTSP. With the exception of the Tiarht poster, which was almost universally present, the assessment team observed an absence of job aids and other consultation materials for providers and/or clients in the ESD-supported service sites the team visited.

IR # 3 Support provided to the field to implement effective and sustainable RH/FP programs

ESD is praised uniformly by USAID Missions and partner staff as being responsive and addressing the Missions' identified needs. Missions funding ESD for long-term projects describe it as an organization that can rapidly respond to their needs for expanding availability and utilization of general MCH/RH/FP services ("one-stop shopping") for population groups such as very poor and isolated rural and peri-urban populations, those living in post-conflict or politically unstable regions, and refugee populations. Although most of these projects do not have an RH/FP focus (Burundi and Yemen focus on MCH; Kenya NEP on HIV/AIDS), ESD has taken advantage of opportunities within these other projects to introduce, integrate, and/or expand RH/FP services, mostly using core funds and focusing on PRH technical priorities. ESD is involved in a variety of activities ranging from supporting broad-based health services for large population groups, to providing STTA to on-the-ground partners for small-scale pilot FP interventions. Documented activities include many training sessions for health workers, community workers, and community members (e.g., religious leaders, peer health educators, female circumcisers), as well as strengthening FP services
and providers.

ESD has also responded to specific requests by USAID Missions and regional offices, using long and short-term technical assistance to improve RH/FP policies and guidelines; address changing social norms for RH/FP such as working with men (Kenya refugee populations, Tanzania) and religious leaders (Bangladesh, Kenya NEP, Nigeria, Pakistan, Yemen); and encourage local organizations to introduce MNCH/RH/FP P/BPs in nine countries with ANE bureau field support funds and WHO funding (Jordan). The overall quality of ESD's work and personnel has been consistently rated as high.

ESD MANAGEMENT AND RELATIONS

The assessment team interviewed 48 persons identified by USAID and/or ESD as relevant to this assessment. These included PRH/SDI personnel, and headquarters staff from other cooperating agencies and NGOs. Information received from these key informants revealed a substantial lack of agreement and/or awareness about what ESD's country-level work consists of and its global relevance. In contrast, most interviewees were aware of the HTSP strategy and the Bangkok Best Practice Program Exchange (BPPE) strategy. Many indicated that they thought these strategies seemed promising but expressed a

desire for evidence that such strategies were in fact effective. This suggests a need for improved communication within the RH/FP USAID family and more rigorous ongoing documentation of models and results (this will be discussed in more detail in following sections).

Notwithstanding the above observations, ESD is considered a project that communicates well both at Washington and field levels and that is very responsive to USAID and country needs. The high quality of ESD field staff was noted during field visits by the assessment team. However, as with all Consortium projects, there is scope for improving internal information-sharing and decision-making.

The role that USAID funding regulations play in determining what activities a global project can implement or support was identified, at all management levels, as a hindrance to achieving global leadership for globally mandated topics. USAID Missions typically set the agenda, with the global project obliged to advocate for buy-in for its mandated activities within the context of other Mission priorities. To its credit, ESD has successfully incorporated FP into field support-funded activities even where projects did not include FP in their scope of work.

OVERALL CONCLUSIONS

Progress to Date and Adherence to Technical Proposal

ESD has proved adept at identifying P/BPs and disseminating knowledge. The project has also demonstrated skill in moving activities forward even in difficult country situations. USAID Missions, MOHs, and partner organizations appreciate the quality of local staff and the responsiveness of ESD/Washington staff in supporting field activities. The assessment team found evidence that ESD has been effective and flexible in using limited funding to promote FP integration and move country-level RH/FP efforts forward. ESD has also made substantial strides toward reaching the most underserved population groups (working with nomadic communities, post-conflict and isolated populations, and working with religious leaders to address very conservative Muslims). During the last year of the project it will be important for ESD to consolidate these achievements and produce evidence that ESD has reached the high-risk populations that are project focus areas, and that ESD has developed models for improving service access and use by these groups.

Global leadership

At the global information level, ESD has addressed all of the PRH technical priorities by participating in technical committees and providing input to technical documents, making presentations at national and international meetings to increase information-sharing about P/BPs, and promoting strategies for addressing barriers to HTSP through working with men, corporations, and religious leaders. ESD is noted as a global leader in making HTSP a globally promoted message and in using programmatic exchanges to disseminate and actively support initiation and scale-up of P/BPs by local implementers in countries.

Knowledge Generation

ESD has been innovative in knowledge generation and communication. The project has actively promoted dissemination of P/BPs through documents, the Internet, e-learning, and sponsoring programmatic exchanges and study tours for national staff. Several CD-ROM–based training sessions have been developed to bring learning closer to the field.

Support to the Field

ESD is universally praised for being responsive to field needs and is particularly good at sharing information. The project has partnered with other organizations where the work is synergistic (in particular ACCESS-FP), and also reports synergistic working relations with Family Health International (FHI)/Contraceptive and Reproductive Health Technologies and Research Utilization (CRTU), Implementing Best Practices (IBP)/WHO, MSH/LMS, and URC. These partnerships have resulted in the sharing of expertise as well as cost, and have allowed ESD to move its FP global agenda forward to a

degree that would not otherwise have been possible. ESD has used small core-fund grants at the country level to promote introduction/and scale-up of P/BPs, foster information sharing (including study tours), and assist local organizations in testing and implementing the desired programmatic aspects that support P/BPs (e.g., networks of community workers).

ESD'S Added Value as a Global Project

In conclusion, the assessment team believes that while gaps exist in fulfilling the original technical proposal and project mandate, ESD has made substantial contributions in a relatively short time to certain areas of global leadership and to knowledge generation and communication.

Using its mandate to focus on FP, ESD has brought important added value to achieving PRH global IRs. The assessment team saw numerous examples of stagnated programs/activities that were moved forward by force of will when ESD arrived in-country. Often the stagnation had resulted from too many people having too many activities, along with the perception that FP "was taken care of"; thus, FP lost priority status.

ESD's HTSP strategy may be globally effective in overcoming social norm barriers to family planning. The strategy is being credited with revitalizing FP in countries that had stalled prematurely in providing FP services and reducing unmet need.

ESD investment of limited funds in identifying opportunities to promote FP integration and moving country-level efforts forward has contributed to global lessons learned. In addition, ESD has shown competence in leveraging funds and TA for advancing its and USAID's mandate.

RECOMMENDATIONS

1. **Strengthen data and analysis methodologies that provide** evidence-based demonstrations of the effectiveness of models in accomplishing clearly defined goals. Examples of the types of data to demonstrate that an indicated objective has been achieved are as follows:

   - Overall improvement in FP use: Longitudinal data showing an increase in new clients and increased visits by continuing clients, and clarity on whether data reflect visits or individual clients, are needed.

   - Increased FP/HTSP education to clients or increased knowledge of target populations: Information on number of persons trained, evidence that health service providers are sharing information, and change in target groups (e.g., PAC or PP women, HIV/AIDS clients, youth, caretakers of children receiving child health services) is needed;

   - There are examples of pre and post-training data for the HIM model and religious leaders' knowledge and attitudes. In addition to pre and post-training knowledge, however, it is important to document knowledge retention for the model.

     - Improved HTSP or FP by high-risk or target populations revealed by data showing FP or HTSP practice by these target populations (e.g., delayed child marriages, FP use by PAC or PP women, HIV/AIDS clients, youth, women counseled at child health services).

2. Document models

- Document where community volunteer models have built on lessons learned: Community volunteers are components of most ESD-supported MNCH projects. Problems in basing a system on community volunteers have been well-documented (e.g., drop-out, need for retraining, weak counseling, community supplies of contraceptives, weaknesses in actually receiving services

through referral, and unreasonable numbers of tasks being added to expected volunteer work)[3] as well as the benefits of introducing DMPA (an injectable, long-acting contraceptive) at the community level to improve FP uptake.

- The team did not have time to assess how ESD is incorporating lessons learned from others' experiences into ESD's community volunteer models; however, the field visit to Guinea showed that some known problems are relevant to the volunteers there. This is discussed more in the body of the report.

3. **Reach sub-groups within poor and hard-to-reach populations:** This relates primarily to projects targeting the general population within a traditionally underserved region.

   - ESD appears effective in providing RH/FP services to general population groups traditionally identified as poor, hard-to-reach, and underserved; however, among these groups there are always sub-groups who are more underserved (for socioeconomic, geographical, religious, age-related, or cultural reasons). The assessment team had understood that, in addition to serving large underserved population groups, the most underserved sub-groups among these fit within the ESD mandate;

     - ESD provided some evidence of having addressed this issue in Burundi (two districts with child immunization rates lower than other districts were targeted for immunization), Nepal (providing PP education and services to the poorest women urban slum dwellers), and Yemen (mobile services are being used for mountain rural populations).

4. **Plan for sustainability[4] of health services where ESD is the main implementing partner with the government:** Although sustainability is not a main objective of the ESD project, a responsibility to the affected population arises when a project initiates services. Since global projects are, by their nature, of limited duration, ESD needs to focus on engaging partners from the very beginning for promoting continuity and/or sustainability.

   - Much experience has made it clear that long-term partners need to sustain government services developed with external support. This may not be an issue for AA projects, but may be one for other FS activities (e.g., Guinea, and potentially in Angola).

   - Some ESD-supported activities are more likely to maintain gains after ESD TA for the pilot ends: UTT (Tanzania) (where there is increased buy-in by Unilever and interest in supporting HIM at other sites in Tanzania by the Champion Project (EngenderHealth bilateral), as well as programs in which ESD is testing a specific model within activities implemented by local partners (PPFP in Egypt and Nepal).

5. **Evaluate knowledge-sharing materials:** Confirmation of the availability and utility of P/BP briefs, virtual learning tools, and training materials to USAID Missions, field offices, service sites, and CAs/NGOs is required to inform distribution strategies and future production.

[3] Burket, Mary K. (MA Technical Communications Associate). *Improving Reproductive Health Through Community-Based Services: 25 Years of Pathfinder International Experience.* October 2006.

[4] This report is focusing on sustainable activities and quality, assuming that financial support will continue to be needed.

I. INTRODUCTION

PURPOSE

This participatory assessment aims to provide the U.S. Agency for International Development's (USAID) Bureau for Global Health (GH)/Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI) with the following information for the Extending Service Delivery (ESD) Project:

- Progress in achieving planned results and lessons learned to date
- Recommendations for maximizing next year's results and lessons learned
- Recommendations for ESD activities that may warrant continued investment
- Recommendations for other Reproductive Health (RH)/Family Planning (FP) activities not covered by ESD

ESD is a five-year, centrally funded Leader with Associate (LWA) Cooperative Agreement that began on October 1, 2005, and will end on September 30, 2010. This assessment covers information through June 2009.

BACKGROUND

Pathfinder International is the prime contractor for the ESD project. Consortium partner organizations,[5] and the experience and skills they bring to the consortium, include the following:

- Pathfinder: Prime for CATALYST (predecessor) project, FP service delivery, community mobilization, project and grants management, youth RH, integration of RH/FP with HIV/AIDS, and monitoring and evaluation (M&E).
- Management Sciences for Health (MSH): Prime for Advance Africa (predecessor) project, management systems, contraceptive logistics and security, repositioning and mainstreaming RH/FP, clinical and community-based distribution (CBD), quality assurance (QA), health system strengthening, and health management information systems (HMIS).
- IntraHealth: Gender, best practices, and provider performance improvement.
- Meridian: Consortium partner for CATALYST project, public-private partnerships, corporate social responsibility (CSR), and behavior change communication (BCC).

Among short-term partners, Georgetown University's Institute for Reproductive Health (GU/IRH) brings expertise in the lactational amenorrhea (LAM) and standard days (SDM) FP methods; Save the Children (SC) developed the partnership-defined quality (PDQ) and community action cycle (CAC) strategies; and Adventist Development and Relief Agency (ADRA) has experience in community mobilization through faith-based organizations (FBOs).

[5] International Centre for Migration and Health (ICMH), an initial partner, brought expertise on refugees/internally displaced persons (IDPs) to the project, but left after the first year.

Project Mandate and Technical Proposal Strategies

The project mandate is to reach underserved and at-risk groups, defined as the marginalized poor in rural or urban areas, youth, refugees/internally displaced persons (IDPs), postpartum (PP) women, post-abortion care (PAC) clients, and people living with HIV/AIDS (PLWHA), and to accomplish the following:

- Develop and test models that reach the focus groups and that improve integration of FP with MNCH and HIV/AIDS services.
- Develop models that contribute to the USAID PRH global leadership priorities (GLPs)— youth, gender, and Maximizing Access and Quality/Implementing Best Practices (MAQ/IBP) —and technical priorities, which include community-based FP, healthy timing and spacing of pregnancy (HTSP), and long-acting and permanent methods (LAPM).
- Identify and disseminate state-of-the-art (SOTA) best practices (BPs).
- Apply multi-tiered, multisectoral approaches, include non-health sectors, and promote gender-based activities.[6]

ESD defined its overarching strategy as placing FP at the forefront of good health and socioeconomic development by mainstreaming evidence-based practices and using SOTA approaches. The project's proposed methodology included strengthening and linking FP services and methods in facilities and the community, developing two-way referrals, and providing RH/FP services in workplaces.

Changes in the ESD mandate from Request for Applications (RFA) to present

During the first year of implementation the following changes in project priorities and expectations took place:

- Lower than expected core funds required major reductions in staff, and resulted in fewer opportunities for staff travel to identify potential areas of collaboration with USAID Missions, and more long-distance technical assistance (TA) for field-based programs.
- In 2006 ESD invested heavily in developing concept papers and providing short-term technical assistance (STTA) toward future country activities in Haiti, Mali, and South Sudan (target populations for the ESD mandate). Activities in these countries were ultimately dropped due to midstream changes in USAID Missions' scope of work and/or strategic approaches.
- After substantial investment in meetings, documents, and country visits to identify activities and seek field support (FS) funds for Repositioning Family Planning activities included in the technical proposal, "directional shifts"[7] in USAID GLPs resulted in removing Repositioning Family Planning from the ESD mandate.
- In 2007 ESD was also asked by USAID to remove contraceptive security from its workplan.
- In view of the GLPs and overlapping mandates among ESD and other USAID-funded activities (ACCESS-FP Project, the Flexible Fund (Flex Fund), and the RESPOND, CRTU, and PROGRESS projects), in 2007 ESD was advised to focus its work on HTSP, CSR, and

[6] A "multi-tiered approach" refers to working at different levels (e.g., community, health center, hospital, regional, central). "Multisectoral strategies" refers to addressing RH/FP through non-health sectors (e.g., education, agriculture, environmental, and social programs) as well as health sectors.

[7] May–October 2006 Management Review document.

integration of FP into other health and non-health settings—areas where the project was perceived as having a comparative advantage.

- The project's intermediate results (IRs) against which ESD is required to report, were changed from those in the original technical proposal to match those of PRH in order to align reporting to USAID/Washington.

The IRs against which the technical proposal and performance monitoring plan plan (PMP) were developed are: IR 1. Strengthened global learning and application of best practices and state-of-the-art program approaches for RH/FP services; IR 2. Increased access to community-level RH/FP services and contraceptive methods; IR 3. Increased capacity for supporting and sustaining RH/FP services. The PRH IRs against which the assessment team viewed project findings are: IR1. Global leadership demonstrated in RH/FP policy, advocacy, and services; IR2. Knowledge generated, organized, and disseminated in response to program needs; IR3. Support provided to the field to implement effective and sustainable RH/FP programs.

Changing the IRs that ESD reports on so that they are in line with PRH removes the focus from FP use and scale-up (actual numbers of clients or services provided) as an outcome. This should reinforce the global aspect of the ESD project, in that its mission is not to expand services, but rather to develop tools and models to be used by in-country programs to improve service delivery and reach underserved and hard-to-reach populations. The indicators in the PMP (developed for the original IRs) are measures of scale-up, so the assessment team used these primarily as guides to general areas to be reviewed for "evidence that strategies are effective," since they reflect measurable items that should improve if a model is effective.

From the second year, ESD management's priorities were the identification, documentation, and dissemination of promising and best practices (P/BPs), rolling out HTSP, integrating RH/FP into other programs, working at the community level by building capacity in local service delivery, and actively promoting NGO-corporate partnerships to support these priorities.

Appendix A provides information on funding for ESD field activities, and Appendix B shows a pipeline analysis provided by ESD. As of June 30, 2009, the project has $15 million in field support (FS) funds and $83 million in Associate Awards (AAs) (with additional funds expected from Pakistan).

II. METHODOLOGY

This was a participatory assessment conducted by two external consultants from the Global Health Technical Assistance Project and three USAID staff. GH Tech provided administrative support. The terms of reference and the time line, with more detail on the methodology, are provided in Appendices C and D.

TEAM MEMBERS AND RESPONSIBILITIES

The assessment team consisted of Nancy Fronczak, Team Leader and external consultant; Emma Ottolenghi, external consultant; Jenny Truong, USAID (FP and youth reproductive health); Virginia Lamprecht, USAID (FP and M&E); and Chelsea Smart, USAID (ESD project management team).

INITIAL STEPS

- Team building and defining expectations (initial two days with external facilitator).
- Briefing by USAID (ESD project Contracting Officer's Technical Representative (COTR) (Maureen Norton) and Technical Advisor (Rushna Ravji).
- Finalizing list of persons to be interviewed, provided by ESD and USAID.
- Developing data collection tools (templates are in Appendix E).
- Producing key informant discussion guides for USAID/Washington, ESD/Washington, ESD Consortium and non-Consortium partners, and USAID Missions.
- Developing country-specific questions for ESD Country Programs and USAID Mission interviews.
- Creating field visit checklists for service sites and program offices.

DATA COLLECTION

Background Document Review: A list of the documents reviewed is in Appendix F.

Interviews: In-person (or by phone if meetings were not possible) interviews were held with Washington and headquarters-based USAID and partner agency personnel (48 persons), phone interviews with USAID and ESD country-level persons (14 persons), and in-person interviews during field visits with USAID, ESD, and partner organizations (68 persons). Appendix G provides the list of persons interviewed.

Site visits: USAID management, in collaboration with ESD, selected Guinea, Kenya, and Tanzania as countries for site visits, based on security, logistics, length of implementation time, and funding source (AA, FS, or core). Burundi was initially selected but was dropped due to security concerns. Country program sites were selected by ESD. Where feasible, the assessment teams randomly selected the actual service sites that were visited. All program site visits were a full day's travel from the capital, allowing only one to two days for data collection outside the capital. The field teams were accompanied by ESD Project Director Milka Dinev (Guinea and Tanzania) and ESD Youth Advisor Cate Lane (Kenya).

ANALYSIS, DEBRIEFING, AND REPORT WRITING

Analysis: Following the country visits, the team met for several days to review data from documents, interviews, country visits, and other analyses, and develop key findings, conclusions, and recommendations.

Debriefings: Debriefings were held with the USAID Contracting Officer's Technical Representative (COTR) and Technical Advisor. After incorporating their feedback, a debriefing was held with ESD/Washington staff. After incorporating additional feedback, a debriefing was held with USAID staff that included mostly persons from GH/PRH/SDI, along with several senior USAID PRH staff.

Report writing: Each assessment team member was responsible for the first draft of one section of the final report, which was then reviewed and approved by all team members. The draft report was submitted to the ESD management team. Revisions were based on feedback on the content, provision of additional information, and clarification from USAID and ESD. A second review resulted in further input from USAID and ESD, including a full review of the document by ESD to correct factual items and provide relevant input. The final draft was submitted to GH Tech for editing.

III. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS RELATED TO PROGRESS IN ACHIEVING RESULTS

IR #1: GLOBAL LEADERSHIP DEMONSTRATED IN RH/FP POLICY, ADVOCACY, AND SERVICES

The assessment team found evidence of global leadership where (1) advocated practices were generally accepted as P/BPs for improving RH/FP; (2) relevant organizations/projects were responding to advocacy and implementing P/BPs; and (3) ESD was addressing identified gaps in knowledge by testing models for improving RH/FP services.

ESD defined a best practice (BP) as "A specific action or set of actions with proven evidence of success in multiple applications and the ability for replication or adaptation. Evidence of success is demonstrated through qualitative and quantitative information regarding the practice."

ESD defined a promising practice as "A specific action or set of actions that has the potential to become a best practice but requires further evidence of success." A "promising practice" has shown success but must be validated by replicating/adapting it to other contexts.

ESD defined practice(s) as "referring either to a single action such as implementing a technique or tool, or to a thematically interrelated set of activities, a 'package' of elements that form a cohesive set of actions that can be implemented to improve already existing programs that enhance RH/FP at community level, or a specific action or set of actions that may include program models, technical guidelines, and protocols."

Methodology for Identifying P/BPs from Existing Experience and Knowledge

ESD applies a systematic strategy for identifying P/BPs, which includes the following:

- Sending questionnaires to USAID Missions, nongovernmental organizations (NGOs), cooperating agencies (CAs), and other organizations relevant to RH/FP services.
- Participating as a member or presenter in technical working groups or special meetings related to the P/BP foci for ESD.
- Conducting literature reviews and formative research before implementing activities (see Appendix J).
- Developing concept papers and RFAs for activities to address specific population groups and/or RH/FP topics where further information or testing of P/BPs is needed. Some of these documents resulted in funded projects (working with urban PPFP services in Nepal) or manuscripts (many concept papers were developed through work with refugee populations).
- Collecting and analyzing evidence of effectiveness of strategies and of P/BPs.

Further detail on activities related to the methodology for selecting P/BPs will be discussed under IR 2; identified P/BPs are listed in Appendix H.

The assessment team feels that the process used for identifying P/BPs was reasonable given "real world" time, capacity, and financial constraints faced by ESD and partners. Identified P/BPs and gaps fully address the ESD mandate as indicated in the project description.

FINDINGS

Most of ESD's work and interventions build on lessons learned from other projects. ESD has documented situations where it has adapted existing P/BPs for different country situations. In addition to identifying existing P/BPs and gaps in knowledge, ESD has implemented strategies and models that may contribute to the state of the art (SOTA) in P/BP for RH/FP.

After reviewing ESD's many activities, the following models/practices have been identified as new P/BPs that may warrant replication and scale-up.

1. Global/regional/national best practice model for disseminating information and supporting introduction/scale-up of P/BPs in countries:

Description

The Bangkok 2007 BPs technical consultation, with the objective of promoting introduction and expansion of P/BPs in MNCH/RH/FP, is the model most cited as successful for rapid dissemination and scale-up of high-impact MNCH/FP best practices. Key factors identified by interviewees and the assessment team as contributing to the success of this model include the following:

- Organizers and participants served as a cross-section of stakeholders and included country government health officials, Mission staff, CAs, country and international NGOs, donors, and multinational organizations.[8]
- Internationally known technical experts led interactive technical sessions focusing on SOTA and evidence-based MCH/RH/FP BPs, conducted skills labs (e.g., insertion of IUDs using pelvic models), and trained participants in e-learning and the Fostering Change and Improvement Collaborative approaches for introducing/scaling up BPs.
- Country teams that included high-level decisionmakers were tasked with developing workplans for prioritizing and implementing P/BPs in their countries. TA was provided for work-plan development and subsequent proposals for funding.
- Small grants were provided to fund proposals accepted by a review panel for implementing workplans to introduce/scale-up P/BPs. Nine projects have now received financial support for initiating or scaling up P/BP activities.
- Follow-up TA was provided in person through country visits to train two grantees in the use of the improvement collaborative approach for quality improvement and scale-up of best practices by using the Virtual Leadership Development Program (Fostering Change), strengthening technical aspects, introducing change methods, and/or M&E.

An example of the level of collaboration at the Bangkok technical meeting and follow-up: In Jordan, the WHO provided seed grant funds, and ESD provided TA for follow-up activities. They collaborated to mobilize a USAID bilateral contractor to introduce PAC in Jordan and scale it up to six MOH hospitals the first year, with a plan to further scale up PAC to all 28 MOH hospitals over the next three years. The Jordan Mission also requested that ESD develop a proposal for organizational development TA to the Jordan Association for Family Planning and Protection to further this work, and has allocated $650,000 in AA funding to do so. Negotiations were ongoing at the time of the assessment.

[8] A total of 18 countries from the USAID-defined Asian Near East (ANE) region were represented. Participants included WHO, UNFPA, USAID country Mission and Washington personnel, CAs, donors, and local NGOs with country presence, in addition to Ministry of Health and other national decisionmakers.

Evidence that the Bangkok BPs Model may be a BP

- Very positive feedback resulted from interviews with organizers and participants.
- A cascade of similar types of workshops has been conducted or planned, using a modified Bangkok model (Mali and Senegal), as well as plans for multi-donor country-specific MNCH/RH/FP interventions (Bangladesh, Kenya, Pakistan, and Yemen) (see Appendix I).
- Thirteen country teams from the Bangkok technical meeting submitted proposals, and five received ESD core-funded awards (1st Tier) up to US$50,000 each (Egypt, India, Indonesia, Nepal, and Yemen). Four additional awards (2nd Tier) have recently been awarded through ESD (Bangladesh, Egypt, India, and Yemen).
- Start-up grant funds were leveraged from WHO for Jordan, and TA support from White Ribbon Alliance (WRA) was supplied for country-level implementation in five countries. Follow-on TA and support was provided by organizations that included URC, WHO, WRA, ACCESS-FP, and GH Tech Project. Total leveraged funding was $722,000.
- All award recipient teams have followed through with implementation of their workplans, some with modifications.
- Afghanistan, Indonesia, Nepal, and Yemen are now scaling up MNCH interventions that began after the Bangkok BPPE, and Egypt and Yemen are implementing the Improvement Collaborative Approach for Scaling-Up BPs.
- Nine countries now participate in the Virtual Fostering Change program (started April 2009).
- Preliminary data from several of the grant activities have been promising (to be discussed more in subsequent sections).

Observations and Recommendations

- ESD has been effective in introducing and scaling up P/BPs using the Bangkok BPs model.
- Very modest grants for country-level activities appear to be effective at providing incentives and resources for initiating new activities and program scale-up. These activities provide information the government can use to assess benefits and feasibility for scale-up.
- Inclusion of all levels of stakeholders, including country decisionmakers, broadens the base of support. Interviewees from CAs, NGOs, and USAID Missions described the collaborative and consultative process used by ESD for the Bangkok meeting and the Senegal BPs activity as instrumental to the project's success.
- Cost-effectiveness studies can provide information to quantify results and better inform model development for replication:
  - ESD is helping countries to collect information that should allow a robust analysis of the results of some of the Bangkok follow-on activities.
  - Evidence of follow-on activities where grants and TA were not components should be collected to provide further evidence for the model. Interviewed partners and USAID Missions were uncertain of what, if any, activities are taking place in these projects.
  - The long-term implications of introducing P/BPs using this model should be assessed.

2. Roll-out Strategy for Healthy Timing and Spacing of Pregnancy (HTSP)

Description

ESD showed global leadership in advocating for consensus on key messages for HTSP and in promoting HTSP as an intervention for reducing barriers and repositioning FP as an MCH issue. Methods used for advocacy will be described in more detail under IR 2.

The approach ESD developed as part of a roll-out strategy for mainstreaming the HTSP message was influenced by a CATALYST study in four countries showing that women and couples are not interested in optimal birth spacing intervals, but rather in the ideal time for mother and infant that is safest for another pregnancy after a birth, abortion, or miscarriage. The HTSP roll-out strategy includes the following:

- Forming an HTSP Champions' Network that includes a core group, as well as national and organizational champions.[9]
- Forming an Internet Community of Practice network.
- Holding regular Champions' meetings to share technical updates and activities.
- Addressing existing gaps in FP services and counseling, developing HTSP tools and materials for training and distribution, and facilitating country adaptation.
- Advocating integration of HTSP messages into FP, HIV, and MCH country policies, guidelines, and pre-service and in-service training, as well as RLs' sermons. The roll-out strategy identifies whom to address and how to move the HTSP agenda from policy to the community level.
- Addressing youth, men, policymakers, and public/private key players for advocacy.

Evidence the Model may be a BP

- The HTSP Champions' Network (181 members in 50 organizations and 29 countries) is disseminating HTSP research findings, information, and messages.
- The number of functioning country Champions' Networks shows that the road map is clear, readily understood, and can be used across cultures with providers, community leaders, and peer health educators.
- Twenty-one partner organizations (including most of the USAID-supported CAs and NGOs) have incorporated HTSP into their global and country-level programs, including integrating HTSP across MNCH and HIV services.
- ESD and partner organization efforts have resulted in the inclusion of HTSP in national policies and guidelines.
- It appears that religious leaders formerly antagonistic to FP accept the HTSP message (this will be discussed in the following section on changing social norms).
- The NGO World Vision is adopting HTSP into its programs for the "improved well-being of children" in multiple countries—the first time World Vision has included FP in its programs.
- Most interviewees remarked that "the information in HTSP is not new," but many noted that HTSP messages presented with supporting data/evidence and with a "name" and health focus

[9] ESD provides core funding support for starting some of the HTSP network secretariats.

appear to be much more accepted in locations where FP messages are not. Promotion of HTSP messages may be rejuvenating the FP discussion in countries where FP efforts had stagnated.

Observations and Recommendations

- Changing the focus from FP to HTSP may have resonated with various cultures and resulted in greater acceptance in some venues, and may have reenergized others where FP programs had stalled.
- HTSP messages, and SDM and LAM, appeal to RLs in conservative Muslim communities because these messages seem to harmonize better with Koranic texts.
- Effective HTSP will increase demand for services. Although ESD's mandate does not include ensuring the availability of quality FP services and commodity supply and distribution, the assessment team felt that any activity creating demand is obliged to ensure that supply gaps are identified and brought to the attention of those who can remedy them. The team did not see any evidence that gaps assessments are considered in settings where HTSP is promoted through the non-health sector.
- Perceptions differ among informants about what HTSP is. Some describe it as an intervention (USAID, ESD, and some documents), while others describe it as a series of evidence-based messages to promote FP to reduce unplanned pregnancy. Some respondents felt the new "jargon" (e.g., previously it was the "four too's"[10]) is confusing and unnecessary. Two individuals stated that "Everyone knows this," and "It's been a component of maternal health for years." This point arose often and spontaneously in interviews ("intervention or not" and "new or not"). Adapting the marketing strategy among senior-level international personnel in order to acknowledge that this is a repackaging of known information as a BCC strategy for policymakers, health professionals, and communities may reduce this as a point of contention.

3. Models for changing social norms

Description

ESD uses interventions that focus on religious leaders (RLs) (Bangladesh, Kenya NEP, Northern Nigeria, Pakistan, Yemen), men (Healthy Images of Manhood (HIM) in Kenyan refugee camps, Tanzania), male and female peer educators, and influential persons such as workers (Bangladesh and Tanzania), mothers' groups (Burundi and Nepal), students (Guinea), mothers-in-law (Northern Nigeria), and workplace managers (Bangladesh, Tanzania), with the aim of changing social norms. Such models include the following:

- Building on existing materials and strategies for working with RLs and males, and revising training materials to incorporate HTSP, information on FP methods, and community development and leadership, with content tailored to the audience.
- Training peer educators/leaders to increase communities' awareness of HTSP/RH/FP and gender, identify and counsel those at risk, and refer persons wanting RH/FP services to existing services.
- Some of the interventions have also been implemented concurrently with activities to improve the quality of existing FP services, often incorporating LAM, SDM, and HTSP into training for existing providers (Guinea, Kenya NEP, and Tanzania), and community-based distribution of methods (Guinea).

[10] Risky pregnancies occur when they are "too early, too late, too close, too many."

Evidence the Model(s) may be BPs

- The team heard anecdotal reports of increased referrals to RH/FP services for target populations and support for using those services. These reports will need substantiation, and the effectiveness of the referrals should be assessed.
  - Example: A couple came to one of the Garissa (Kenya NEP) Muslim RLs for advice. He had recently married a new wife, and his first wife told him she would not allow him in her bed until he was tested twice at three-month intervals and showed he was HIV negative; the sheik supported her position.
- There are some data on the use of FP services, but the data are preliminary at this time. Information on uptake of FP services with these models is discussed in Section 5.
- There is evidence (e.g., a number of sermons that include messages, post-training attitude surveys) that religious leaders (Bangladesh, Egypt, Kenya, Nigeria, Yemen) support HTSP, promote its messages, refer couples to LAM and SDM providers, and discourage harmful practices such as child marriage and female genital cutting (FGC) where practiced.
- Post-training survey responses show that peer educators trained in HIM report changing their attitudes toward abuse of women and the male role in RH/FP and family health care (Kenya refugee populations, Tanzania).
- UTT (Tanzania) has supplied data showing that referrals are consistently being reported for RH/FP/HIV/AIDS services.

Observations and Recommendations

- Changes in social norms and attitudes remain difficult to assess in the short term, but evidence of changes in RH/FP practices associated with new interventions (e.g., training RLs) will demonstrate the cost-effectiveness and added value of investing in the training and supervision of non-traditional health educators (RL) and HIM/PEs.
  - Where models combine influencing social norms with increased availability of reliable FP services (Kenya NEP, Kenya refugee camps), it would be useful to try to demonstrate that improvements are not solely due to improved availability of FP services.
  - Pre-intervention baseline information on unmet demand, attitudes, and service availability would be useful for interpreting changes.
- When documenting the models, ESD should describe how the intervention has maintained the quality and quantity of HTSP/FP messages made by RLs and PEs;
  - Example: The Champion Project (EngenderHealth bilateral in Tanzania) plans to work with ESD and UTT and PE for scale-up and capacity building during ESD's last year. This should provide the longer term technical support for training needed to maintain quality counseling on FP and use of HIV/AIDS services.
- ESD plans to expand the RL strategy to Christians as well as to lay RLs.

4. Models for leveraging corporate/business private-sector support for RH/FP

Description

ESD leverages the corporate/business private sector by promoting corporate social responsibility (CSR) and corporate partnerships. ESD describes CSR not as a private-sector intervention, but rather as a cross-cutting activity that expands the mechanisms (and resources) for a project to do its work.

- Based on the work of CATALYST and others, ESD is producing and disseminating evidence that investment in RH/FP for employees leads to economic benefits for private businesses and corporations. ESD's Return on Investment (ROI) study from RH/FP interventions in a Bangladesh garment factory is widely cited as one of the few studies from the developing world that quantifies the economic benefits of investing in employee health.[11]

- ESD is leveraging corporate/business private-sector support, which could form the basis of a model that benefits the corporation while achieving better worker health:

  - ESD leveraged the corporate structure of several pharmaceutical companies (Bayer Schering Pharma and Wyeth) to develop and produce behavior change communication (BCC)/information, education, and communication (IEC) materials, including a 16-page brochure for health providers and a four-page brochure for clients based on the HTSP 101 Brief. ESD contributed staff time, and Business for Social Responsibility (BSR) hired a design firm and disseminated 40,000 brochures through their corporate representatives in nine African countries.

  - Unilever Tea Tanzania (UTT)) Project: ESD provided TA for training existing UTT employee HIV/AIDS peer educators and nearby community PEs in HIM, HTSP, and referral to existing services, with the aim of improving male use of HIV/AIDS services and participation in RH/FP. ESD is also pilot-testing integration of HIV/AIDS services into existing FP services, and has helped link UTT and the MOH FP services for training providers and ensuring FP supplies. Training included Tanzania FP guidelines, which discuss HTSP, LAM, and SDM (introduced by ESD). ESD is working with UTT staff to encourage the MOH to move the UTT FP service sites closer to the community.

  - Bangladesh (Levi Strauss): ESD has supported a local NGO in providing FP services to factory workers and HTSP training to caretakers at the factory's child care center. Using case studies and the CSR Toolkit (BPs from the CATALYST Project), ESD has trained NGOs working at the community level to develop commercial partnerships in health care.

- ESD has formed alliances with NGOs concerned with private-sector worker rights,[12] business groups responsive to the CSR issue,[13] and public/private sector health-service providers.

- ESD has built M&E into the model implementation to provide evidence of ROI.

- ESD has linked corporate health initiatives with the MOH—providing training and referrals, and linking corporate health services with government RH/FP and HIV/AIDS programs when feasible.

- ESD has made presentations on CSR, ROI, and HTSP to business groups to promote investment in employee health, health education materials, provider job aids, and to encourage CSR businesses working at the network level to influence individual members.

[11] *Effects of a Workplace Health Program on Absenteeism, Turnover, and Worker Attitudes in a Bangladesh Garment Factory*, April 2007.

[12] Such as Health Solutions International in Bangladesh, and Verité, an organization that monitors workplace compliance with international codes of conduct.

[13] Groups such as Business for Social Responsibility (BSR), a business association with more than 200 corporate members, and Calvert (the leading socially responsible investment firm in the United States).

Evidence that the Model Strategies may be BPs

- The David and Lucile Packard Foundation; the Global Business Coalition (GBC) on HIV/AIDS, Tuberculosis, and Malaria; Vérité;[14] and the Calvert Group have become partners with ESD in supporting workplace RH/FP and other health initiatives.
- The ESD ROI study resulted in leveraged funding from the Lucile and David Packard Foundation[15] for the BSR's Health Enables Returns (HER) Project, which promotes women's workplace health through application of the study's findings. ESD is studying ROI for BSR in factories in Bangladesh, Egypt, and Pakistan (where the HER project has expanded into three factories).
- The Calvert Group is revising the Calvert Women's Principles[16] to establish demonstration projects and provide companies with guidance and BPs in putting the principles into effect.
- ESD and GBC co-sponsored a symposium on NGOs and corporate public-sector partnerships in Tanzania.
  - The UTT project is a result of this symposium; UTT is very supportive of the HIM intervention and is considering expanding the project to Unilever sites in Kenya.
  - Recent information indicates that UTT has assumed all costs associated with training of peer educators, indicating greater ownership by the corporation and potential sustainability of the strategy.
- There are increasing requests for participation from BSR members.
- ESD has leveraged more than half a million dollars in in-kind and direct support from corporations for RH/FP and women's health activities.

Observations and Recommendations

- Increased advocacy to USAID Missions to promote corporate/NGO partnerships to expand RH/FP and HTSP might improve uptake for CSR activities. The assessment team thought a roll-out strategy similar to the one developed for HTSP might be useful.
- Evidence of the benefits to corporations that provide services to surrounding communities should be sought where relevant (e.g., similar to "fair trade" strategies).
  - Example: During the field visit, UTT management expressed concern that the UTT program may be at risk because of the cost of providing HIV/AIDS services for communities where their staff live. ESD plans to address this.

[14] Vérité, a leading NGO that pioneered the use of social audits to improve working conditions worldwide, has been helping the Calvert Group to operationalize its Women's Principles.

[15] At the instigation of local NGOs and ESD, Levi Strauss garment factories in Bangladesh and Pakistan have partnered with NGOs that provide RH/FP services (paid for by Levi Strauss) and have participated in the ROI studies. Roughly $18,500 in grant money was leveraged from the Levi Strauss Foundation to support Aga Khan University's and ESD's participation in the HER project in Pakistan.

[16] The Calvert Women's Principles were launched in partnership with UNIFEM to provide companies with a global code of corporate conduct focused exclusively on empowering, advancing, and investing in women worldwide.

5. Testing models to reach underserved and hard-to-reach populations

Working within the constraints created by funding sources, ESD has successfully identified opportunities to implement activities with the potential to become P/BP models. Models being implemented with ESD support include the following:

1. Integration of FP with MNCH/RH services in underserved/post-conflict regions (Angola, Burundi, Guinea, Kenya NEP, Yemen (Guatemala is under discussion)):
   - National-level revision of guidelines to include HTSP, LAM, SDM, and the importance of integrating FP messages into other relevant services (child health, PAC, PP care, HIV/AIDS, services for youth).
   - Strengthening the quality of government FP and community-based services (supervision, training for counseling in HTSP and, in some cases, technical training and supply security).
   - Training MCH/RH service providers and community workers who work with high-risk and target groups to counsel and refer to FP services.
   - Using different P/BPs for facility and community-level activities and interventions, based on the implementing environment.
2. Integrating FP services within HIV/AIDS services (Kenya NEP and Tanzania UTT):
   - Training providers to make some FP methods available at HIV/AIDS service sites, with referrals to other sites for LAPM.
   - Using peer health educators and HIM to reduce gender barriers to the use of RH/FP services.
3. Integrating FP with community PP care (Egypt, Nepal, Nigeria (new—Bangladesh and India)):
   - Training community workers providing PP care to counsel on HTSP and refer for PPFP (in Nepal this strategy is implemented through mothers' groups).
4. Integrating FP with PAC by partnering or supporting PAC service providers:
   - Advocating for FP information and services for PAC clients to be integrated into general FP and PAC guidelines and training.
   - Partnering with ACCESS-FP for training and activities related to PAC in some countries.
   - In some projects ESD is strengthening general FP services and financially supporting the ACCESS-FP supervision and training related to FP and PAC.
   - Providing TA post-Bangkok BPPE for PAC FP (Jordan).
5. Multisectoral integration of HTSP using different models:
   - Reducing cultural and gender barriers with strategies varying by country: Training RLs (Bangladesh, Kenya NEP, Northern Nigeria, Yemen), using the HIM model with PEs (Tanzania UTT and previously in Kenya refugee setting), training non-health personnel (community volunteers, peer educators, RLs, men, mothers-in-law, women's groups) in HTSP.
   - Funding P/BPs follow-on activities from the Bangkok BPPE that focus on MNCH or RH/FP and that include adding HTSP (and LAM in Nepal) to the services being supported (Bangladesh, Egypt, India, Indonesia, Nepal, Pakistan, Yemen) (see Appendix Q for details).

6. Integrating RH/FP into factory/plantation health services (CSR):
   - Supporting corporate health services to strengthen RH/FP (Bangladesh, Tanzania).
   - Training peer health educators to educate and refer for FP (Bangladesh, Tanzania).
   - Documenting ROI and Health Enables Returns (HER) in ESD-supported RH/FP services (Bangladesh, Egypt, Pakistan, Tanzania UTT).
7. FP with a youth focus using different models:
   - Training youth peer educators (Guinea).
   - Training RLs in HTSP and discouraging child/youth marriages (Northern Nigeria and Yemen).
   - Focusing on young married women for PPFP (Nepal, Northern Nigeria, Yemen).
8. Expanding availability of FP through private providers among professional organizations:
   - Providing organizational development for midwives' associations; training and supporting private-sector midwives to provide FP services (Yemen).
9. Expanding access to long-acting FP methods:
   - Providing STTA to the Ethiopia Pathfinder bilateral project activities using a model whereby community workers promote FP, counsel, provide short-term methods, and bring clients to a clinic where trained government service providers come periodically to provide long-acting methods.

The countries provided as examples may not be all-inclusive. More detailed information on each program is provided in Appendix O.

Evidence the Model Strategies may be BPs

FP services and contraceptive supplies have become more widely available and reliable in some programs (Guinea, Kenya NEP), and there is evidence of increased FP uptake where ESD has supported FP activities and/or targeted risk groups for HTSP/FP education and referral. For example:

- Guinea: Contraceptive use rose from a baseline of 2% in August 2007 to 9% (December 2008) in the previously severely underserved forest region, and rose from 13% (March 2007) to 22% (December 2008) in Upper Guinea.
- Nepal: Among the target population of PP women (n=391), 60% were using LAM at one month postpartum. At six months PP, 79% (n=316) were using an FP method; at 12 months PP, 84% (n=257) were using an FP method; and at 18 months PP, 80% (n=154) were still using an FP method.
- Twelve private-sector Yemeni midwives newly trained and supported by ESD to provide FP services reported that they provided modern FP methods during 641 visits during the first half of 2009, including making 72 IUD insertions. ESD reports most of these were PP women.

Other data provided by ESD require more context and trends to interpret, but do provide evidence of ongoing use of FP services:

- FP services at UTT (Tanzania) facilities show steady numbers of FP clients, with evidence of gradual increase (the average number of new FP clients was 11 per month in January–June 2007, as compared to an average of 16 per month in January–June 2009. In January–June 2009 there

were 16 insertions and three sterilizations. Due to the very high prevalence of HIV, ESD strongly supported use of condoms through 25 trained PHEs, who in 17 months have distributed 122,492 male and 5,321 female condoms.

- FP services integrated within HIV services in UTT, which previously did not offer FP, show uptakes in FP by HIV clients (17 new FP clients and 70 repeat visits in January–June 2009).
- In Dadaab, Kenya refugee camps, average FP clinic visits increased from 151 per month (January–March 2007) to 341 per month (April–August 2007), which was attributed by NGO service providers to the work of ESD-trained community FP educators. ESD also trained peer educators in HIM and GBV over the same time period; however, further follow-up was not possible in these sites.
- SDM is being tested in one Kenya NEP District where HTSP is being introduced through religious leaders. The assessment team was told that SDM is being accepted in this conservative area where most acceptors are new to FP use (Kenya NEP).
- In Guinea ESD has partnered with Jhpiego for PAC FP by increasing contraceptive availability, training staff, and supervision related to PAC and FP. ESD is collecting data on FP uptake among PAC clients; however, data available to date do not demonstrate a difference in uptake since the partnership began.[17]

Data for Other Services

- UTT data show increased use of HIV/AIDS services by males in UTT (with a dramatic increase in the number of UTT employees and their families who received HIV testing in June 2009); peer health educators distributed 81,603 male condoms over an 11-month period. Data to document increased use of condoms by HIV/AIDS clients will strengthen the evidence that this is an effective intervention.

Observations and Recommendations

- **Strengthen data and analysis methodologies** that provide for evidence-based demonstrations of the effectiveness of models in accomplishing clearly defined goals. Examples of the types of data to demonstrate that an indicated objective has been achieved are as follows:
  - Overall improvement in FP use: Longitudinal data showing an increase in new clients and increased visits by continuing clients, and clarity on whether data reflect visits or individual clients, are needed.
  - Increased FP/HTSP education to clients or increased knowledge by target populations: Information on number of persons trained, evidence that health service providers are sharing information, and change in target groups (e.g., PAC or PP women, HIV/AIDS clients, youth, caretakers of children receiving child health services) are needed.
  - There are examples of pre and post-training data for the HIM model and religious leaders' knowledge and attitudes. In addition to pre and post-training knowledge, however, it is important for the model to document knowledge retention.

[17] Data from Jhpiego, Guinea prior to collaboration with ESD showed that 86% of women receiving PAC services also accepted an FP method. Comparison of Jhpiego March 2007 reports with ESD December 2008 data shows an increase in the proportion of PAC women receiving FP counseling (from 94% to 100%), but a decrease in the proportion of PAC women using contraceptives (86% to 72%).

- **Improved HTSP or FP by high-risk or target populations** revealed by data showing FP or HTSP practice by these target populations (e.g., delayed child marriages, FP use by PAC or PP women, HIV/AIDS clients, youth, women counseled at child health services).
  - Some data are available (Nepal PPFP, reports of child marriages averted (Ethiopia)).
    - Document models
  - Document model components: Evidence of effectiveness, as well as inputs and activities of other organizations that might have contributed to results; what needs to be incorporated in replications to maintain the level and quality of results; and lessons learned by ESD.
    - For example, where FP services are incorporated within HIV/AIDS services, linkages with FP training and supplies will be critical.
  - Document where community volunteer models have built on lessons learned: Community volunteers serve as components of most of the MNCH projects ESD supports. Problems in basing a system on community volunteers have been well documented (e.g., drop-out, need for retraining, weak counseling, community supplies of contraceptives, weaknesses in actually receiving services through referral, and unreasonable numbers of tasks being added to expected volunteer work),[18] as well as the benefits of introducing DMPA (an injectable, long-acting contraceptive) at the community level to improve FP uptake.
  - The team had insufficient time to assess how ESD is incorporating lessons learned from others' experiences into its community volunteer models; however, the field visit to Guinea revealed that some known problems are relevant to the volunteers there. Observations from Guinea include the following:
    - ESD is using a network model and linkage to health centers to address continuity and quality for community-based RH/FP volunteers in Guinea. This model has been used in other countries, so how ESD has incorporated lessons learned on community networks for health into the model should be documented to add to global learning.
    - Several programs in Guinea are beginning to increase commodity distribution and activities, as per the expectations of the volunteers. Lessons related to the time, training, and incentives necessary for volunteers to perform high-quality multiple tasks have been documented. ESD will contribute to global learning when the project documents how it has built on earlier lessons to avoid the same problems.
    - While demonstrating their health education methods, community workers in Guinea promoted condoms and pills (which the workers sell) but did not mention other methods, including LAPM, that can be provided through referral.
    - The PE presentations at Tanzania UTT focused on "Know your status" for HIV (the program priority) and promoting more responsible male behavior with women and children. After talking with the PEs, the assessment team concluded that the PEs' knowledge of FP methods and the messages on FP for HTSP and HIV/AIDS were weak, although there is some evidence the PEs are making referrals for FP. The main objective in working with the PEs was to promote uptake of HIV/AIDS services. Effectively adding HTSP/FP to the PEs' responsibilities may require additional strategies.

[18] Burket, Mary K. (MA Technical Communications Associate). Improving Reproductive Health Through Community-Based Services: 25 Years of Pathfinder International Experience. October 2006.

- **Demonstrate improved HTSP by high-risk or target populations** through documenting improved FP or HTSP practices (e.g., delayed marriage, increased inter-pregnancy intervals).
  - Nepal PPFP data provide such documentation.
  - Future UTT (Tanzania) data will be more convincing if longitudinal data show that HIV/AIDS clients are increasing their FP practices proportionally over their baseline contraception prior to integration.
  - Overall improvement in use of FP practices, longitudinal data showing an increase in new and continuing clients, and clarity on whether data reflect visits or individual clients are needed.
  - Increased FP/HTSP education to clients or increased knowledge by target populations, information on numbers trained, evidence that health service providers are sharing information, or improved knowledge in targeted groups (PAC or PP women, HIV/AIDS clients, youth, caretakers of children receiving child health services), are needed.
    - There are examples of pre and post-training data regarding HIM and RLs' knowledge and attitudes. The model should also document knowledge retention and its continued application.
- The availability of core funds that can be applied flexibly has allowed P/BPs to be introduced and scaled up in several countries where anecdotal evidence indicates they would not otherwise have been introduced (e.g., working on and documenting activities on HIV/FP with UTT in Tanzania and FP with the MCH project in Burundi).

6. Building the organizational capacity of professional associations

Description: Midwives as RH/FP providers

Building on the AMKENI (USAID/Kenya bilateral project) model cited by ESD as a P/BP that involves strengthening midwives' associations in order to improve the availability and quality of RH/FP services, ESD has initiated activities with the Yemeni Midwives Association (YMA), providing technical and management training, and fortifying YMA's organizational structure, as well as promoting the introduction of FP services by members within their private practices.

Evidence the Models may be BPs

- The Kenya Mission asked ESD to document the AMKENI model as a BP approach.
- ESD reports that the YMA revised its five-year strategic and operational plans, improved its financial management skills, learned to write funding proposals (two proposals were funded by non-USAID sources), and developed the basic business and technical skills to support members in establishing private practices in underserved areas.
- Twelve private-sector Yemeni midwives now provide FP services (preliminary data appear in Section 5 under evidence that the models may be P/BPs).

Observations and Recommendations

- P/BPs for organizational development should be identified, and the situational context documented when they are used. Indicators for organizational development are needed.
- The contextual situation, including linkages with technical support systems, education, and remuneration levels for midwives' associations and network members, should be documented to provide a better understanding of the model for replication.

- Issues specific to professional associations and networks' lack of cohesion or sustainability should be identified (e.g., the process and outcomes associated with the ANE network should be documented).

IR #2: KNOWLEDGE GENERATED, ORGANIZED, AND COMMUNICATED IN RESPONSE TO FIELD NEEDS

This IR is essential in linking IR 1 (global leadership) and IR 3 (support to the field). In this section the assessment team discusses materials identified or developed by ESD, their dissemination and use both globally and at country level, strategies used to organize communications, and methods to facilitate learning.

Findings

Knowledge generated

ESD has generated knowledge using the following methods:

- Conducting studies (using original data collection or literature review) and producing documents to inform discussions with partners and stakeholders to help identify P/BPs and develop program activities (Appendix H).
- Commissioning articles based on data analysis to present information supporting the project's recommendations for HTSP, and linking them to maternal-child health (Appendix K).
- Identifying opportunities for data collection (typically through local NGOs) to establish evidence related to P/BPs. Some activities are ongoing, others are completed. They include:
  - Collection of birth weights and birth-spacing data (Nepali Technical Assistance Group) in order to establish the relationship between them for HTSP documentation.
  - Collection of Return on Investment information (Bangladesh, Pakistan, Tanzania).
  - Using TAHSEEN household survey data to identify significant changes and update four TAHSEEN BP documents: *Integrated Community-based Postpartum Care; Postabortion Care; Birth Spacing;* and *Mobilizing Community Outreach Workers*.
  - Mail/e-mail survey of MotherNewBorNet members in order to identify P/BPs for PP care and FP services.
  - Documenting strategies identified as P/BPs for which documentation did not previously exist (Egypt TAHSEEN and Kenya AMKENI project).

Materials Development

Appendix L lists the training materials developed and the reference materials used in their development. Many of these generic materials were locally adapted prior to use.

Developing training materials: ESD has built on the experiences and materials of its core partners in developing new training materials, pre-testing them in ESD or collaborative partner programs, and revising their content based on programmatic input. ESD training materials include:

- A Training Curriculum for Mobilizing and Building the Capacity of Muslim Leaders as Champions of RH and FP, updated to include community development and leadership.
- Healthy Images of Manhood (HIM) Facilitators' Training Manual to Improve Men's Role in Health Programs for Unilever Tea Tanzania (UTT), updated to include modules on HTSP/FP.

- Postpartum Family Planning for Healthy Pregnancy Outcomes, a training manual for providers on community-based PP services, which includes counseling on HTSP and appropriate PPFP methods.
- HTSP Trainers' Reference Guide, Toolkit. and training materials for multi-tiered, multisectoral integration of HTSP.
  - The strategy for disseminating HTSP includes generic materials for all levels, from policy to community. Country-specific adaptations of the HTSP brief have been produced by ESD in multiple languages.
- Youth-friendly PAC guidelines, including counseling cue cards developed for Kenya.
- RH/FP Training Manual for Refugee Community Health Workers, adapted from existing materials to include HTSP.

Developing globally relevant IEC materials

IEC materials specific to country programs and needs have been developed, as well as the ESD/ Bayer Schering Pharma (BSP) HTSP globally relevant promotional and educational materials.

Knowledge organization and communication

At the global level ESD has applied the following methods:

- Organizing and/or participating in BPPEs (Appendix I)
- Sponsoring country-level participation in national and international-level BPPEs
- Funding South-to-South study tours for RLs and midwives
- Using core funds for small grants to local organizations to cover their costs in organizing and implementing meetings for advocacy and information exchange
- Developing briefs and a promising and best practices series that summarize various P/BPs and situations where they are most relevant
- Developing/participating in virtual knowledge materials and events
- Forming an HTSP Community of Practice.
- Testing CD-ROM-based learning
- Making presentations at international meetings (Appendix M)
- Making presentations to USAID/CA groups (Appendix N)
- Facilitating the update or development of national-level policy, guidelines, and training materials for RH/FP; focusing on counseling clients on FP as a component of ANC, MCH, PP, PAC, HIV/AIDS, and child health services; advocating for adding HTSP, lactational amenorrhea (LAM), and standard days method (SDM) contraceptive methods
- Developing and sharing generic job aids for counseling related to RH
- Reviewing literature, participating on technical committees, and attending meetings and discussions with other organizations in order to identify existing tools and strategies generally accepted by the international community as P/BPs.

Examples of materials and their originators identified by ESD as P/BPs and used in project activities include the following (a full list of P/BPs identified by ESD is provided in Appendix H):

- Corporate Social Responsibility Toolkit (CATALYST Project)
- Community Action Cycle (CAC) (SC)
- Balanced Counseling Guide (Population Council)
- Family Planning Checklists (Family Health International)
- WHO Providers' Family Planning Pocket Guide
- Positive Deviation/Hearth (SC)
- Performance Assessment Improvement (PAI) (Management Sciences for Health (MSH))
- Health Watch Framework (MSH)
- Reproductive Health Response in Conflict Consortium (RHRC) Refugee Health Materials
- Management and Organization Sustainability Tool (MOST) (MSH)
- Business Planning for Health (MSH)
- Virtual Leadership Development Program (Fostering Change) (MSH)
- FP Compliance Training (Tiahrt and Mexico City Policy)
- Improved Collaborative Approach for Scaling up Best Practices (University Research Corporation (URC)).

Observations and Recommendations

- There is evidence that the Bangkok BPPE model for organizing and communicating P/BPs, information supporting the evidence base for HTSP, and documentation of ROI have been effectively communicated.
- Sponsored visits to BPPEs and meetings were appreciated by interviewees.
- The fact that ESD has built on materials developed by other organizations (including many previous and ongoing USAID-supported projects), and has adapted them, serves as evidence that these are P/BPs.
- ESD has presented and discussed P/BPs in international forums through participation in technical committees, and has been active in organizing meetings and ensuring that ESD priority topics were included. ESD is a member of most technical groups that are relevant to the project's mandate.
  - ESD has made contacts with the Reproductive Health Response in Conflict (RHRC) Consortium and has used RHRC information. ESD should consider joining the consortium in order to obtain and contribute knowledge and experience.
- ESD needs to document results from information-sharing through BPPEs and e-learning.
- ESD needs to document implementation processes in order to provide key information relevant to models.

  - Example: A follow-up survey for MotherNewBorNet was intended to identify models for PP care and FP services, but ended up merely describing the status of community-based postpartum care and postpartum family-planning services implemented by MotherNewBorNet member organizations. Global learning requires that data be critically analyzed in order to explain why some PPFP programs were discontinued, which models were effective, and to explore the varying contexts in which they were implemented.

- Materials development for community/service-level use should be strengthened.
  - Counseling materials developed by ESD and labeled as "youth-friendly" should outline more clearly how the materials and their messages can be adapted to be more effective when used in settings (such as PAC or PP clinics) where FP services are limited (e.g., ensuring that referral aspects for receiving services are covered).
  - Some "youth-friendly" materials have not been sufficiently adapted to serve the differing implementation strategies that would result in improved use of services by youth.
  - Some of the ESD-developed materials for community workers were verbose and included graphics that were not self-explanatory (Guinea). These materials were not developed with P/BPs that targeted a low-literacy readership.
  - Good IEC materials are expensive to produce. Before developing new ones, ESD and other agencies should decide whether such materials are needed and make sure that, if produced, they are cost-effective, durable, and appropriate to their intended users.
- Despite efforts to coordinate with other CAs and NGOs where mandates overlap, duplication in materials continues to occur.
  - ESD should focus on developing materials at the community level because where there is overlapping mandate among the CAs (e.g., ACCESS-FP and PPFP, EngenderHealth and PAC/FP, FHI and HIV/FP), the CAs primarily supply input or identify needs and develop materials for facility-level FP and integration.
  - ESD should continue to coordinate with partner organizations and urge them to include FP/HTSP information into their facility-level materials.
  - Where overlap exists in the community, it is critical that key messages be harmonized in order to prevent confusion among users.
- BCC/IEC strategies for topics other than HTSP are less developed than those for HTSP.
  - A collaborative assessment to identify current BCC/IEC strategies that seem most promising should be conducted.
  - ESD should investigate conditions that influence USAID Missions and CAs in order to incorporate, or choose not to incorporate, FP components into ESD's ongoing programs. For example, a program aimed at decreasing maternal mortality or child health would not assume that FP would be an integral component of that program. Results can be used to modify existing materials or produce new ones, as well as document whether funding mechanisms are perversely resulting in sub-standard strategies.
- Case studies that illustrate lessons learned in specific settings would help augment P/BP strategies for program implementation.
- Evaluate knowledge-sharing materials and distribution methods:

- When asked about their familiarity with ESD-developed briefs and materials, most interviewees were familiar only with project-specific materials for their country and those related to HTSP.
- Few job aids, IEC materials developed for in-country use by service providers, and IEC materials for clinic attendees were found at service sites during field visits (with the exception of Tiarht posters everywhere and Balanced Counseling materials in Tanzania).
- Validation of the availability and utility of P/BP briefs, virtual learning tools, and training materials to USAID Missions, field offices, service sites, and CAs/NGOs is necessary to inform distribution strategies and future production.
- ESD should improve its strategies for distributing materials to their end-users at country level, should familiarize users with the materials' contents, and should train users to use the materials to improve service efficiency and quality. Experience has shown that providers and health educators are often uncomfortable using flip-charts and pictorial aids, which may be related to the didactic education they and/or their children received.

IR #3: SUPPORT PROVIDED TO THE FIELD TO IMPLEMENT EFFECTIVE AND SUSTAINABLE RH/FP PROGRAMS

Information on ESD models and activities has been provided in IR #1 and IR #2. Country-by-country details on projects and activities are available as follows:

- Appendices A and B provide information on funding sources, amounts, and pipeline.
- Appendix O supplies information on country project beneficiaries, descriptions, evaluation strategies and tools, major results to date, and partners.
- ESD created several tables that clarify its integration activities/plans (Appendix P), describe the current status of the Bangkok BPPE follow-up activities (Appendix Q), list community FP activities (Appendix R), and furnish information on P/BP activities post-Bangkok BPPE that are supported by ESD TA and/or for which funding is provided (Appendix S).

Observations and Recommendations

- ESD provides structured information and education to all partners in all countries on the Tiahrt guidelines for RH/FP activities.
- ESD has provided and supported a significant number of trainings and increasing numbers of clients are using MNCH/RH/FP/HIV/AIDS services.
- ESD appears effective in providing RH/FP services to general population groups traditionally identified as poor, hard-to-reach, and underserved; however, among these groups there remain underserved sub-groups (for socioeconomic, geographical, religious, age-related, or cultural reasons). The assessment team had understood that in addition to serving large population groups who have been underserved, the most underserved sub-groups would fit within the ESD mandate.
  - ESD has addressed this issue in Burundi (two districts with child immunization rates lower than other districts were targeted for immunization), Nepal (PP services for young, very poor slum-dwelling women), and Yemen (mobile services for mountain rural populations).
  - In India the CARE Community IMCI project (using a post-Bangkok 1st Tier grant) works with the Chhattisgarh State MOH to identify and target the poorest, most remote rural communities within the generally poor communities they serve.

- Disaggregating data to determine if underserved sub-groups exist among the generally underserved populations where ESD is supporting services would be useful.

- Many ESD models for integration and expanding access to FP are based on client education and referral for services, yet it was not evident to the assessment team that mechanisms exist to document whether referrals are effective or whether any methods are being used to facilitate client follow-up on referrals.
  - The problem with ineffective referrals is well known, which is likely why referrals were listed as a priority activity in the project proposal.
  - Where results depend on successful referrals, ESD should assess referral systems and test models.

- Research shows that making methods available to women at the PAC service site is acceptable and effective; this strategy is considered a priority in the USAID/PAC technical resource package. However, when the assessment team visited the very well-run hospital in Kenya NEP where ESD is instrumental, the impressive space dedicated to PAC lacked the methods available—the nurse in charge was not even aware that such methods are an integral component of PAC services.

- Although sustainability[19] is not a primary goal of the ESD project, a level of responsibility to targeted populations arises when ESD initiates services. Since global projects are, by their nature, of limited duration, the project needs to plan on engaging on-the-ground partners from the very beginning in order to promote continuity and sustainability.

- Experience shows that long-term partners need to sustain government services that were developed with external support. While this may not be an issue for AA projects, it may be one for other FS activities (in Guinea, and possibly upcoming in Angola).
  - In Tanzania, where there is increased buy-in by Unilever and increased interest from Champion Project (EngenderHealth bilateral) in supporting HIM at other sites in Tanzania, along with programs where ESD is testing a specific model within activities implemented by local partners (PPFP in Egypt and Nepal), gains from ESD-supported activities are more likely to be maintained after ESD TA for the pilot project ends.

- ESD links with other NGOs, CAs (IntraHealth, IRH, Meridian, MSH, Pathfinder, SC), and other global projects with overlapping mandates (ACCESS-FP, BASICS, FHI/CRTU) for complementary activities and TA examples include the following:
  - Burundi and Guinea have multiple groups working with community workers and civil society; Burundi also has NGO-supported water and sanitation projects.
  - In Guinea, German Technical Cooperation (GTZ) is implementing a quality certification system in facilities where ESD works.
  - In Tanzania health extension workers and communities are being supported (via training, commodities, and supervision) by FHI with home-care and HIV/AIDS services.
  - In Kenya APHIAII/NEP partners provide financial and technical support to further efforts to reach special populations (e.g., the Supreme Council of Muslim leaders, a community

[19] This report is focusing on sustainable activities and quality, assuming that financial support will continue to be needed.

organization of people affected by or infected with HIV (Mwangaza), orphanages linked to mosques).

- Missed opportunities to improve quality of and access to ESD-implemented programs were noted: Job aids should always be distributed to service delivery sites in the field when a program begins, and use of these aids must remain an integral part of provider training.
- Opportunities were missed to promote P/BPs among country multilaterals and bilaterals, particularly in countries where ESD lacks a presence but consortium partners are on the ground.
- Clients who attend HIV/AIDS services are also at risk for unplanned pregnancies; some notable missed opportunities to incorporate other services into HIV/AIDS-dedicated services include:
  - Countries with significant HIV prevalence, where HIV/AIDS services have not been integrated into projects that include RH/FP, MNCH, PPFP, HTSP (Burundi, Ethiopia, Nigeria, and Sudan). The World Bank, in its online documents, stresses the importance of integration: "Low prevalence does not imply low risk." Even in countries with strong HIV/AIDS components there was evidence of RH/FP missed opportunities; for example, in the Moonlight Services in Garissa Kenya where mostly young unmarried men are offered HIV voluntary counseling and testing, there were no IEC materials on sexually transmitted infections (STIs), FP, or information on where FP services are available.
  - Men are now considered key gatekeepers to women's health but do not appear in some of ESD's projects where including them makes sense, such as PPFP (Nepal), young married women (Nigeria), INMCH (India).
  - Youth Reproductive Health: Young people are a large proportion of the neediest populations and should explicitly be included in all programs where capacity-building is addressed. Because free-standing youth services may not be cost-effective, it is important to provide special counseling and other service elements (e.g., training providers in youth-specific counseling, dedicated IEC materials) specific to youth in these programs.
- USAID Mission representatives, ESD partners, and high-level government representatives at both the regional and provincial levels in visited countries expressed great appreciation for ESD's work in supporting the project's priority goals.

  "ESD has been a wonderful partner. APHIA2 success is due to ESD."
  —Kenya Provincial Head of Department of Public Health and Sanitation.
- In spite of security issues that impede both movement and the ability to provide direct TA in some countries (notably in Burundi, Guinea, Kenya, and Yemen), ESD has managed to move programs forward effectively, identifying strong local field staff and getting systems and infrastructure in place for project implementation.

IV FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS RELATED TO STRUCTURE AND MANAGEMENT

MANAGEMENT STRENGTHS/BEST PRACTICES

In its country visits the assessment team found evidence that ESD has hired competent and qualified local staff. ESD has delegated authority as staff become ready, and appears invested in building staff capacity as needed. One senior project staff member in an Associate Award felt that ESD/Washington placed a high degree of trust in his capabilities, and he noted that the local staff appreciate the support they receive from ESD/Washington in completing tasks for which they have limited capacity, such as documenting and disseminating descriptions of project activities to a public audience. Staff in countries such as Guinea had access to computerized country-level monitoring and evaluating systems and a well-qualified team in place to support its use.

STRUCTURAL OR MANAGEMENT CHALLENGES

Award timing: Several respondents told the team that because the ESD project was not awarded at a time when there could have been overlap with the CATALYST and ADVANCE Africa projects, some USAID Missions (Egypt, Peru) chose to commence bilateral projects rather than wait for ESD to initiate. Other informants believe that this lack of overlap is common and that USAID Missions have many mechanisms for obtaining technical assistance based on their particular strategic objectives and the large number of centrally funded projects, which often have overlapping mandates.

Overlapping mandates: An overlapping mandate exists with the ACCESS-FP AA, which was awarded at the same time as ESD. The ACCESS-FP AA mandate is to expand FP access to PP women, one of the underserved groups identified in the ESD program description. To the credit of these projects' managers, both projects' activities have been, and continue to be, coordinated.

USAID knowledge of mandate: The assessment team's interviews with USAID staff in the Office of Population and Reproductive Health revealed mixed awareness of the ESD mandate. Several staff stated that they thought the primary focus was HTSP; others did not associate ESD with best practices or with meeting the needs of underserved populations; and some believed that the ESD mandate was community-level FP and that this was not being fulfilled.

Funding: Several ESD, consortium, and partner staff felt that the limited level of core funding inhibits the level of TA that Washington-based technical experts can provide in person, which reduces ESD's effectiveness and reach. The problem of limited core funding may not be specific to ESD, but it clearly frustrates staff because it limits their abilities to provide TA and share global lessons with the field. ESD staff are also aware that the level of funding received did not meet the expectations of the partner organizations.

Staffing: Respondents reported that lower-than-anticipated level of funding from the field, including the loss of anticipated FS from Haiti, Mali, and Sudan due to changed strategic directions in USAID Missions, forced the project to release 15 staff members from the 40 who were initially employed.

Security in countries where ESD implemented activities was a problem that at times affected the pace at which activities could be conducted and ESD's ability to provide TA in the field.

ROLE OF FUNDING SOURCE IN DRIVING ESD EFFORT

The ESD Project was given a $135 million (core and FS) funding ceiling and, to date, has received roughly $15 million in core funds, mostly from the Office of PRH. ESD has also received $15 million in field support from nine USAID Missions (Angola, Ethiopia, Guatemala, Guinea, Jordan, Kenya, Nepal,

Sudan, and USAID/East Africa) and two Bureaus (Africa and Asia/Near East). In addition, ESD has obtained $83 million in FS-AAs from Burundi, Jordan ($650,000 AA funding pending), Kenya (Central, Nairobi, and Northeastern Provinces), USAID/EA, and Yemen. Table 1 provides details on the country, project, and type of funding for USAID-funded ESD work.

Like most global projects, ESD is somewhat constrained in the types of activities it can implement in any given country because (1) project activities must fit into ESD's overall program mandate as reflected in its technical proposal; (2) the source of funding brings restrictions on what activities can be supported with those funds (PRH, President's Emergency Plan for AIDS Relief (PEPFAR), etc); and (3) the type of mechanism used (e.g., field support, Associate Award, core funds) affects ESD's budget and project management, including who determines what activities will be conducted and which partners will be involved. Since ESD is a Leader with Associates (LWA) agreement, USAID Missions can fund ESD using either FS or AA funds. Core funds are intended for initiating small-scale models and global-level activities. FS funds, on the other hand, are the source intended for implementation. Both sources of funding are needed if ESD is to fulfill the activities expected from a global project.

With FS, USAID Missions typically "buy into" a global program's mandate that allows them to access significant TA. These activities often require a country presence for the global project with the overall responsibility of managing the activity in Washington.

With AAs, the management responsibility is based at the Mission or operating unit at USAID/Washington that initiates the AA, and the level of TA provided by the Leader is determined by the amount of funds set aside for that activity in the agreement's budget. USAID Missions appreciated FS when they did not feel they had sufficient staff to manage the projects or new agency, but preferred AAs overall because AAs allow Missions to exert more control over activities. One major advantage of using the LWA mechanism is the ability to harness programmatic strengths and expertise by creating a consortium consisting of a prime organization, which receives the cooperative agreement, and its designated partners. The ESD consortium displays a wide array of talents, reflected in the diverse mix of activities in ESD's portfolio.

ESD RESPONSIVENESS

Relationships between ESD, USAID/Washington, and USAID Missions are good, with interviewees particularly praising the degree of information-sharing and responsiveness. ESD's well-earned reputation of being responsive, effective, and flexible in its work with USAID Missions, partner and bilateral CAs, large and local NGOs, private voluntary organizations, and multilateral agencies should further USAID's global priorities in its field-based activities.

USAID MANAGEMENT OF PROJECT

The USAID management team directs ESD and advocates for the project within USAID and multilaterals. It was widely noted that the team has been a very strong advocate for ESD's work in HTSP, and this fact has often been cited when Washington-based staff have been asked about ESD's specific contributions.

Despite its good relations, a few communication concerns between USAID Missions, ESD, and USAID/Washington with regard to promoting the ESD project were noticed by respondents.

- Perceptions of slow buy-in to the project during its first few years were attributed by some to ESD's dependence on USAID/Washington for "marketing" the project. Most interviewees believe that global projects should be assigned this task.
- There were mixed opinions from ESD staff about communicating with USAID/Washington. Some staff felt that they can directly communicate with the GLP Champions as long as the COTR and TA were kept informed. Others felt that direct communications with the GLP were impeded

and that such conversations with GLP Champions would improve activity planning, budget activity, and technical leadership within activities. Some staff felt that the extra layers of bureaucracy resulting from communications being channeled from ESD staff through the COTR/Technical Advisor to other USAID staff make dialogue cumbersome.

- The guidelines for direct communications from different levels of ESD staff to USAID staff should be clarified.

Recommendations for more effective USAID-ESD communications also include:

- Investing in methods to increase awareness of ESD activities (and contributions that such activities can make to many Mission MCH objectives) for the Office of PRH audience.
- USAID should provide clear and reasonable expectations for the completion of HTSP activities and results for the remainder of the project.

ESD MANAGEMENT OF CONSORTIUM

Project start-up was perceived by several respondents as having been more difficult than usual for these projects, which slowed the process, and several suggestions were made to strengthen the relationship among consortium partners:

- There were challenges to the partnership from the merging of two predecessor projects (CATALYST and Advance Africa) in that there were perceived to be overlapping areas of expertise. Several respondents said that within a consortium, organizations typically focus on their own strengths, so there should have been more discussion between consortium members on how to address this overlap.
- ESD should use its leadership role to discuss significant issues with its partners, such as partner roles and overlapping areas of expertise; spend more time discussing strategies and prioritizing workplan activities rather than simply updating other partners on progress of activities; and work on building trust and communication between partners.
- Partners attend quarterly meetings, but several partners suggested that meetings should be better structured so as to encourage discussion on how the project is working and on partners' perceptions of the partnership.
- ESD should revisit its vision with partners periodically for the duration of the project in order to ensure that partners have a shared understanding of what that vision is and how to achieve it.
- ESD should regularly review project objectives with USAID and partners in order to adapt to potentially new priorities from new funding sources.

ADDRESSING CHALLENGES FOR CURRENT AND FUTURE PROJECT

Several senior staff recommended that future projects overlap with older projects by six months so that project activities can transition smoothly from one funding mechanism to the other.

For future projects, consider hiring staff conservatively at commencement of the project so as to remain flexible with the level of funds received.

The level of core funding available to the ESD Projects resulted from decisions made by senior-level management in the Office of Population and Reproductive Health, and it is unlikely that this funding level will change during the remainder of the project. Furthermore, it appears from the assessment team's interviews that low levels of core funding is a trend that will continue, and future projects should take this into consideration as soon as they are initiated.

V CONCLUSIONS

ESD is a strong program that is respected for its working methods and work quality among USAID Missions and country partners. Despite difficult country situations (insecurity, geographic, and other barriers related to social conservatism and gender norms), the progress ESD has been able to make within its projected timeframe is laudable.

- There is much evidence of promising and best practices, with early indications that efforts may be achieving results. The HTSP strategy is often mentioned as contributing to overcoming social norm barriers to FP and revitalizing FP in countries where FP programs have stalled. Gender and social norms that impede the use of RH/FP services are being explicitly addressed through a variety of strategies.
- Strategies and models for reaching hard-to-reach and marginalized populations are being tested in various geographic regions, as are strategies for bringing FP and HTSP services to underserved high-risk women.
- Multi-tiered and multisectoral approaches are being applied.
- ESD has shown competence in leveraging funds and other resources for TA.
- Limitations created by funding rules require a global project such as ESD to identify opportunities for models and learning. This restricts the number of models/sites for testing the same type of model to be implemented, and hinders development of models and data collection and analysis methods.

In summary, ESD has made substantial contributions to certain areas of global leadership and knowledge generation, and in expanding health services to hard-to-reach populations.

APPENDIX A. FUNDING OBLIGATIONS AND PIPELINE FOR ESD FIELD ACTIVITIES

Funding for ESD Field Activities*						
Country/ Region	Program	Fund Dates	Status	Funding Source	Amount Obligated/ Awarded	Balance May 31, 2009
Core-Funded Activities						
Bangladesh	Integration of FP and CSR		Periodic TA	ESD Core		
Burundi	FP into MCH	2009	New into AA activities	ESD Core		
Ethiopia	STTA for LAFM and health extension workers (HEW) for FP to bilateral-funded FP and IntraHealth projects	2008	Ongoing	ESD Core		
N Nigeria	RH/FP young couples		Periodic TA	ESD Core		
Tanzania	CSR FP and HIV	2007	Ongoing	ESD Core		
Yemen	TA for Yemen Midwives Association and establishing midwives' private practices	2006	Ongoing	ESD Core		
Multi-country	Supporting HTSP Champions networks		Ongoing	ESD Core		
TOTAL CORE					15,136,718	1,979,879
Activities Funded with Field Support to ESD from USAID Missions						
ANE	Religious leaders (Pakistan, Bangladesh, Yemen)	Sept 2006	Ongoing	ANE FS	1,164,500	337,928
ANE	Best practices workshop and small grant follow-up (1st tranche 5 awards; 2nd tranche 4 awards)	Sept 2007 into 2008	Ongoing	ANE FS	2,748,401	1,491,292
Africa Bureau	Integration of FP with HIV services (started with Kenya NEP)	Sept 2008	Ongoing	AB FS	100,000	96,499
Angola	Family Planning project	Sept 2007 into 2008	Award March 2008	FS	1,491,360	696,964
Ethiopia	Bridge program (PF and Intrahealth); $600,000 in 2007 was for Intrahealth Fistula activities).	April 2007 into 2008	June 2007–September 2008	FS	5,807,437	64,729

Funding for ESD Field Activities*						
Country/ Region	Program	Fund Dates	Status	Funding Source	Amount Obligated/ Awarded	Balance May 31, 2009
Guatemala	TA for RH/FP guidelines and policies to evaluate APROFAM (CA)	Sept 2006 into 2007 May 2009 new	Ongoing	FS	318,670	196,075
Guinea	FP in two regions	Sept 2007 2 years	September 2007– August 2009	FS	2,200,000	826,3493
Jordan	For STTA to Jordan Association of FP and protection for organizational development activities	Sept 2008	Ongoing	FS	650,000[1]	567,222
Kenya	Gender issues (Kakuma and Dadaab refugee camps)	Sept 2006 1 year	Complete	REDSO East	200,000	0
Nepal	Evaluation of CEDPA project	July 2006	Award January 2007	FS	19,073	0
Sudan	TA and development of RH/FP policies/guidelines	2005	FS		550,000	0
Activities Funded with Field Support from ANE to Scale Up Best Practices						
Bangladesh	Grant to local NGO (Shimantik) scaling up of healthy fertility and post-partum FP rural experiences in urban areas of Sylhet	2nd tier	Just starting	ANE FS		
Egypt	Grant to SC for postnatal care and PP/FP scale up	1st tier 2007; 2nd tier 2009	Ongoing	ANE FS		
Egypt	Population Council Scaling up the provision of FP messages in antenatal and postpartum services in Upper Egypt	2nd tier 2009	Just starting	ANE FS		
India	Grant to Care International for IMNCI treatments and HTSP	1st tier 2007	Ongoing	ANE FS		
India	Grant to Population Council for increasing postpartum check-ups and contraceptive use among young women in India	2nd tier 2009	Just starting	ANE FS		

Funding for ESD Field Activities*						
Country/ Region	Program	Fund Dates	Status	Funding Source	Amount Obligated/ Awarded	Balance May 31, 2009
Indonesia	Grant to JNPK/MOHP for comprehensive emergency obstetric care (CEmOC) and neonatal emergency care	1st tier 2007	Ongoing	ANE FS		
Nepal	Grant to local NGO (NEP) for Urban PPFP; grant to local NGO (MIRA) to facilitate synergies to scale-up maternal and newborn best practices in Nepal	1st tier 2007	Ongoing	ANE FS		
Pakistan	PE for MNCH Best Practices	2nd tier planned	Planning phase	ANE FS		
Yemen	Grant to Basic Health Services (BHS)/ MOPHP for five IMNCH BPs	1st tier 2007; 2nd tier 2009	Ongoing	ANE FS		
TOTAL FS					15,249,441	4,277,058
Associate Awards						
Kenya	APHIA II NEP	May 2007	5 years	FS-AA (PEPFAR)	7,279,490/ 18,000,000	2,156,633
Kenya	APHIA NAIROBI	New 2009	2 years	FS-AA	6,310,000/ 16,000,000	6,291,911
Kenya	APHIA Central	New 2009	2 years	FS-AA	6,310,000/ 16,000,000	6,285,754
Yemen	Extending Service Delivery Project Basic Health Services Project BHC	December 2005	2006–2009 3 years	FS-AA	15,557,884/ 25,000,000	3,183,497
Burundi	MCH	October 2007	3 years	FS-AA	3,303,729/ 6,255,110	1,460,853
TOTAL AA					**39,490,559/ 82,543,110**	**20,038,727**

* Amount obligated through May 2009.
[1] This funding was for an AA project that is currently on hold. FS funding in smaller amounts is being allocated quarterly for STTA organizational strengthening activities with local FP Organization.

APPENDIX B. CORE FUND PIPELINE

Core Fund Pipeline*					
Date	Mod #	**Country**	**Area**	**Total per Mod#**	**BALANCE**
09/30/2005	Initial Award	NR	Population	5,000,000	
07/07/2006	Mod #2	NR	Population	3,300,000	
09/14/2006	Mod #3	NR	Population	100,000	
09/28/2007	Mod #6	NR	Population	3,742,729	
09/29/2008	Mod #8	NR	Population	2,993,989	
TOTAL CORE:				**15,136,718**	**1,979,879**
*Updated through May 2009.					

APPENDIX C. TERMS OF REFERENCE

Final Scope of Work
Participatory Assessment of THE ESD project

Revised March 24, 2009

I. PURPOSE

The purpose of this participatory assessment is to provide the U.S. Agency for International Development's (USAID) Bureau for Global Health (GH)/Population and Reproductive Health Office (PRH)/Service Delivery Improvement Division (SDI) with an assessment of the Extending Service Delivery (ESD) Project. ESD is a five-year global project that began on October 1, 2005, and will end on September 30, 2010. As the project is in the fourth year of implementation, PRH/SDI has commissioned this participatory assessment to examine the project's progress toward achieving planned results and lessons learned to date. In addition, the assessment will complement a USAID field mission survey conducted by PRH/SDI to determine need for and anticipated future requirements of a new family planning and reproductive health (RH/FP) project. The assessment team will identify ESD activities that may warrant continued future investment, as well as other RH/FP initiatives not covered by ESD that would likely contribute to improving access to, use, and quality of RH/FP, and by integrating with other health services.

II. BACKGROUND

In September 2005, GH/PRH/SDI awarded the Extending Service Delivery Project for Reproductive Health and Family Planning, a 5-year Leader with Associate (LWA) Cooperative Agreement, to a consortium of five organizations: Pathfinder International, the recipient of the Leader Agreement, and its partners—IntraHealth International, Management Sciences for Health (MSH), Meridian International Group, and International Center for Migration and Health (ICMH). Short-term partners include the Georgetown Institute for Reproductive Health, ADRA, and Save the Children. Since that time, one partner—ICMH—elected to leave the partnership. The ESD LWA is designed to allow USAID Missions and Bureaus easily to access high-quality technical assistance and support for increasing the use of quality RH/FP services at the community-level among poor, at-risk, and other underserved groups. USAID Missions may use traditional field support mechanisms to obtain the services of the project or they may issue their own, locally-managed Associate Awards. The project has a ceiling of $135 million, with $35 million of that designated as core and the remainder as field support; Associate Awards do not count against the ceiling. Most of ESD's core funding is from the population account; ESD has also received a small amount of funding from the CSH and HIV/AIDS accounts. To date, ESD has received four Associate Awards ($21,720,559) from USAID Missions (Yemen, Basic Health Services Program; Kenya, North Eastern Province; Burundi, Maternal and Child Health Project; and USAID/East Africa.) ESD has received $15,030,771 in field support from Sudan, USAID/East Africa, Ethiopia, Angola, Guinea, and Guatemala Missions, and from the ANE and Africa Bureaus.

ESD's overarching strategy is to place FP at the forefront of good health and socioeconomic development by mainstreaming evidence-based and state-of-the-art RH/FP best practices. This strategy is complemented by supporting strategies that include: Integration of services (e.g., integrating FP with HIV/AIDS, and with maternal health such as postpartum care); reaching underserved groups (such as marginalized poor in rural or urban areas, youth, refugees/internally displaced persons (IDPs), postpartum women, post-abortion care clients); multi-tier, multisectoral approaches (e.g., working at the community, facility, regional and/or national levels and programs, including non-health activities); and promoting gender-based activities (e.g., male involvement in FP). By both developing and applying proven and promising approaches, ESD is improving quality, accessibility, and use of RH/FP services through the following three intermediate results:

IR #1: Strengthened global learning and application of best practices and state-of-the-art program approaches for RH/FP services

IR #2: Increased access to community-level RH/FP services and contraceptive methods

IR #3: Increased capacity for supporting and sustaining RH/FP services

More information on ESD's work at the global level and in the ESD-focused countries is available on the ESD website at www.esdproj.org.

III. STATEMENT OF WORK

The assessment team will have three main tasks:

- Task 1: Review ESD's technical and programmatic activities, including strengths, weaknesses, successes, and constraints. Based on the assessment findings, the team will: Present results achieved to date, including technical leadership results; document any performance gaps; identify lessons learned; and make recommendations toward achieving planned results in the remaining period of project implementation.
- Task 2: Examine ESD's structure and management, as well as the benefits and disadvantages of the ESD mechanism, a Leader with Associate Awards Cooperative Agreement.
- Task 3: Identify those ESD interventions and activities that warrant future investment, as well as other RH/FP best practices and approaches not covered by ESD that would likely contribute to improving access to, use, and quality of RH, FP, and other health services.

The assessment questions that the team will answer are provided below. The team is expected to clarify any questions that they might have about the assessment questions in discussions with PRH/SDI at the start of the assessment.

TASK 1: Assess Progress to Date Toward Achieving Planned Results
(Estimated level of effort—40%)

1. What has been ESD's progress to date in achieving planned results, both global leadership and field programs' results, based on the project's performance indicators (provided in the Results Framework and the project's Performance Monitoring Plan), the project's self-assessment, and any other data gathered? Please identify any gaps in performance and steps to be taken to address these gaps.
2. To what extent has ESD followed the original Program Description found in the response to the RFA, to address topics such as: (1) the integration of RH/FP into other health services (child health, HIV); (2) working at all levels (community, facility, regional/national) to create sustainable and well-used RH/FP services; (3) promoting gender equity;(4) tailoring interventions to different underserved groups (rural and urban poor, youth, postpartum women, PAC clients, refugees/IDPs, PLWHA, or at risk; and (5) repositioning FP in Sub-Saharan Africa? To what extent has the program evolved over time and how will these changes affect the achievement of results as envisioned?
3. What strategies has ESD developed to reach each of the identified underserved and at-risk groups (refugees, internationally displaced persons, post-abortion care clients, etc.) in addition to postpartum women? To what extent did these strategies inform ESD programming and activities? To what extent has ESD achieved its primary objective to increase use of RH/FP services among these various groups?

4. How is ESD contributing to USAID/PRH Global Leadership Priorities (particularly youth, gender, MAQ/IBP, and PAC) and technical priorities—community-based family planning, HTSP, LAPM, FP-MNCH integration, and FP-HIV/AIDS integration?

5. What strategies did ESD use to establish itself as a global leader in ESD technical and priority areas? What have been ESD's most important lessons learned to date?

6. What are the promising or best practices models to reach underserved groups identified for improving RH/FP service delivery and implemented by ESD? How has ESD supported the scale-up and mainstreaming of proven FP/MNCH best practices and interventions? What tools has ESD developed to advance the state of the art? Please provide a list of key tools and best practices developed by ESD and other partners that are being scaled-up/mainstreamed.

7. What contributions has ESD made to global leadership, advancing research and innovation, and using-low cost approaches to transfer evidence-based best practices to the field?

8. How does ESD work with ESD Associate Awards to bring evidence-based best practices to Associate Award projects? Are there any lessons that should be replicated?

9. Is ESD responsive to USAID Missions and country-specific interests? How do USAID Missions view ESD's performance at the country level?

10. What are the assessment team's expectations regarding the project's future progress?

11. What does the team believe will be the ESD Project's legacy?

TASK 2: Evaluate ESD's Structure and Management
(Estimated level of effort—20%)

1. What are the management strengths, including management best practices, of the project?

2. What were the most significant structural or management challenges (e.g., with regard to project design, staffing, partnering, or funding) faced by the project?

3. How should these challenges be addressed to enhance achievement of results, both during this project and for any future project (if appropriate)?

4. How has ESD demonstrated the added value of a global project versus a bilateral project? How has ESD complemented the work of bilateral projects? What has been the role of core funding in field-supported activities?

5. What are the strengths/limitations of USAID management of this project? How could USAID management be improved during the remainder of the project and for future projects of this type?

6. How is the ESD Consortium partnership working? What has worked well and what have been its challenges?

7. An important function of ESD is M&E. What are the issues, challenges, and lessons learned in monitoring, evaluation, and reporting?

TASK 3: Identify ESD Interventions and Approaches that Warrant Continued Investment in the Follow-on Award
(Estimated level of effort—40%)

THIS SECTION WILL BE DRAFTED AS A FUTURE DIRECTIONS MEMO AND SHOULD BE EXCLUDED FROM THE ASSESSMENT REPORT.

1. What are the key ESD initiatives, interventions, and approaches that warrant continued/additional investment (for example, promising initiatives that could be scaled-up or applied in different settings)? Criteria for selecting promising activities and approaches may include:

   - Contributing to behavior change and increased use of RH/FP services through the introduction and application of HTSP models.
   - Creating a demand for FP by integrating with maternal and child health services (postpartum FP, PAC) and HIV/AIDS.
   - Expanding utilization of FP through private-sector, NGO-corporate-public-sector partnerships.
   - Promoting RH/FP through the non-health sector (for example, mobilizing religious leaders to become champions for RH/FP).
   - Using innovative approaches to fast-track dissemination of high-impact FP/MNCH best practices, combined with focused, low-cost technical assistance for application and scale-up of best practices (launching the ANE and Africa best practices activities).
   - Meeting the RH/FP needs of displaced persons.

2. Are there other promising, potential models and approaches not developed by ESD that should be considered for future investment?

3. What are the outstanding issues and important gaps related to improving access to, use, and quality of RH/FP, and other health services that still need to be addressed?

IV. METHODOLOGY

The assessment team shall use a variety of methods for collecting information and data. The following essential elements should be included in the methodology, as well as any additional methods proposed by the team.

PRH/SDI/Team Planning Meeting (TPM)/Preparation of the Evaluation Workplan The participatory assessment team will consist of three to four members, including two outside consultants and one or two USAID staff members. A junior USAID staff member may also be included if needed. The team will hold planning meetings with the PRH/SDI and the ESD Management Teams. At the USAID meeting, the team will review the scope of the assessment, clarify any questions related to the assessment questions, and finalize the schedule. The team will then meet to prioritize key assessment questions and discuss the general methodology to be used. The team will be responsible for developing the overall final assessment workplan, defining the responsibilities of individual team members, and developing interview questionnaires, including standardized data collection instruments that will be used by all team members. A plan for data collection and analysis will also be developed with the workplan.

The outcome of this meeting will be a detailed Assessment Work Plan, including milestones and deliverables with due dates clearly established, as well as roles/responsibilities of the team members. The Assessment Work Plan will be reviewed by the USAID activity managers and approved. In addition, the completed data collection and analysis plan, including all the completed data collection instruments, will be reviewed and approved by USAID before the consultants begin field work/depart for the field.

Data Collection Tools: Based on the assessment questions and approaches discussed during the Team Planning Meeting, the team will also develop the following data collection tools:

1. Interview Guides

2. Interview Questionnaires

The data collection tools will be presented to PRH/SDI for discussion and approval prior to their application in order to verify their appropriateness. These tools will be used in all data collections situations, especially during country field visits to ensure consistency and comparability of data.

In addition to formal briefing and debriefing meetings, the team may contact the PRH/SDI ESD management team as necessary to provide updates on their progress and obtain additional guidance on logistics, additional data, and information sources, etc.

Self-Assessment by ESD: Prior to the assessment team beginning its work, ESD will have completed and submitted in January 2009 a self-assessment report to USAID. This report will be provided to the team and will serve as a key component of the team's document review. The ESD self-assessment questionnaire is attached.

USAID Field Mission Survey: Prior to the assessment team's departure for the field, PRH/SDI will have compiled the findings of a USAID Field Mission survey focused on assessing selected Missions' perceptions of issues associated with the ESD Project, and recommendations for future investments for improving RH/FP service delivery. Survey questions will be tailored for those Missions that have worked with ESD.

Document Review: GH Tech, PRH/SDI, and/or ESD will provide the assessment team with a package of briefing materials related to the ESD project review. This documentation will include:

- ESD RFA and Pathfinder proposal
- ESD progress reports, workplans, and management reviews which are developed and reviewed as part of the continuous monitoring of the project
- ESD's self-assessment report
- Technical, research, and program documents.

The team is also expected to collect and annotate additional documents and materials, which it will make available to PRH/SDI for future use. The team will also review ESD's website. *A list of potential background documents is attached.*

Key Informant Interviews: The team will conduct qualitative, in-depth interviews with key stakeholders and partners (a preliminary list of stakeholders and partners is attached, but the assessment team should add to this list as necessary.) The team will prioritize key interviews with key stakeholders and partners in collaboration with USAID. Whenever possible, the team should conduct face-to-face interviews with informants. When this is not possible, e-mail and telephone surveys should be conducted. If possible, virtual interviews through video conferencing should also be considered.

Key informants should include, but not be limited to:

- ESD project staff
- Relevant staff from the ESD Consortium members (Pathfinder International, MSH, Intrahealth, and Meridian International Group) and other ESD partners, Georgetown University, ADRA, and Save the Children
- USAID staff who currently manage projects focused on improving RH/FP service delivery and GLP and TP Champions
- USAID/Washington (PRH/SDI) ESD project management staff

- USAID Missions, including those in countries in which ESD works
- ESD in-country partners, including donors and private-sector entities.

Field Visits: The assessment team will split into two teams (each team will have one GH Tech consultant and one USAID staff member) and will travel to a sample of 2–4 countries (Kenya, Tanzania, and Guinea) in which ESD is implementing substantial activities. The team is expected to interview project staff, USAID Mission PHN staff, other implementing organizations, and ESD partners (including local NGOs, Ministry of Health staff, private and commercial enterprises, professional associations, etc.) in the sample countries. Each country visit will last nine days (seven days in-country and two days travel time).

E-mail/Telephone Surveys and Virtual Interviews: The team should design and implement e-mail and/or telephone surveys, and/or conduct virtual interviews to poll USAID partners, including Field Missions that have worked with ESD, regarding their level of satisfaction and experience with the project.

Data Analysis: As the team reviews the documents available and interview list, and develops the data collection tools, team members will ensure that they will in fact possess the data they need to respond adequately to the evaluation questions. Once all data have been collected, several days will be spent carefully compiling, reviewing, and identifying key findings, prior to making a presentation of preliminary findings to USAID.

V. DELIVERABLES

Approved Assessment Work Plan: The team will prepare an approved assessment workplan, including milestones and deliverables, with due dates clearly established. This plan may include, but is not limited to, the following items:

- Key assessment questions, methods, and tools
- Data collection and analysis plan
- Time line for key activities, including product due dates
- Schedule of interviews, both internal and external
- Schedule of formal debriefing presentations to USAID and ESD
- Roles and responsibilities of team members.

Debriefing Meetings: After the completion of data collection and analysis and a first draft of the assessment report, the team will debrief the USAID/ESD management team. Any feedback or comments on the first draft will be incorporated by the assessment team. The team will then hold debriefing meetings with PRH and ESD (two separate meetings) to present the major findings and recommendations of the assessment. The debriefing meetings will involve an oral presentation and a written executive summary. Succinct briefing materials appropriate for the audience will be prepared and distributed during the briefings. The meetings will be planned to include time for dialogue and feedback.

Draft Assessment Report and Future Directions Memo: The team will produce two documents—an assessment report and a Future Directions Memo. The assessment report will include all components of the evaluation report outlined in Annex 3, excluding the Future Directions section. SDI will provide this draft report to ESD. The draft Future Directions section will be submitted as a separate, well-marked Internal USAID Memo for PRH/SDI internal review and consideration. Within 10 working days of receiving the draft report and Future Directions Memo, USAID and ESD Project partners will provide comments and suggestions to the evaluation team leader, which shall be addressed in the final assessment report and memo. The team will then submit a final assessment report and Internal Memo within 10

working days after USAID and ESD partners have provided their feedback on the draft documents. After the final draft report and memo have been reviewed by USAID and the final contents signed off, GH Tech will have the document edited and formatted, and will provide the final documents to USAID.

Final Assessment Report and Future Directions Memo: The team will submit a final, edited assessment report and Future Directions Memo within 10 working days after USAID has provided its feedback on the draft report (noted above.) The final report should include, at a minimum, the following: Executive summary; scope and methodology used; important findings (empirical facts collected by the assessment team); conclusions (assessment team's interpretations and judgments based on the findings); and recommendations (proposed actions for management based on the conclusions.) This information will be organized to answer the assessment questions listed on pages 2–4 of this scope of work. The report should be no longer than 35 pages, excluding annexes. The final Future Directions Memo (a separate document) should not be longer than 3–5 pages and should include lessons learned, implications for future designs, and lessons for others to incorporate into similar programs. The team will work with USAID and GH Tech to produce the final assessment report for public distribution and the Future Directions Memo for USAID/PRH/SDI internal circulation. GH Tech will be responsible for the final documents. *A proposed assessment report outline is attached*. The final documents will be submitted to PRH/SDI both in five hard copies and in electronic form.

The final documents will be edited/formatted by GH Tech and provided to USAID approximately one month after USAID has reviewed the content and approved the final revised version of the report and memo.

List of Documents: The team will provide PRH/SDI with a list of documents and materials reviewed for the evaluation. This list will be included as an annex to the assessment report.

VI. DURATION, TIMING, AND SCHEDULE

It is anticipated that the period of performance will be approximately

6–8 weeks, including the 10 days during which USAID and ESD will provide comments on the draft report. The team will be authorized to work a six-day workweek when in the field, including traveling to/from the field on weekends.

The following is a sample schedule. The assessment team should propose a schedule and exact dates for the evaluation prior to initiation of the assignment. It is hoped that the participatory assessment will commence o/a March 18, 2009.

Task/Deliverable	Timing	LOE Revised			
		Team Leader	Team Member	TPM Facilitator	Total LOE
1. Review background documents		3 days	3 days		6 days
2. Travel to/from DC	2 days	0 days	2 days	0 days	2 days
3. Team Planning Meeting/PRH/SDI Team Pre-Assessment Meeting	3days	3days	3 days	4 days (includes 1 day of prep)	10 days
4. Development of data collection tools	2 days	2 days	2 days	0 days	4 days
5. Information/data collection. Includes interviews with key informants, domestic field visits, etc.	5 days	5 days	5 days	0 days	10 days
6. Country Visits (Kenya, Tanzania and Guinea)	15 days	15 days	15 days	0 days	30 days
7. Data Analysis	5 days	5 days	5 days	0 days	10 days
8. Draft assessment report	4 days	4 days	4 days	0 days	8 days
9. Debriefings with PRH/SDI and ESD team	2 days	2 days	2 days	0 days	4 days
10. USAID and ESD provide comments on draft report	10 days	0 days	0 days	0 days	0 days
11. Prepare final assessment report	3 days	3 days	2 days	0 days	5 days
Total # days	**50 days**	**42 days**	**43 days**	4 days	**89 days**

VII. TEAM COMPOSITION

A two-member external assessment team is proposed. Between them, team members should have substantial and demonstrated knowledge of international public health in the fields of family planning and reproductive health, as well as maternal, neonatal, and child health issues and HIV/AIDS. Specifically, team members should have between them:

1. 7–10 years of experience in international public health in the fields of family planning and reproductive health. Additional experience in safe motherhood, child survival, and HIV/AIDS would be beneficial.
2. 7–10 years of experience working in public health in developing-country settings, including expertise in several of the areas listed below. Between the two external evaluators, there should be complementarities in the skills sets in the following areas:
   - Community-based RH/FP programs
   - FP-MNCH integration, including postpartum FP
   - FP-HIV integration
   - NGO-corporate-public partnerships
   - Working with displaced persons and youth
   - Research, monitoring, and evaluation
   - Capacity building.

In addition, each team member should have, at a minimum, the following skills and experience:

1. An advanced degree in public health, or other relevant course of study
2. Demonstrated skill in written and oral communication
3. Demonstrated knowledge of USAID policies and procedures
4. Ability to work effectively and communicate with a diverse set of professionals.

One of the team members will be designated as the Team Leader. Additional qualifications/responsibilities of the Team Leader include:

- Strong organizational skills to ensure the team stays on schedule.
- Excellent English language skills (both written and verbal) as s/he will take the lead role in finalizing the written report.
- Strong interpersonal skills (including negotiating) to facilitate working with a wide variety of individuals at USAID, ESD, GH Tech, and in the field in the completion of this assignment.

A USAID direct-hire Foreign Service New Entry Professional and/or a staff member from USAID's PRH Office may also be involved in the assessment as team members.

VIII RELATIONSHIPS AND RESPONSIBILITIES

1. Overall Guidance: The PRH/SDI ESD Management Team will provide overall direction to the assessment team.

2. PRH/SDI Contact: Maureen Norton, COTR, and Rushna Ravji, Technical Advisor, for the ESD project will be the official contacts for the assessment team.

3. Responsibilities:

- GH Tech will be responsible for travel logistics, including obtaining country clearances, for GH tech consultants. GH Tech will also assist with setting up interviews, meetings, etc., as needed.
- GH Tech will work with the consultants to produce the two documents, an assessment report for public distribution, and the Future Directions Memo for internal USAID distribution. GH tech will be responsible for the final documents.
- Consultants will be responsible for coordinating and facilitating assessment-related field trips, interviews, and meetings as needed.

IX. RESTRICTIONS

The prime contractor, sub-contractors, and any consultants are subject to the restrictions set forth in USAID CIB 99-17, under evaluation.

APPENDIX D. ASSESSMENT TIME LINE AND DETAILED METHODOLOGY

Time Line for ESD Participatory Assessment	
March 18–20	Background reading
March 23–26	Team Planning meetings
March 27–April 1	Key Informant Interviews (phone or in-person for persons based in Washington)
April 4–April 10	Field Visit Guinea (Team 1)
April 4–April 11	Field Visit Kenya (Team 2)
April 12–April 19	Field Visit Tanzania (Team 1)
April 17–18	Key Informant Interviews (potentially) and begin drafting report (Team 2)
April 20–24	Finish outstanding interviews, data analysis, begin draft report, and draft conclusions and recommendations
April 24 and April 27	Review key findings, conclusions, and recommendations with USAID–ESD Management Team
April 28	Debriefing with ESD Project
April 28	Debriefing with USAID, O/PRH
May 8	First draft report submitted to USAID via GH Tech
By May 13	Comments received from USAID
During week after receiving comments from USAID	External assessment team members revise report, team members contribute as needed
Around May 20 One week after receiving comments from USAID	Final assessment report submitted to GH Tech

This was a participatory assessment conducted by two external consultants and three USAID staff. During field visits, ESD staff facilitated arrangement of meetings and provided additional insights into findings and perceptions, but they were not present during interviews with the MOH and partners.

PLANNING PROCESS

Team Members and Responsibilities

Nancy Fronczak, Team Leader and external consultant, was responsible for team organization, additional scheduling as necessary, and quality control of deliverables. She was responsible for leading the field team visits to Guinea and Tanzania.

Emma Ottolenghi, external consultant, was responsible for leading the field team visit to Kenya and for providing technical and management input to the team.

Jenny Truong, USAID, was on the Kenya site visit team and provided technical expertise and USAID program inputs related to family planning and youth reproductive health.

Virginia Lamprecht, USAID, was on the Guinea and Tanzania site visits and provided technical expertise and USAID program inputs related to family planning services and M&E.

Chelsea Smart, USAID, was on the Guinea and Tanzania site visits and provided USAID program inputs related to the ESD program. She is part of the ESD project management team.

Initial Steps

- Team building and defining expectations (initial two days with external facilitator)
- Briefing by USAID (ESD project Contracting Officer's Technical Representative (COTR) (Maureen Norton) and Technical Advisor (Rushna Ravji) on assignment Scope of Work and priority issues to be addressed by the assessment team
- Finalization of persons to be interviewed, based on list of persons recommended by ESD and USAID
- GH Tech administrative support

DATA COLLECTION

Development of Data Collection Tools

During the first two weeks of developing the methodology, separate key informant discussion guides were developed for USAID/Washington, ESD/Washington, ESD Consortium and non-Consortium partners, and USAID Missions. Country-specific questions were developed for ESD Country Programs and added to the generic USAID Mission interviews. Field visit checklists were developed to guide the teams when visiting service sites and program offices. These two checklists were used as guides by the teams to improve consistency in field-based data collection among the three countries. Appendix E provides the templates used for data collection.

Background Document Review

Initial background documents were provided by GH Tech, with additional relevant documents identified and collected over the course of the assessment. Appendix F provides a list of the documents reviewed by the assessment team.

Interviews

All Washington-based interviews included at least one external consultant, and most included at least one USAID team member. USAID team members did not participate in interviews with senior USAID team members. Appendix G provides the list of persons interviewed from Washington and during field visits.

Site Visits

USAID management, in collaboration with ESD, selected Kenya, Guinea, and Tanzania as countries for site visits, based on security, logistics, length of implementation time, and funding source (Associate Award (AA, FS, or core). Burundi was initially selected but was dropped due to security concerns. Milka Dinev, the ESD Project Director, accompanied the team to Guinea and Tanzania. Cate Lane, the ESD Youth Advisor, accompanied the team to Kenya.

Country-program sites visited were selected by ESD. Where feasible, the assessment teams randomly selected the actual service sites that were visited. All of the program site visits were a full day's travel from the capital, which allowed only 1–2 days for data collection outside of the capital. During the field visits, the teams were in e-mail contact sharing information in order to promote comparability of methods used and to share comments and/or new issues that might have arisen.

ANALYSIS, DEBRIEFING, AND REPORT WRITING

Analysis

Following the country visits, the team met for several days to review their data and develop key findings, conclusions, and recommendations. Data from documents, interviews, country visits, and other analyses based on available information informed the conclusions and recommendations.

Debriefings

Three separate presentations were made to concerned audiences. First, key findings, conclusions, and recommendations were presented to the USAID COTR and Technical Advisor. After incorporating their feedback, a presentation was conducted with ESD/Washington staff. ESD Project staff provided insights where they disagreed with conclusions, asked for clarification where they felt comments were not clear, and corrected factual errors. The assessment team made the final decision with regard to the conclusions and recommendations. Finally, results were presented to USAID staff that included mostly persons from GH/PRH/SDI along with several senior USAID PRH staff.

Report writing

Each team member was responsible for the first draft of one section of the final report. The draft was reviewed and agreed upon by all team members. The draft report was submitted to the ESD management team for review and comments. Revisions were made based on feedback on the content, provision of additional supporting information, and clarification from USAID and ESD, including a full review of the document to correct factual items and provide input they felt was relevant. The final draft was submitted to GH Tech for editing.

APPENDIX E. DATA COLLECTION INSTRUMENTS

FIELD VISIT CHECKLIST

Field Visit Checklist		
	Country_____ Dates_____	
	When meeting with ESD in-charge person/s or surrogate in the field:	**Notes**
1	Relationship of ESD at field level with MOH/other public services?	
2	Are any of ESD activities being implemented in collaboration with other international or national NGO partners? What are the funding sources? Primarily MCH, HIV (PEPFAR), PRH funds? Any additional multinational funding (e.g., United Nations Population Fund (UNFPA))?	
3	Are any of ESD's activities considered to be pilot? Are they funded by core, field, or partner award funds?	
4	If pilot, how are they documenting the pilot for lessons learned, evaluation, and potential scale-up?	
5	What role has been assigned to Consortium partners? Will we be meeting with any of them?	
6	Are there any USAID priority program or technical "champions" working with you on any particular strategy? Will we be meeting any of them?	
	Review all ended and ongoing activities in that site.	
7	Which best practices are promoted in this activity?	
8	Which activities and preliminary results have potential for designation as a "new" best practice? E.g., integration of certain programs, working with private corporations, working with religious leaders, community participation, etc.	
9	How long have these activities been ongoing (clarify timing under different and predecessor projects if follow-on, or if another group was assisting the project prior to ESD).	
10	If an activity/sub-project ended prematurely, what is/are the reason/s?	
11	Were any activities started with previous projects (e.g., Advance Africa or CATALYST?). If yes, were they modified, added to, or lengthened?	
12	If there are any preliminary outcomes data from any project or activity, please provide.	
13	How do these activities relate to the USAID 3 IRs?	
14	What have been the main lessons learned in implementation?	
15	How many project sites do you manage?	
16	Which site or sites will we be visiting?	
17	Why select them for our visit?	

Field Visit Checklist		
	When in ESD field office	
18	Ask to see all ESD materials which have been used in program implementation.	
19	Ask to see non-AID and non-ESD materials and job aids being disseminated/used in field activities.	
20	Have any materials/job aids been designed, produced, and used here and in other ESD or non-ESD programs? Probe for relative value of these and for what is missing/or materials which could be of greater assistance but don't exist.	
21	Are there any men and/or youth-focused activities going on?	
	Finally, with field ESD rep:	
22	On which underserved population are you focusing your activities?	
23	What do your plans include for the next 18 months?	
24	Have you received the appropriate technical and administrative assistance and oversight from ESD/DC? (May relate to consortium partner and its HQ.)	
25	What is your relationship with the USAID Mission?	
26	What is your relationship with the MOH? Any other national ministry?	
27	Do you work with any FBOs or religious leaders?	
28	What do you consider to be ESD's legacy from this program?	
29	In retrospect, if you had to do it again, what would you change? (E.g., where the program might be located, activities or partners selected?)	
30	Are you planning for successful elements of your project to continue post-ESD?	

CHECKLIST OF OBSERVATIONS AND INFORMATION RECEIVED FROM SITES WHERE ESD RH/FP SERVICES ARE IN PLACE

Note: This list will be applicable mostly to clinical sites. For community services, there are some applicable items, but these may be modified. Perhaps for community-based services via CHWs, a narrative report may be better.

Assessment Guide for Service Sites		
	ITEMS	**NOTES**
1	Country	
2	Site location	
3	Day/Hour of visit	
4	Type of site: Community-based (CB); small health post (HP); health center (HC); hospital (H); other____	
5	Service organization: Overnight short-term care (ON); routine inpatient services (with 24-hour planned staffing) (IPD); 24-hour emergency services with staff officially assigned (either onsite or on call) (ER); outpatient services only with limited hours (e.g., five days per week, eight hours per day) (OPD)	
6	Personnel: Medical_____ Nursing_____ Other client service_____ Support staff ____ Community workers_____	
7	CHW activities: MCH education; FP education; household visits; CBD: pills-condoms-injections-LAM-SDM	
8	Site services: ANC-delivery-postpartum-PAC-newborn health-neonatal sepsis-care for sick child-immunization-FP-HIV testing-PMTCT-ART-Treatment HIV infected infections-VA for healthy child-VA for newly delivered mom	
9	Commodities observed: Pills-injections-condoms-IUD-implant-high dose VA-zinc	
10	FP services: FP methods-counseling; screening for eligibility; managing side-effects and complications; specific clinical skills and training	
11	FP methods offered: Pills-injections-condoms-IUD-implant Sterilization-Male-Female—LAM-SDM	
12	FP counseling integrated in site where service offered: PP-PAC-newborn health-immunization-HIV	
13	FP commodities provided in service site: PP-PAC-newborn health- immunization-HIV testing-Child health- pharmacy (note which are available where)	
14	Blood pressure equipment in all areas where combined oral contraceptives provided/prescribed	

Assessment Guide for Service Sites		
	ITEMS	**NOTES**
15	Stockouts for FP commodities past 6 months	
16	FP guidelines observed in service site for: FP-PP-PAC- newborn health-immunization-HIV-general OPD (note these may be embedded in general RH guidelines)	
17	FP client individual chart/records seen	
18	Separate adolescent RH services: Welcoming atmosphere (pictures/posters/focus for adolescent), adolescent-relevant educational materials, providers have extra training related to working with adolescents, etc., any specific focus for adolescent services? E.g., HIV/STI, FP, nutrition, PAC. Other specific adolescent-friendly aspects	
19	General infrastructure: Running water inside-tubewell/well outside Electricity—routinely sporadic Walls/floor/windows/roof without major damage Site where visual and auditory privacy is available for client counseling Site where visual and auditory privacy is available for client examination Waiting area with seats; protects from sun/rain; pharmacy and lab (if available). Cleanliness	
20	Infection prevention signs: Hand washing soap and running water in reasonable proximity to main OPD service area ; no sharps lying around/sharps box available; chlorine water in bucket where clinical services take place; Autoclave/dry heat sterilizer; boil/steam/chemical high-level-disinfecting equipment and materials; latex (rubber) gloves observed in many sites? Only one location/storeroom	
21	Proper disposal of contaminated waste (no IV bags/ bandages/obviously contaminated materials on grounds/visible unless protected (incinerator? landfill? wall or fence around them?)	
22	Assess number of clients in waiting room: Women? Children? Men? Young people/adolescents (boys, girls)?	
23	Communication, education materials present in waiting room or service site: Video, brochure, etc., any specifically to do with FP, HTSP, FP for HIV+ clients? Try to identify who developed them.	
24	Materials/job aids, flowcharts seen/where? Identify materials developed by ESD or identified for BP (e.g., HTSP counseling messages)	
25	HTSP specific: Messages observed? (which media) Who is being educated?	
26	Record-keeping: By hand–computerized	
27	Training received by provider staff: FP-specific; HTSP; integrated FP-other	

Country Activity Form for ESD Participatory Assessment

Our participatory assessment report will consider the aspects of the field programs that relate to the global program's mandate, as well to the objectives of the field activity. We want to be able to show the evidence for stated results to date, and also show that there are processes in place that will make it likely that the planned results will be achieved. As the ESD Assessment is participatory, we are asking for input from ESD staff. Please complete this form for the countries for which you are the main point person(s) from ESD HQ—perhaps in coordination with the point person from ESD in the country (if applicable). Please note that we sent out a similar form to the country point persons earlier this month; thus far only a couple have been received back.) **Bold the responses that apply,** add clarification where relevant, and create more space as needed.

Note: This is to be an outline, not a detailed report. Please keep the responses very brief—if we want more detail for a specific item, we will ask you later.

Guide for ESD and Partner Organization Field Visits		
#	**Items**	**Responses and Comments**
	GENERAL PROGRAM INFORMATION	
1	**Country Name:**	
2	**Source(s) of Funding and amount of funding *(bold** all that apply):*	
	USAID/Washington core USAID/M (Field Support) USAID Associate Award Bangkok grant (specify) Other(s) (specify)	
3.	**Main partners**	
	***(bold** if there is a formal agreement or MOU between ESD and the partner)*	
4.	**Underserved groups specifically addressed** *(**bold** if applicable; also briefly describe any special strategy to reach this group (e.g., youth: separate youth friendly services; Youth: school peer-to-peer education; PAC: technical training of health center staff and community awareness raising for services, etc.)*	
	Postpartum FPM Most poor/underserved (e.g., special populations who may suffer discrimination due to location, tribe, religion, etc.) Youth PAC HIV+ Other (specify)	
5.	**Program Components** *(bold if program addresses item; place a star next to the item if a clear strategy was developed to build a model that included indicators to demonstrate whether or not the model was successful)*	
	HTSP—messages, advocacy, mobilization Training in HTSP (specify cadre trained, e.g., service providers, religious leaders, etc.) Integration of HTSP into MNCH/PNC FP counseling (specify cadre trained, e.g., community workers, health service providers)	

Guide for ESD and Partner Organization Field Visits		
#	**Items**	**Responses and Comments**
	Introduction of new methods (specify methods) Expansion of existing but less available methods (specify methods) Clinical training in FP methods (eligibility; how to provide; resolving common problems) (specify cadre trained—e.g., community workers for injectable; health workers for all methods, etc.) Integration of FP into MNCH/PNC Integration of FP into HIV services Integration of FP into child health services PAC PMTCT Long Acting/Permanent Methods (LAPMs) (training or promotion) Contraceptive security Other (specify)	
6.	**Special focus groups for delivering FP messages/services**	
	Religious leaders Non-traditional healers Private sector (specify) Adolescent peer-to-peer Male peer-to-peer Other (specify)	
7.	**Level of program work** *(mark all that apply in any service area)***:**	
	Household Community mobilization Community-based education Community-based distribution of FP methods Health centers Hospitals District-level training District-level capacity building (non-training) National level	
8.	**Program coverage** *(if applicable)*	
	Number of districts/regions _____ Population in program area _____ Beneficiaries targeted by program efforts_____ Number of different program offices including central office _____	
8.5	**Overall Strategy** *(If applicable, describe strategy used to determine what activities were to be implemented, how, and by whom. List any tools that were used to develop strategy (limit to one paragraph))*	
9.	**Models developed or in process of being developed** *(brief description of model if applicable).* ***Note:*** *Model implies you are testing a strategy and will document the strengths and weaknesses in using the strategy for achieving the objectives.*	

Guide for ESD and Partner Organization Field Visits		
#	**Items**	**Responses and Comments**
	Describe in detail if models are being used to identify and reach the underserved and at-risk groups (e.g., introduction of provision of injectable by community workers; development of women's groups to promote HTSP messages and FP information. Explain how they have informed other ESD programming (e.g., model will be used to expand services in 2 more regions, model will be documented as one for reaching school age youth, etc.)	
10.	**Unique materials developed by your country program for the program activities**	
	Provide names and type (e.g., "Healthy Mother"- flipchart for community education; "Family Planning Methods"- Training of trainers for FP service provision, etc.).	
11.	**Implementation strategies that focus on long-term sustainability**	
	E.g., Training of government trainers; training of government educators in curriculum revision; organizational development/other strategies for leaving community-based organizations that will be advocates; support community volunteer workers, etc.	
12.	**Implementation strategies that focus on building capacity in knowledge and practice**	
	E.g., national-level workshops; country study-visits; other	
13.	**Implementation strategies that focus on building capacity in service implementation and quality**	
	E.g., National curriculum/protocol revision, integrating COPE into district management approaches; integrating supervision checklists into management level activities, etc.	
14.	**Implementation strategies that focus on expanding service availability**	
	E.g., mobile services, expanding scope of FP services offered by community workers, etc.	
	MONITORING AND EVALUATION	
15.	**Research or assessments implemented and/or planned by this activity:**	
	List types of activities *(e.g., baseline KAP; baseline LQAS for indicators of effectiveness, final KAP survey planned, etc.)*	
16.	**Indicators for <u>effectiveness</u>.** *List by specific objectives or outcomes:*	
17.	**Indicators for <u>sustainability</u>**	
	Examples may include indicators for sustainability of interventions by the project such as activities for monitoring and improving quality, community-based workers, information systems, maintaining results?)	
18.	**Indicators for <u>capacity building</u>**	
	E.g., numbers trained; supervisory checklists adapted by government; etc.	
19.	**How is the project measuring or planning to <u>measure progress in achieving objectives at both the country and global levels</u>—any evidence of progress?**	

Guide for ESD and Partner Organization Field Visits		
#	Items	Responses and Comments
20.	**Any other unique aspects of program you want to share?**	

DISCUSSION GUIDE FOR USAID WASHINGTON

Program

1. One of the primary objectives of ESD is to exhibit global leadership and advance research and innovation related to best practices toward achieving increased access to sustainable community-level RH/FP services and contraceptive methods. In the few years the ESD project has been functioning do you think that the project has made strides toward global leadership in identifying promising or best practices?

2. Are you familiar with some of the best practices ESD is promoting toward expanding availability of quality RH/FP services? If yes, what are these?

3. Please discuss some of the strengths and weaknesses or gaps related to ESD activities and strategies.

4. The RFA identified seven groups of underserved populations (youth; displaced persons/refugees; post-abortion care clients; people living with HIV/AIDS/high risk; postpartum women; rural and urban poor; and men) for ESD focus. Do you have comments about how ESD has addressed these populations?

5. Has ESD been able to scale up successful strategies and address the major gaps identified in the predecessor project (Advance Africa and CATALYST) evaluations, in order to increase access to high-quality community-based RH/FP services?

6. There are many different global programs that have objectives to expand quality services related to RH/FP. These include RESPOND, ACCESS-FP, MCHIP, PROGRESS, Flex Fund, and others. What do you think is the added value/niche of the ESD project toward improving MCH and RH/FP?

Management

7. Has ESD been able to strike a balance in responding to Mission and Washington needs, recommendations, and suggestions while keeping the focus on the ESD primary objectives, including increasing access to RH/FP? Please give us some illustrative examples.

8. How have the GLP and TP Champions worked with the ESD project?

9. Do you think the Consortium partners on the ESD award all bring appropriate strengths to the project and have they been adequately used?

10. It has been only three and a half years since ESD was established. What should ESD do in the remaining time to increase the likelihood of sustainability of the community-based services it is/has established?

11. What recommendations would you make to improve ESD performance?

QUESTION GUIDE FOR ESD/WASHINGTON

Program

1. What has been the strategy used within ESD to identify "best practices"?
2. We note that many of your field activities/programs (such as Burundi, the fistula project in Ethiopia, most of the best-practice projects implemented as a result of the Bangkok workshop) don't explicitly include increasing access to FP services at community level. Please tell us if increased FP service access is a side effect of these. If so, provide examples or discuss.
3. What have been your major challenges to increasing access to high-quality FP services in your field-based activities?
4. There was a best practices workshop in Asia—was there a reason this strategy wasn't used in sub-Saharan Africa?
5. What is the ESD plan for the corporate responsibility pilots? How are you documenting lessons learned and plans for sharing and expanding beyond Unilever?
6. Pathfinder has been a leader in establishing and supporting FP services at levels closer to clients for many years. Please describe how the LWA award has added value to Pathfinder's previous efforts related to ESD objectives.
7. What has been the process for measuring whether your strategy is having an impact in achieving increased HTSP?
8. How did the ESD project determine how much time and attention to pay to the different underserved populations identified in the RFA?

Management

1. Other than the items described in your self-evaluation, are there any other project design issues that should be addressed in this assessment, in order to improve the next year and future projects?
2. How have the GLP and TP Champions worked with the ESD project?
3. Discuss the ESD relationship with USAID/Washington. Can you identify any particular aspects that were most or least helpful?
4. How could USAID management be improved during the remainder and for future projects?
5. Discuss the ESD relationship with USAID Missions in the field. Can you identify any particular aspects that were most or least helpful?
6. After the difficulties of the first year that you describe in your self-evaluation, have there been any other significant challenges in working with your Consortium partners?
7. Can you discuss some of the pros and cons of the Associate Award funding managed at the field level—as they relate to achieving the ESD objectives?

QUESTION GUIDE FOR ESD PARTNERS (CONSORTIUM AND OTHERS)

Technical

1. There are many different global programs that have objectives to expand quality services related to RH/FP. These include RESPOND, ACCESS-FP, MCHIP, PROGRESS, and others. What do you think is the added value of the ESD project toward improving MCH and RH?
2. What strengths did your organization bring to the ESD project?
3. How has the ESD project interacted with your programs?
4. Do you have any comments on the process used by ESD for identifying best practices and for promoting their implementation? Please discuss some of the strengths and weaknesses of the process.
5. Are you familiar with ESD field implementation activities? If yes, are there any comments on particular activities that seem most promising for achieving ESD objectives of expanding implementation of best practices for RH/FP and increasing access to community-level RH/FP services and contraceptive methods?
6. Are you familiar with the materials ESD has developed, such as the country-specific brochures on HTSP, publications on HTSP, their review of documents and projects to identify the advantages of certain strategies (e.g., HTSP, working for corporate responsibility, addressing gender), online network and packages and tools?
7. The Bangkok meeting that discussed "best practices" and "promising" program strategies related to MNCH and integrated services resulted in follow-up in countries in Asia on activities they proposed to expand in their countries.
8. Are there underserved and high-risk groups that you think are not being adequately addressed where ESD might focus more attention?

Management

9. We understand that during the first year of implementation there were serious challenges in the work between Pathfinder and Consortium partners. After the difficulties of the first year have there been any other significant challenges in working with Pathfinder and the ESD project?
10. Were there any issues related to communication between your organization and ESD and USAID Missions that you want to discuss?

QUESTION GUIDE FOR USAID FIELD MISSION

Generic Technical

1. What has been the most significant contribution the ESD work has made toward your Mission fulfilling its objectives?
2. Has ESD been able to strike a balance in responding to Mission and Washington needs, recommendations, suggestions...and keeping its focus on its primary objectives, including increasing access to RH/FP services? Please give us some illustrative examples.
3. Can you identify any unique contributions related to the ESD work and increased use of contraception by underserved groups in your country?
4. There are many different global programs that have objectives to expand quality services related to RH/FP. These include RESPOND, ACCESS-FP, MCHIP, PROGRESS, and others. What do you think is the added value/niche of the ESD project toward improving MCH and RH?
5. Does the Mission identify underserved groups as a priority for health? What has ESD done to address the needs of underserved groups?
6. Are you familiar with the materials ESD has developed, such as the country-specific brochures on HTSP, publications on HTSP, ESD review of documents and projects to identify the advantages of certain strategies (e.g., HTSP, working for corporate responsibility, addressing gender), online network?
7. Are there any tools or practices that have been tested or used in your country that ESD may or may not know about, but that you think should be identified as potential best practices for scale-up and use by other countries?
8. What are your thoughts about the overall quality of the TA received from the ESD project?

Generic Management:

1. Have there been administrative or management issues about communication and implementation related to the ESD and coalition partners' work in your country? Please describe.
2. Are any GLP/TP Champions active in your country programs? Please specify.
3. Please discuss the ESD relationship with your Mission. Can you identify any particular aspects that were most or least helpful?
4. How would you recommend a future project be changed to facilitate Mission administrative tasks?
5. How could USAID management (either at Washington or mission-level) be improved during the remainder and for future projects?

APPENDIX F. DOCUMENTS REVIEWED

ESD MANAGEMENT DOCUMENTS:

ESD Project Monitoring & Evaluation Plan (December 2006)
USAID Request for Applications (RFA) for the Extending Service Delivery Project
Self-Evaluation of the ESD Project (February 2009)
Memoranda for ESD Management Reviews (May 2006 through December 2008)
Annual Workplans: 2005/2006–2008/2009

QUARTERLY REPORTS

ESD Vision: Technical Proposal (in response to the RFA)
Responses to Evaluation Surveys: Burundi, Guinea, Ethiopia, Tanzania

ESD TECHNICAL APPROACHES

Repositioning Family Planning
Family Planning Integration
Youth-Focused Reproductive Health and Family Planning Services (May 2006)
Family Planning for Women During the Postpartum Period: A Community Approach
A Comprehensive Approach To Postabortion Care
Displaced Populations

OTHER REFERENCE DOCUMENTS:

Advance Africa Results and Lessons Learned (2000-2005)

ANE BEST PRACTICES TECHNICAL ACTIVITY

Final Report from the Bangkok Conference
The ANE Country Teams' Action Steps Analysis
ANE Activity Updates e-newsletter: February 2009, September 2008, February 2008
Technical Presentations from the Meeting

DOCUMENTATION & DISSEMINATION OF BEST PRACTICES

Technical Briefs/Reports:

The TAHSEEN Model for Reaching the Urban Poor in Egypt

Summary Brief: The TAHSEEN Integrated Model

Private Nurse Midwives Networks (Clusters) in Kenya

Adaptation of the Bolivia Community Postabortion Care Model in Egypt and Peru

USAID AMKENI Integrated Model in Reproductive Health

Integrating HIV Service in Local Family Planning: The Zimbabwe Experience

Training Manuals:

Mobilizing Muslim Religious Leaders for RH/FP at the Community Level: A Training Manual

- Manual
- Annexes
- Handouts

Healthy Images of Manhood (HIM): A Training Manual
Postpartum Family Planning for Health Pregnancy Outcomes

Healthy Timing and Spacing of Pregnancy: A Trainer's Reference Guide (August 2008)

Best Practice Tools Series:

#1: Management and Organizational Sustainability Tool (MOST)

#2: Business Planning for Health

#3: Six Domains of Gender Analysis: An Analytical Tool

#4: Partnership-Defined Quality

Corporate Social Responsibility

Technical Briefs/Reports:

Effects of a Workplace Health Program on Absenteeism, Turnover, and Worker Attitudes in a Bangladesh Garment Factory (April 2007)

Effects of a Workplace Health Program in Bangladesh: A Presentation

Increasing Access to RH/FP Through Public/Private Partnerships in Guatemala:

Lessons Learned from APROFAM's Employer-Based Reproductive Health/Family Planning Services

Corporate Social Responsibility: Why Invest in Employee Health?

CSR in Africa: A Desk Study (March 2006)

Worksite Health Promotion Programs: Online Research

21st Century Corporate Social Responsibility: Advancing Family Planning and

Reproductive Health (June 2002)

Gender

Six Domains of Gender Analysis Country Program Documents

HTSP

Technical Briefs/Reports:

HTSP 101 Brief (English, French, Spanish)

HTSP Country Profiles: Afghanistan, Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Nepal, Pakistan, Philippines, West Bank/Gaza, Yemen

Report of a WHO Technical Consultation on Birth Spacing. World Health Organization, 2006.

Policy brief on Birth Spacing Report from a World Health Organization

Technical Consultation. WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safer. World Health Organization, 2006.

Conde-Agudelo, Agustin, Anyeli Rosas-Bermúdez, and Ana Cecilia Kafury-Goeta. "Birth Spacing and the Risk of Adverse Perinatal Outcomes: A Meta-analysis." *Journal of the American Medical Association (JAMA)* No. 295:1809-1823, April 19, 2006.

Conde-Agudelo, Agustin, José M. Belizán, and Cristina Lammers. "Maternal-Perinatal Morbidity and Mortality Associated with Adolescent Pregnancy in Latin America: Cross-Sectional Study." *American Journal of Obstetrics & Gynecology*, No. 192:342–349, February 2005.

DaVanzo, Julie, et al. "The Effects of Birth Spacing on Infant and Child Mortality, Pregnancy Outcomes, and Maternal Morbidity and Mortality in Matlab, Bangladesh." *British Journal of Obstetrics and Gynecology* 114(9):1079–1087.

DaVanzo, Julie, Lauren Hale, Abdur Razzaque, and Mizzanur Rahman. "The Effects of Pregnancy Spacing on Infant and Child Mortality in Matlab, Bangladesh: How They Vary by the Type of Pregnancy Outcome that Began the Interval." *Population Studies: A Journal of Demography*, 62, No.2:131–154, 2008.

Dewey, K.G., and R.J. Cohen. Birth-Spacing Literature: Maternal and Child Nutrition Outcomes. Paper prepared for the Academy for Educational Development and the CATALYST Consortium, 2004.

Tools:

HTSP brochures from Bayer-Schering/ESD Partnership

Patient brochure

Provider brochure

HTSP pocket guide (English, Arabic, Spanish, French)

HTSP Trainers' Reference Guide (English, French)

Strategy Documents:

HTSP Rollout Strategy

Meeting notes from HTSP brainstorming

The HTSP Core Group Meeting Proceedings and Presentations: May 2007, April 2009

HTSP Country Profiles: Pakistan, Nepal, Jordan, Indonesia, Yemen, West Bank Gaza, Philippines

Postpartum Care

Community-Based Postpartum Care Services in MotherNewBorNet Member Programs (October 2008)

Postpartum Family Planning for Healthy Pregnancy Outcomes: A Training Manual

Refugees/Displaced Persons

Technical Briefs/Reports:

Lessons Learned from Religious Leaders' Training in Dadaab Refugee Camp, Kenya

Refugee Knowledge and Attitudes Toward Gender-Based Violence: Assessment of ESD Project Outcomes in Kakuma Camp, Kenya. (April 2008)

Somali Refugee Attitudes, Perceptions, and Knowledge of Reproductive Health, Family Planning, and Gender-Based Violence Findings from Discussion Groups with Adult Men and Women, Youth, Religious Leaders, and Health Workers in Dadaab, Kenya. (May 2008)

Youth

Adolescents and the Impact of Early Pregnancy in Senegal: Results of a Gap Analysis and Recommendations to USAID/Senegal for Developing and Implementing Effective Adolescent Reproductive Health Programs. (November 2008)

Concept Paper: Supporting Post Abortion Care in Kenya and Tanzania through Dissemination of Youth Friendly PAC Technical Guidelines and PAC Global Resource Package. (December 13, 2007)

Promoting Healthy Timing and Spacing of Pregnancy to Young Married Women in Nigeria: A Collaboration Between the COMPASS Project and the Extending Service Delivery Project.

Youth-friendly post-abortion materials

YFPAC cue cards

Post-Abortion Care: Counseling Adolescent Clients

YFPAC Counseling Techniques

YFPAC Counseling Principles

Rights of the Client

YFPAC Pain Management

Guinea

ESD in Guinea Overview

Project Monitoring and Evaluation Plan and Description

Quarterly Reports

Strategic Objective Grant Agreement

ESD Guinea Compliance Plan

Memoranda of Understanding between ESD/Guinea and JHPIEGO/ACCESS-FP

Kenya

APHIA II North Eastern Province (NEP) Program Description
APHIA Workplans

Bi-weekly Technical Updates

Quarterly Reports

Technical Reports:

- Kenyan Sexual Networks Assessment
- Islam and Health Conference Report Complete
- Islam and Health Conference Report four-page Executive Summary

Tanzania

UTT Peer Health Educator Reports

Report of ESD Strategic Mapping Team on Key Findings to Unilever Tea Tanzania Ltd. (May 2007)

Community Action Cycle (CAC) Training For Peer Health Educators. (September 2008)

Healthy Images of Manhood: A Facilitator Training Manual to Improve Men's Roles in Health Programs at Unilever Tea Tanzania. (January 2009)

Interview Notes as prepared by Participatory Assessment Team Members

APPENDIX G. PERSONS INTERVIEWED

Name	Country	Organization	Title
Dr. Goma Onivogui	Guinea	Ministry of Health and Public Hygiene	National Director
Dr. Sidhati	Guinea	Ministry of Health and Public Hygiene	Director of Family Planning/Reproductive Health
Dr. Maurice Cécé Goa	Guinea	Ministry of Health and Public Hygiene-Health Region in Faranah	Regional Director
Dr. Mariama Cire Bah	Guinea	USAID/Guinea	Reproductive Health Specialist
Steve Edminster	Guinea	USAID/Guinea	Technical Office Team Leader
Dr. Pogba Prosper Theoro	Guinea	Project Faisons Ensemble	Health and Governance Counselor
Dr. Baillo Barry	Guinea	Project Faisons Ensemble	Manager of VCT
Dr. Aissata Fofana	Guinea	Project Faisons Ensemble	Senior Health Advisor
Mohamed Elkebir Basse	Guinea	TOSTAN-Guinee	National Coordinator
Ibrahim Bangoura	Guinea	TOSTAN-Guinee	Regional Coordinator for Lower Guinea
Dr. Mamadou Aliou Diallo	Guinea	Association Guinéenne Pour le Bien-Etre Familial (AGBEF/International Planned Parenthood Federation (IPPF))	M&E
Jean Gossaga Aly Kourouma	Guinea	Association Guinéenne Pour le Bien-Etre Familial (AGBEF/IPPF)	Chief of Marketing Division
Dr. Robert Sarah Tambalou	Guinea	Association Guinéenne Pour le Bien-Etre Familial (AGBEF/IPPF)	Executive Director
Cécé Célestin Goumou	Guinea	Plan International-National Bureau Kissidougou	Chief of PFISR Project
Dr. Phillip Onyebujoh	Guinea	WHO	Leader of Evidence for Treatment of TB/HIV, Special Programme for Research & Training in Tropical Diseases
Dr. Mamadou Cissé	Guinea	WHO	National Administrator of the Development of Health Services
Dr. Moussa Koré	Guinea	WHO	Community Based Activities

Name	Country	Organization	Title
Dr. Sekou Yalani Camara	Guinea	Ministry of Health and Public Hygiene-Health Region in Dabola	Director of Health Prefecture-Dabola
Dr. Yattara Osmaue	Guinea	Ministry of Health and Public Hygiene-Health Region in Dabola	Doctor in charge of Prevention
Dr. Ibrahima Pita Bah	Guinea	ESD	Counselor of Community Activities
Dr. Thierno Mariama Barry	Guinea	ESD	Clinical Counselor
Dr. Yero-Boye Camara	Guinea	ESD	Project Director
Dr. Marleyatou Diallo	Guinea	ESD	Regional Coordinator of Faranah
Oumar Bailo Diallo	Guinea	ESD	Data Entry Assistant/IEC Responsible
Jacqueline Arobot	Guinea	ESD	M&E specialist
Thierno Amadou Bah	Guinea	ESD	Head of finance
Aicha Toure	Guinea	ESD	Administrative Assistant
Foromo Beavogui	Guinea	ESD	Finance Assistant
Dr. N'Faly Bangoura	Guinea	Ministry of Health and Public Hygiene-Health Region in Faranah	Provincial Health Director
Jean Baptiste Kamano	Guinea	Ministry of Health and Public Hygiene-Health Region in Faranah	Community Based Activities
Ibrahim Sory Diallo	Guinea	Ministry of Health and Public Hygiene-Health Region in Faranah	Statistics
Justine Kowrouma	Guinea	Banko Health Center	Nurse
Abdoul Gaotiry Balde	Guinea	Banko Health Center	Chief of Health Center
Pierre Yomba Leno	Guinea	Banko Health Center	Community Agent Supervisor/Nurse
Dr. Julitta Onabanjo	Tanzania	UNFPA	Representative
Rita Badiani	Tanzania	Pathfinder International	Regional Advisor
Dr. Romuald Mbwasi	Tanzania	MSH/Tanzania	Senior Technical Advisor
Dr. Pasiens S. Mapunda	Tanzania	Pathfinder/Tanzania	Deputy Country Representative

Name	Country	Organization	Title
Grace Lusiola	Tanzania	EngenderHealth	Chief of Party
Feddy Mwanga	Tanzania	ACQUIRE	Technical Director
Dr. Sarah J. Maongezi	Tanzania	MEWATA (Medical Women Association of Tanzania)	Executive Director
Dr. Marina A. Njelekela	Tanzania	MEWATA	Chairperson
Charles Llewellyn	Tanzania	USAID/Tanzania	Health and Population Team Leader
Andrew C. Mitei	Tanzania	Unilever Tea Tanzania Limited	Operations Director
Dr. Mmbaga	Tanzania	Unilever Tea Tanzania Limited	Director of the Lugoda Hospital and the Unilever Health System
Dr. Ana	Tanzania	Unilever Tea Tanzania Limited	Head of Care and Treatment Center
Dr. Nchimbi	Tanzania	Unilever Tea Tanzania Limited	Assistant Medical Officer
Ms. Eva Kiwovele	Tanzania	Unilever Tea Tanzania Limited	Assistant Matron Lugoda Hospital
Dr. [name uncertain]	Tanzania	Unilever Tea Tanzania Limited	Doctor at Lugoda Hospital and the Unilever Health System
Albert Mwakalambile	Tanzania	Unilever Tea Tanzania Limited	Peer Educators Coordinator
Head of Factory	Tanzania	Unilever Tea Tanzania Limited	Head of Kilima Factory
Dr. [name uncertain]	Tanzania	Unilever Tea Tanzania Limited	Head Doctor for the Kilima Factory Hospital
Karen Klimowski	Kenya	USAID/Kenya	PHN officer, Office of Population and Health (OPH)
Bedan Gichanga	Kenya	USAID/Kenya	Health Management Systems Specialist, OPH
Dr. Kimani Mungai	Kenya	IntraHealth	Country Director
David Adriance	Kenya	ESD	APHIA II NEP
Daraus Bukenya	Kenya	MSH	Global Technical Lead for AIDS and TB
Dr. Omar A. Omar	Kenya	Ministry of Public Health and Sanitation	Assistant Director of Medical Services
Dr. Yusef Guled	Kenya	Ministry of Public Health and Sanitation	Provincial Director of Medical Services

Name	Country	Organization	Title
Dr. Osman Warfa	Kenya	Ministry of Public Health and Sanitation	Provincial Director of Public Health and Sanitation
Dr. Noor Seikh	Kenya	Ministry of Public Health and Sanitation	Provincial arm of National AIDS/STI Control/NASCOP
Peter Onyancha & Roy Meoly	Kenya	National Organization of Peer Educators (NOPE)	Associate Program Officer, Training Officer
15 people	Kenya	ESD-Garissa Staff	APHIA II NEP staff
3 people	Kenya	Supreme Council of Kenya Muslims	Religious Leaders
Director, nurses, and medical director	Kenya	Provincial General Hospital: Sisters Maternity Home (SIMAHO)	
30 women and 3 men	Kenya	Mwangaza (People Living with HIV/AIDS group)	
2 people	Kenya	Al-Farouq orphanage	Religious Leaders
	Kenya	Moonlight VCT center	
Mengistu Asnake	Ethiopia	ESD	Project Director
Tilahum Gyday	Ethiopia	ESD	Deputy Director
Tanou Diallo	Burundi	ESD	Project Director
Hirondiana Cucupica	Angola	ESD	Project Director
Hamouda Hanafi	Yemen	ESD	Project Director
Saud Qassam Saleh	Yemen	ESD	Deputy Director
Cathy Solter	Boston	Pathfinder	Senior Advisor
Caroline Crosby	Boston	Pathfinder	Senior Vice President
Victoria Jennings	DC	Georgetown	Project Director
Laura Raney	DC	Georgetown	Communications Director
Diana Silimperi	Boston	MSH	Vice President of Health Services
Steve Redding	Boston	MSH	Technical Advisor for HIV
Godfrey Sikipa	Boston	MSH	Director of Health Services Delivery
Betsy	DC	White Ribbon Alliance	Senior Advisory

Name	Country	Organization	Title
McCallon			
Pape Gaye	NC	Intrahealth	CEO
Maureen Corbett	NC	Intrahealth	Senior Vice President
Vickie Baird	DC	Meridian International	CEO
Pat Daly	DC	Save the Children	Deputy Director
Koki Agarwal	DC	JHPIEGO-MCHIP	Project Director
Cat McCaig	DC	ACCESS-FP	Project Director
Susan Zimicki	DC	C-Change	Project Director
Stephanie Lazar	Burundi	USAID	Program Manager
Lisa Childs	Egypt	USAID	Program Manager
George Sanad	Egypt	USAID	Program Manager
Linda Kentro	Nepal	USAID	Program Manager
Anne Peniston	Nepal	USAID	PHN Officer
Monique Mosolf	India	USAID	PHN Officer
Bart Bruins	Angola	USAID	PHN Officer
Iman Awad	Yemen	USAID	PHN Officer
Maureen Norton	DC	USAID/Washington	COTR of ESD
Rushna Ravji	DC	USAID/Washington	Technical Advisor of ESD
Carolyn Curtis	DC	USAID/Washington	COTR of RESPOND, PAC Champion
Trish MacDonald	DC	USAID/Washington	TA of RESPOND, LAPM and FP/MNCH Integration Champion
Victoria Graham	DC	USAID/Washington	Flex Fund
Mary Ann Abetya-Behnke	DC	USAID/Washington	FP/HIV Integration Champion
Dana Vogel	DC	USAID/Washington	Division Chief of PRH/SDI
Patricia Stephenson	DC	USAID/Washington	COTR of PROGRESS
Nahed Matta	DC	USAID/Washington	COTR of MCHIP
Gary Cook	DC	USAID/Washington	ANE Senior Health Advisor

Name	Country	Organization	Title
Jim Shelton	DC	USAID/Washington	Senior Medical Advisor
Jeff Spieler	DC	USAID/Washington	
Ellen Starbird	DC	USAID/Washington	Deputy Director of PRH Office
Scott Radloff	DC	USAID/Washington	Director of PRH Office
Mihal Avni	DC	USAID/Washington	Gender Champion
Diana Prieto	DC	USAID/Washington	Gender Champion
Milka Dinev	DC	ESD	Project Director
Fabio Castano	DC	ESD	Technical Director
Carla White	DC	ESD	M&E Advisor
May Post	DC	ESD	Senior Reproductive Health Advisor
Cate Lane	DC	ESD	Youth Advisor
David Wofford	DC	ESD	Senior Commercial Sector Advisor
Jeanette Kesselman	DC	ESD	Capacity Building and Sustainability Advisor
Pauline Muhuhu	DC	ESD	Best Practices Advisor
Leah Freij	DC	ESD	Gender Advisor
Kristen Stolka	DC	ESD	Program Officer
Alana Hai'slon	DC	ESD	
Shannon Pryor	DC	ESD	Program Officer
Maija Kroeger	DC	ESD	Communications Officer
Maribel Diaz	DC	ESD	Senior Program Officer
Caroline Tran	DC	ESD	
Maggie Usher	Switzerland	WHO	Sr. Reproductive Health Advisor
Suzanne Reiers	Switzerland	WHO (USAID seconded)	Sr. Reproductive Health Advisor

APPENDIX H: EXISTING TOOLS FOR P/BP

Existing Tools Identified as Promising or Best Practices (P/BP)			
Name of Tool	Subject	Originator	Description of Practice/Strategy
Community Action Cycle (CAC)	Community planning	Save the Children (SC)	Community planning for change.
Positive Deviation/Hearth	Community behavior change	SC	Promoting behavior change in community by identifying model households for practices desired.
Corporate Social Responsibility (CSR) Toolkit	CSR	CATALYST Project	NGO-corporate partnership model for training community-based NGOs to provide sustainable health services to underserved populations.
Business Planning for Health	Organizational Development (OD)	Management Sciences for Health (MSH) and PROCOSI, an NGO network in Bolivia	Enables organizations to systematically assess their existing services and products and their management systems and organizational practices. The program focuses on crafting business plans that introduce new products and services that are truly demand-driven.
Management and Organization Sustainability Tool (MOST)	OD	MSH	Structured, participatory process that allows organizations to assess their own management performance, develop a concrete action plan for improvement, and carry out their plan.
Reproductive Health in Refugee Situations: An Inter-Agency Field Manual	Refugees	Reproductive Health Response in Conflict Consortium (RHRC)	Issues related to RH needs and providing RH services in the refugee setting.
Raising Voices Best Practice, Domestic Violence: A Training Process for Community Activists	Gender	Raising Voices/Center for Domestic Violence Prevention	Adapted for Somali refugee setting with UNHCR input.
Six Domains of Gender Analysis An Analytical Tool	Gender	Cultural Practice for InterAgency Gender Working Group	Identifies six areas in which gender can be analyzed and enables users to identify and systematically assess gender considerations in each of these areas.
A Guide for Fostering Change to Scale Up Effective Health Services	Change and scale up	MSH/IBP	This guide links effective change practices with proven clinical and programmatic practices to achieve results by: (1) increasing awareness of proven approaches to effective change; (2) describing principles that are fundamental to effective change;(3) providing “how-to” steps for successful change; (4) describing key challenges related to the steps and recommending strategies, tools, or approaches for meeting those challenges; and (5) offering cases that show how the steps

Existing Tools Identified as Promising or Best Practices (P/BP)			
Name of Tool	Subject	Originator	Description of Practice/Strategy
			have been implemented in real situations.
Improved Collaborative Approach for Scaling up Best Practices	Service quality	URC	Quality Improvement intervention that introduces a shared technical package and quality improvement methods in similar health facilities at the same time.
Performance Assessment Improvement (PAI) and Health Watch Framework	Service quality	MSH	
Partnership Defined Quality (PDQ)	Service quality through community involvement	SC	PDQ engages communities and health care providers to work together in defining, implementing, and monitoring activities intended to improve the quality of care.
Balanced Counseling Guide	Service quality	Population Council	
Family planning service checklists	Service quality	FHI	
WHO Providers FP Pocket Guide	Service quality	WHO	
Community-based M&E	M&E	World Bank	CBME is intended to fit into participatory rural approaches. Steps to its implementation include: (1) prepare, (2) introduce M&E concept to community, (3) develop community M&E work program, (4) monitor development activities, and (5) evaluate and re-appraise local development.
Community mapping tools	M&E	MSH	*Radar de Gestantes (Surveillance tool for pregnant and PP women); PF Community Mapping Training: A Trainer's Guide (MSH REACH)*
Project H	Gender	Institute Promundo	Designed to help young men critically reflect on and challenge traditional gender norms and existing definitions of masculinity. Specific sections adapted for working with peer health educators in Tanzania.
Men as Partners	Gender	EngenderHealth	Participatory health education initiative to constructively engage men in RH and HIV.
DOCUMENTED IMPLEMENTATION MODEL			
Integrating HIV Services in Local Family Planning: The Expanded Community-Based Distribution Model and Zimbabwe Experience	Integrated community-level HIV and FP services	Advance Africa	Demonstrates that work of community-based distributors can be expanded to include HIV/AIDS prevention and referral without undermining performance in FP method distribution. Modifications to referrals and supervisory systems…[contributed to]… quality assurance…strategy includes financial and technical assistance.

Existing Tools Identified as Promising or Best Practices (P/BP)			
Name of Tool	Subject	Originator	Description of Practice/Strategy
TAHSEEN Model for Reaching the Urban Poor Integrated Multisectoral Family Planning Model: A Movement to Enable Adoption of Healthier RH/ FP Behaviors (Technical Brief)	Integrated community-based postpartum care; post-abortion care; birth spacing; mobilizing community outreach workers.	Catalyst Project	Focus at the community, district, and governorate levels for sequenced set of mutually reinforcing activities including clinic renovations, technical and management training, and community mobilization. Focus at the central level, primarily with MOHP, to institutionalize policies and systems for sustainability. Four packages for an integrated approach to RH/FP services covering partnership, capacity building, supervision, and service access.
AMKENI Integrated Model in Reproductive Health Programming in Kenya	FP/HIV integration	EngenderHealth	Increase access to and quality of RH/FP/CS services, including HIV/AIDS prevention services. (1) Improve the capacity of health facilities to provide RH/FP/CS services—including HIV/AIDS-related services; (2) work through communities fostering preventive health care-seeking behavior and community groups in order to create a supportive environment for change; and (3) strengthen the Ministry of Health's (MOH) decentralized training and supervisory systems (DTSS) for RH service providers and facilitate the application of the performance improvement approach.
Private Nurse Midwife Network Clustering System	Midwives networks and provision of PAC	IntraHealth	A model that emphasizes the importance of peer support systems in improving provider quality of care. • Membership by choice • Business approach to the development and management of networks • Good governance • Adherence to membership standards • Recognition by government agencies responsible for technical services, community organization, and administration • Linkages and ongoing interaction with other service providers of crucial community services • Innovations to maximize access and utilization of community resources.
TAKAMOL		ESD identified this as a P/BP but did not receive agreement from TAKAMOL or USAID Egypt for documenting the model.	Takamol multisectoral and integrated model, its scale-up, adoption, replication, and effectiveness in increasing and sustaining access to and use of RH/FP/MCH services by underserved populations in Egypt.
Post-Abortion Care Synthesis paper	PAC	*Adaptation of the Bolivia Community Post-Abortion Care Model in Egypt and*	Documenting three successful applications of community PAC mobilization.

Existing Tools Identified as Promising or Best Practices (P/BP)			
Name of Tool	Subject	Originator	Description of Practice/Strategy
		Peru	
Other BP interventions identified			
Improving provision of IUDs through four programmatic changes	LAPM	USAID BP packages	Provide IUDs to nulliparous women; provide IUDs as an option for HIV-positive women; eliminate provision of prophylactic antibiotics before IUD insertion; and reduce follow-up visits to one visit. Incorporating this BP may help reduce unintended pregnancies among HIV-positive women and free providers' time.
Broadening the method mix by adding the Standard Days Method (SDM)	SDM	USAID BP packages	
Systematic screening of clients to improve health service integration	Integration of FP	USAID BP packages	Guide providers in assessing the needs of clients and ensuring that they receive all the appropriate services for themselves and their children.

APPENDIX I. SUMMARY OF PROGRAMMATIC EXCHANGES ACTIVITIES

Programmatic Exchanges	
Summary of contents	**Follow-on activities**
FP/MNCH Best Practices in Asia and the Near East • Meeting Bangkok 2007 • A total of 18 countries from the USAID-defined Asia/Middle East (AME) region were represented. Participants included WHO, UNFPA, USAID country Mission and Washington personnel, CA representatives, donors, country team members from local NGOs, and CAs with country presence, in addition to MOH and other national decisionmakers.	Follow-on activities • Thirteen country teams submitted proposals as a result of the Bangkok PE, and five received ESD tier one awards up to US$50,000 each (India, Indonesia, Nepal, Yemen and Egypt). Four additional second tier awards through ESD have been started. • Leveraged funding is promising. Follow-on grant funds were leveraged from WHO (Pakistan, Afghanistan, and Jordan) and TA support from WR (five countries) to support country-level implementation. Follow-on TA funded by the different organizations was provided through URC, WHO, WR, and FHI.
FP/HIV Integration • Meeting Washington DC 2006 • Sponsored by USAID • MOHs and U.S.-based NGOs/USAID, WHO, e-participation	Follow-on activities uncertain
Symposium on NGO-Corporate Public Sector Partnerships • Tanzania October 2006 • Sponsored by ESD and the Global Business Coalition (GBC) on HIV/AIDS, Tuberculosis and Malaria • Around 70 participants; 40 organizations; eastern and central Africa, corporations, NGOs, national governments • Leveraged funding: $25,000 related to workshop and $45,000 from UTT for UTT activities • Action plans developed by 35 organizations	Follow-on activities • Unilever Tea Tanzania (UTT) requested partnership to improve male responsibility and behavior related to RH/FP. • Leveraged $6,700 for $45,000 from UTT for training and work-related costs of existing peer health extension workers. • Social Investment Coalition (SIC), a working group of 15 Tanzanian corporations, associations, and NGOs established. The Medical Women Association of Tanzania (MEWATA) serves as Chair of the SIC.

Programmatic Exchanges	
Summary of contents	**Follow-on activities**
	• PF Tz held follow-up brainstorming meeting (December 2006) with 11 participants on Saving Mothers' Lives and Youth HIV/AIDS/ RH and Livelihoods. • ESD TA to develop a program to improve healthy motherhood and reduce maternal mortality in Tanzania. • SIC leveraged $25,000 from UNICEF to conduct an assessment of the corporate social responsibility (CSR) environment and the potential for social investment partnerships in Tanzania.
Community-based family planning • Mali June 2007 • Sponsored by IBP/MAQ (ESD is a member) in collaboration with WHO/AFRO, FLEX Fund, and the Population Council • Around 60 participants; five countries (Cameroon, Ethiopia, Ghana, Madagascar and Mali); teams composed of key government officials, NGO representatives, USAID, MOH, UNFPA • Country teams developed plans of action for the following 12 months, ESD selected Ethiopia to provide follow-up TA (for health extension workers).	Follow-on activities The teams developed plans of action for the following 12 months, articulating gaps requiring targeted technical assistance to strengthen further scale-up. ESD selected Ethiopia to provide follow-up TA, focusing on factors that facilitate well-performing Health Extension Workers and how they successfully integrate RH/FP into service delivery. Countries: Cameroon, Ethiopia, Ghana, Madagascar, and Mali.
PAC • Senegal October 2008 • Sponsored by West Africa PAC Conference • Around 120 participants from Guinea, Mali, Togo, Rwanda, Senegal, Niger, and Burkina Faso • ESD's youth-friendly PAC, HTSP, and RL materials were distributed to conference participants.	Follow-on activities • Guinea MOH participant (sponsored by ESD) has moved forward to scale up PAC in Guinea, with most prefectures now having PAC action plans. • ESD is working with the Guinea delegation to facilitate the expansion of PAC in Guinea.

APPENDIX J. DOCUMENTS PRODUCED TO INFORM PROGRAMS

Formative Studies and Review Documents to Inform Programs		
Program/Study Populations	**Topic**	**Study Dates**
Study Kenya/Refugee camps	Somali Refugee Attitudes, Perceptions, and Knowledge of Reproductive Health, Family Planning, and Gender-Based Violence	Release: 2007
Study Kenya/Refugee camps	Refugee Knowledge and Attitudes Toward Gender-Based Violence: Assessment of ESD Project Outcomes in Kakuma Camp, Kenya, April 2008	Study: March–November 2007 Release: 2008
Literature review Refugees and DPs	Promising and Best Practices for Extending RH/FP Services to Refugees and Displaced Populations	Draft concept paper: April–June 2006
Literature review Conflict areas	Peacekeeping and Reproductive Health: An Opportunity for Innovative Action	Concept paper: July–September 2006
Literature review Refugees/displaced persons	Compilation of Tools, Programs, and Guidelines on RH/FP Service Delivery to Refugees and Displaced Persons (background document)	Concept paper: July–September 2006
Literature review Refugees/displaced persons and CSR	CSR Strategies for strengthening partnerships with DPs/refugees (hold for infeasibility)	Draft concept paper: July–September 2006
Multi-country document review Integration FP and HIV	Community-based FP-HIV integration model applicable to different settings (e.g., PMTCT, VCT, home-based care, etc.) (draft)	April–June 2006
Study Kenya NEP Nomadic/refugee populations	Sexual Network Assessment (Kenya NEP)	
Study CSR Bangladesh	Effects of a workplace health program on absenteeism, turnover, and worker attitudes in a Bangladesh garment factory	Intervention 2004–2006 Study: 2006 Release: April 2007

Formative Studies and Review Documents to Inform Programs		
Program/Study Populations	**Topic**	**Study Dates**
Study South Sudan refugees/displaced persons	Reproductive Health/Family Planning Service Provision for Returning Populations to South Sudan: Assessment Findings & Recommendations	Draft: July–September 2006
Study Multi-country-PP care	Community-Based Postpartum Care Services in MotherNewBorNet Member Programs	Study: 2007 Release: 2008
Document review CSR in Africa	HIV/AIDS Workplace Programs in Africa	2006
Study CSR Tanzania	Report of ESD Strategic Mapping Team on Key Findings to Unilever Tea Tanzania Ltd., May 2007	2007
FP and HIV Strategy document (literature review)	Integrating Family Planning into HIV-AIDS Prevention, Care and Treatment Services at the Community Level. Lessons learned on FHI's experience implementing FP-HIV integration programs at the community level (e.g., Kenya and South Africa) and incorporate and use findings to strengthen application of ESD's FP/HIV/AIDS integration strategy	Draft: December 2007
BP documentation (Study)	Updated TAHSEEN 4 BP documents with new household survey results: *Integrated Community-Based Postpartum Care; Postabortion Care; Birth Spacing; Mobilizing Community Outreach Workers*	2007
Repositioning FP	Review of Family Planning Policies and Programs in Africa, a Summary Brief. The abstract summarizes research findings of an analysis of the enabling and disabling factors to supporting FP efforts in 10 African countries following the ratification of the 2005–2014 WHO/AFRO Framework for Accelerated Action.	2007
FP and HIV (literature review, interviews, and programmatic experience)	Programmatic Considerations for Strengthening the Integration of Family Planning and HIV Service Delivery Programs	

APPENDIX K. PEER-REVIEWED PUBLICATIONS

Conde-Agudelo, Agustin, Anyeli Rosas-Bermúdez, and Ana Cecilia Kafury-Goeta. "Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-analysis." *Journal of the American Medical Association (JAMA),* No. 295:1809–1823, April 19, 2006.

Conde-Agudelo, Agustin, Anyeli Rosas-Bermúdez, and Ana Cecilia Kafury-Goeta. "Effects of Birth Spacing on Maternal Health: A Systematic Review." *American Journal of Obstetrics & Gynecology*, No. 196:297–308, April 2007.

DaVanzo, Julie**,** Lauren Hale, Abdur Razzaque, and Mizanur Rahman. "Effects of Interpregnancy Interval and Outcome of the Preceding Pregnancy on Pregnancy Outcomes in Matlab, Bangladesh." *British Journal of Obstetrics and Gynecology*, July 6, 2007.

"Achieving Healthy Pregnancy Outcomes Through Healthy Timing and Spacing of Pregnancies." *Pop Reporter, 7, No. 15, April 30, 2007,* guest editorial.

"The Effect of Birth Spacing on Infant and Child Mortality: A Systematic Review and Meta-Analysis." *The Lancet*, 2008.

APPENDIX L. MATERIALS DEVELOPED BY ESD

Materials Developed by ESD			
Key issue	**Training Manuals**	**Type**	**Contributing Documents**
Barriers Religious leaders (RL)	Training Curriculum for Mobilizing and Building the Capacity of Religious Leaders as Champions of Reproductive Health & Family Planning	Training Manual	Scale-up of TAHSEEN Religious Leaders Model. Added modules on community development and leadership.
Barriers Gender	Healthy Images of Manhood (HIM). A Facilitator Training Manual to Improve Men's Roles in Health Programs at Unilever Tea Tanzania (UTT)	Training Manual	Instituto Promundo's *Project H-Working with Young Men Series; Raising Voices Rethinking Domestic Violence: A Training Process for Community Activists; EngenderHealth Men as Partners: A Program for Supplementing the Training of Life Skills Educators; Family Health International Tanzania Bringing Program H to Tanzania: Adapted Manual for Field Testing; ACQUIRE Project/EngenderHealth and Instituto Promundo Group Educational Manual. Added modules on* RH/FP.
PP/FP and HTSP	Postpartum Family Planning for Healthy Pregnancy Outcomes (February 2009): A Training Manual for Health Service Providers	Training Manual	
HTSP	HTSP Trainers' Reference Guide (and toolkit)	Training Manual	
HTSP	HTSP pocket guide	Guideline	
CB/PP/FP	Includes *CBPP FP Trainers Notebook* and *CBPP FP Counseling Reference Booklet* to create a complete *CBPP FP Trainers Reference Guide*	Trainers reference guide	ESD, ACESS-FP, GU/IRH (Yemen, Guatemala).
Refugees/ IDPs	RH/FP training manual for refugee community health workers	Training manual	Reproductive Health for Refugees Consortium (RHRC) and CARE training curriculum, *Moving from Emergency Response into Comprehensive RH/FP Programs.*

APPENDIX M. PRESENTATIONS/PARTICIPATION IN GLOBAL FORUMS

Date	Venue	Organizer	Topic
2006	USA	USAID	Reproductive Health and Family Planning in the 21st Century: Reaching Further, Congressional Briefing
2006	USA	GHC and MSH	RH/FP Interventions for Fragile State Settings (participant)
2006	USA	GHC	Roundtable on Repositioning FP
March 2006	Egypt	WHO/UNFPA	Participant. Purpose of the meeting was to examine progress made in the implementation of the Strategic Partnership Program for the introduction of maternal and neonatal health, family planning, and STI guidelines in participating countries (Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan, Syria, and Yemen).
July 2006	India	MotherNewBorNet Annual Meeting	Community-Based Postpartum Care 3 plus model (TAKAMOL) and Healthy Timing and Spacing of Pregnancies for Improved Maternal and Newborn Health.
October 2006	USA	Healthy Women Healthy Economies Health Services Roundtable (Global Business Coalition (GBC) on HIV/AIDS and its Healthy Women Healthy Economies initiative and the David and Lucile Packard Foundation)	Current business approaches to HIV workplace programs, business solutions for integrating women's health services into the fight against HIV/AIDS.
May 2006	Thailand	USAID ANE Bureau's Regional Anticorruption Workshop	Health Sector Anti-Corruption Efforts and the TAHSEEN Experience (CATALYST/Egypt multisectoral, community-based model with a focus on anti-corruption and good governance). Presented tools for measuring results: Democracy & Governance (D&G) Checklist for Health Programs, D&G Indicators for Health Programs.
May 2006	Tanzania	Regional Forum on Youth, RH, and HIV	Community mobilization for adolescent reproductive health (ARH). Hosted roundtable with Brian Kayongo of Adolescent Reproductive Health Advocates in Zambia.
2006	Senegal	Annual Meeting of World	Chaired the symposium on Repositioning

Date	Venue	Organizer	Topic
		Bank Institute RH Training Institutions Network. "XVIèmes Journées Médicales, Pharmaceutiques, Odontologiques, et Vétérinaires—Morbidité et Santé"	FP; (1) participated in the francophone PAC/IBP network meeting coordinated by Centre de Formation et de Recherche en Santé de la Reproduction (CEFOREP); (2) Met with representatives of the Pan African Parliamentarians group which includes 5 representatives from 48 African countries.
February 2007	Bali	International Conference of Muslim Leaders to Support Population and Development to Achieve the Millennium Development Goals (MDGs)	ESD experience with scaling up the TAHSEEN RL model. "Building Momentum for MCH/RH/FP Programming Through Religious Leaders," and introduced HTSP, Commercial Sector (NGO-corporate partnerships) and the Integrated, Multisectoral Approach into the final Sanur-Bali Declaration, which states participants' commitment to continue to support RH/FP in their respective countries (124 RL from 17 different countries). The conference aimed to revitalize the support of Muslim leadership for RH/FP, gender equity, and women's empowerment globally.
September 2007	DRC	9th Congress of the Society of African Gynecologists and Obstetricians (SAGO)	Pregnancy Spacing and Newborn and Maternal Health: Using New Findings to Achieve Healthy Pregnancy Outcomes (HTSP). Approximately 100 physicians from Anglophone and Francophone Africa.
2007	Tanzania	Mewata Scientific Technical conference	HTSP
2007	Thailand	Scaling up High Impact Family Planning and Maternal, Newborn, and Child Health Best Practices in Asia and the Near East	Chaired and presented (HTSP); introduced best practices models in NGO-Corporate Partnerships.
2007	Tanzania	East Central and Southern Africa Health Community (ECSA)	Best practices presented of the ESD-documented Kenya Private Nurse Midwives Network-a peer support system; 14 countries participated from the ESC region.
June 2007	Mali	CB FP IBP/MAQ	Collecting information on two CB FP best practices such as the *Ethiopia Health Extension Program* and the *Ghana Community-Based Health Planning and Service (CHPS) Program*. Disseminated information on select BPs and ESD's HTSP Pocket Guide; ESD's partners' Tools Series; ESD Summary Briefs; and the two DVDs, *Expanded Community-Based Distribution Model: Zimbabwe*

Date	Venue	Organizer	Topic
			Experience, and *TAHSEEN Integrated Multisectoral Family Planning Model, Egypt experience.*
2007	USA	Businesses for Social Responsibility Conference	Led a video session to showcase the Zimbabwe Expanded CBD Program, *Expanded Community-Based Distribution Model: Zimbabwe Experience.*
June 2007	USA	Global Health Council	Co-facilitated with MSH a training session on the use of the IBP *Guide for Fostering Change*; Return on Investment (ROI) study, The Benefits of Investing in On-site Health Services: Effect on Employee Absenteeism, Turnover, and Attitudes in a Bangladesh Garment Factory, Health-Care Workers: Meeting the Human Resource Challenge.
December 2007		5th African Population Conference	Review of Family Planning Policies and Programs in Africa
2008	USA	Global Health Council	• Co-facilitated with USAID and WHO/Geneva a workshop titled "From Local to Global: Scaling up Community-based Programs to Strengthen Health Systems" at the Global Health Council Conference (follow-up to the Mali workshop on CB RH programs held June 2007 and the ANE Technical Meeting held in Bangkok in September 2008). This highlighted the approaches and components of CB RH/FP programs, applied in Ethiopia, Madagascar, Mali, and Pakistan to successful scale-up, applying the Fostering Change guide. Over 80 participants attended. • Presented "Beliefs and Practices in RH/FP/GBV among Somali and Sudanese Refugees" in a panel session titled *Battle Zone: Reproductive Health of Challenged Populations in Conflict and Refugee Settings*. • Presented "Community Mobilization: Post Abortion Care in Bolivia, Peru and Egypt" in a panel session titled *Attitude and Access: Abortion and Post Abortion Care*. • Moderated *Transforming Communications about*

Date	Venue	Organizer	Topic
			Reproductive Health panel session.
April 2008	S Africa	Countdown 2015 Meeting	How family planning can help achieve MDGs 4 and 5. Around 400 participants, including Ministers of Health, UNFPA, WHO, and NGO/CAs.
2008	Vietnam	Health Enables Returns (HER project) Stakeholder Convention	ROI
2008	Bangladesh	H&M.KappAhl suppliers workshop	ROI
2008	USA	Global Health Council	How family planning can help achieve MDGs 4 and 5.

APPENDIX N. PRESENTATIONS/PARTICIPATION IN USAID AND PROJECT-RELATED GROUPS AND MEETINGS

Presentations to USAID and U.S.-Based Technical Working Groups			
Date	**Venue**	**Organization**	**Topic**
May 2006	USA	Contraceptive Security Working Group	Contraceptive Security Workshop: Reviewing Experience and Identifying Next Steps
June 2006	USA	Post-Abortion Care (PAC) Consortium meeting	Community Mobilization Around PAC: Bolivia, Peru, and Egypt
June 2006	USA	USAID	How Can RH/FP Programs Contribute to Democracy and Governance? (presentation)
2006	USA	Sustainability Action Group (SAG)	Sustaining RH/FP Programs (participant)
2006	USA	UNFPA Adolescent Reproductive Health Inter-agency Working Group	Develop a conceptual framework for promoting, implementing, and evaluating community involvement's effect on adolescent reproductive health programming (participant)
October 2006	USA	USAID/MAQ	IntraHealth Private Nurse Midwives Network (Cluster) in Kenya model
2006	USA	IUD Working Group	TAHSEEN: Community-Based IUD Intervention
October 2006	USA	IBP Initiative Consortium Meeting	ESD plans/activities
June 2007	USA	IBP Initiative Consortium Meeting	Scaling up FP/MNCH Best Practices in Asia and the Near East Technical Meeting, held in Bangkok in September 2007, and at the IBP Consortium Meeting held at AED on June 1, 2007

Presentations to USAID and U.S.-Based Technical Working Groups			
Date	**Venue**	**Organization**	**Topic**
January–March 2007	USA	International Finance Corporation (IFC) working group (private-sector arm of the World Bank Group)	Foster integration of ESD Healthy Images of Manhood models into IFC's strategy for HIV prevention in the workplace (participant)
March 2007	Pakistan	Ulema's Workshop (Constella Futures)	Present and discuss the research findings from focus group discussions conducted with Ulemas or religious leaders, to assess their knowledge and perceptions of family planning/child spacing (participant)
2007	USA	Georgetown University/Institute for Reproductive Health	HTSP evidence, the WHO technical consultation recommendations
May 2007	USA	FP-HIV integration meeting organized by the FP-HIV GLP Integration Working Group	Participant. FHI updated on progress on the six-country assessment it is conducting to collect information on FP-HIV integration models (with a focus on FP into ART, HIV into FP, and FP into VCT), and their potential for scale-up.
September 2007	Tanzania	1st Regional Forum on Best Practices in Health Care and the 17th Directors Joint Consultative Committee Meeting (USAID)	Use of private nurse-midwives to reach underserved populations
October 2007	USA	IBP (Implementing Best Practices)	"ANE Technical Activity: Update and Next Steps." The meeting was attended by WHO, USAID, and more than 15 U.S.-based partners.
November 2007	USA	ACCESS-FP, Health Communication Partnership (HCP), and the INFO Project based at Johns Hopkins Bloomberg School	Three-week HTSP global online forum for disseminating HTSP resources, information, and tools

Presentations to USAID and U.S.-Based Technical Working Groups			
Date	**Venue**	**Organization**	**Topic**
		of Public Health Center for Communication Programs in collaboration with the Implementing Best Practices in Reproductive Health Initiative and WHO/RHR.	
December 2007	USA	Health Communication Partnership at the JHU/CCP in collaboration with ACCESS-FP, ESD Project, INFO Project, and USAID	Global videoconference on HTSP: "Changing Norms for Healthy Spacing of Pregnancy: New Research and Programs." The videoconference linked public health professionals in Baltimore, Jordan, Kenya, Uganda, and Geneva. The videoconference featured new qualitative and quantitative research on HTSP from Jordan, Uganda, and Egypt, and a unique program experience from Kenya. ESD's colleague, Sheikh Hussein Mahad of CIPK, presented on his experiences with HTSP and working with religious leaders in Garissa, and with ESD.
2008	USA	Post-Abortion Care (PAC) Consortium meeting	
October 2008	USA	FP/HIV Integration Working Group	In collaboration with EGPAF on the PMTCT Expert Technical panel and FHI facilitation.
November 2008	USA	IBP meeting	Presented "Spreading Innovation: Taking FP/MNCH Best Practices to Scale"
November 2008	Egypt	General meeting Pathfinder International ANE technical meeting	Participant
November 2008	Tanzania	Medical Women of Tanzania Annual General Meeting; University of Dar es Salaam	Presentation on HTSP to 40 colleagues at the MOH, medical faculty, and students at the University of Dar es Salaam
Uncertain	Kenya	Kenyatta University	ESD presented P/BP information related

Presentations to USAID and U.S.-Based Technical Working Groups			
Date	**Venue**	**Organization**	**Topic**
		Nursing and MPH Programs, Center for Africa Family	to HTSP, AMKENI, and private nurse midwives, USAID Global Health e-learning modules.

APPENDIX O. PROJECT ACTIVITIES

Progress Toward Results to Date: Major Field Activities									
Country	**Beneficiary Population/Program Area**	**Program Description**	**Program Evaluation Strategies and Tools**	**Major Results to Date**	**Partners**	**Funding Level (in thousands)**			
						<100-	**100–499**	**500–999**	**>1,000**
Core-Funded									
Bangladesh (2009)	Mothers of young children who use day care services; 1–3 factories in Dhaka are in pilot program.	CSR model being developed to integrate HTSP into the regular work of the day care providers. Provide HTSP messages to mothers who use factory day care center; mothers are referred for FP services.	• Training of day care staff in HTSP in 1–3 factories • No indicators yet; ESD will work with Phulki to develop indicators during the initial phase. • Sustainability will be determined if factories elect to continue activities.	• New activity	Phulki (an NGO that manages day care centers at 135 factories)				
Bangladesh (2007–present)	Employer-based health care services for 450 factory workers (mostly women). Part-time health clinic on premises.	BSR (Business for Social Responsibility) model. Health Enables Returns (HER) project. Strengthen/expand clinical services FP services (condoms, pills, and injections). Refer for other methods.	• A Health Needs Assessment used as a baseline was conducted in 2004 by Health Solution PDA (a local NGO) to assess workers' attitudes and absenteeism. • Return on Investment (ROI) study results demonstrated cost savings if company invested in health care for its workers (for each $1 spent on health, the company	• Follow-up study pending • Based upon its experience to date, ESD helped to launch HER model at two factories in Pakistan and another HTSP focused project in Bangladesh with Phulki (an NGO) (see above).	Health Solution PDA (NGO); Levi Strauss for leveraged funds; funded also by David and Lucille Packard Foundation				

Progress Toward Results to Date: Major Field Activities									
Country	Beneficiary Population/Program Area	Program Description	Program Evaluation Strategies and Tools	Major Results to Date	Partners	Funding Level (in thousands)			
						<100-	100–499	500–999	>1,000
			saves $3.) • Similar Return on Investment (ROI) Study will be conducted by ESD in 2009 to show impact of program on workers' attitudes and absenteeism.						
Burundi (2009)	(See AA award entry)	Integration of HTSP into MCH (into existing AA)	• New activity	• New activity					
Ethiopia (2007–2009)	Health Extension Workers. Coverage: four districts in two regions.	Program designed to strengthen elements of Health Extension Program (HEP), in particular performance of the health extension workers (HEWs). • Phase one: Rapid assessment to determine factors affecting performance. • Phase two: Tailor capacity-building for HEWs using a South-to-South learning approach.	• Phase one: Rapid Assessment targeting both well and poor-performing HEWs to determine the underlying factors affecting performance. Determine strengths and weaknesses of HEP. • Phase two: (not done) tailor capacity-building for HEWs using a South-to-South learning approach matching weaker performing HEWs and their support teams with stronger ones. MOH took preliminary results of Rapid Assessment and made	• Phase 1 (Rapid Assessment) completed. Preliminary assessment results shared with MOH, which made following changes to HEP: HEWs to be placed in "home" regions; at least two HEWs assigned per health post; health posts to be equipped and training provided to HEWs on how to repair equipment; training in basic curative services and in safe deliveries (skilled birth attendants); increased funds for supportive supervision; and standardized criteria to measure HEW job performance.	MOH, WHO				

Progress Toward Results to Date: Major Field Activities									
Country	Beneficiary Population/Program Area	Program Description	Program Evaluation Strategies and Tools	Major Results to Date	Partners	Funding Level (in thousands)			
						<100-	100–499	500–999	>1,000
			positive changes to the HEP program. Model considered robust enough to be scaled up to other parts of the country, should the government have the resources to do it.	• Phase 2 not done due to the length of time required to get all parties to agree on activities.					
Nigeria	Child and youth marriage and pregnancies; working with their "gate-keepers" including RLs, husbands, and mother-in-laws. 18 clinics in 4 LGAs in Kano State.	Training providers in youth-friendly approaches and HTSP; training FOMWAN members in community outreach for HTSP; Training RLs in HTSP	• Pre- and post-test on providers' knowledge of providing youth-friendly services and survey among training participants.	• Participants at the health facilities developed action plans for disseminating HTSP information and promoting FP services for young married women.	COMPASS (USAID bilateral); FOMWAN (Assoc. Muslim Women)				
Pakistan (2008)	Women factory workers in Karachi. Factories have roughly 2,000 workers each.	Business for Social Responsibility Model (HER project) featuring peer education. Project is building the capacity for company nurse to offer RH/FP services including provision of FP methods.	• Needs assessment for women's health • Return on investment study measuring turnover and absenteeism		Levi Strauss leverage $20,000; Aga Khan University				
Tanzania (2008)	6,000 employees and their families (30,000 including employees) and those living in surrounding area of tea estates owned by Unilever Tea Tanzania. Unilever runs a 67-bed hospital and 12 dispensaries,	CSR with Unilever Tea Tanzania, (UTT) Ltd. Program features use of HIM to (1) mainstream gender into RH/FP services using peer health educators and HIM strategy. Trained peer health educators (PHEs) to work to help change	• HIM: Trained 29 peer health educators (PHEs) in one week in HIM (Healthy Images of Manhood); of these 22 also completed one week of Community Action Cycle training. • Evaluate PHEs	• HIM-informed community outreach activities have reached 135,000 workers and community residents and have increased men's enrollment of HIV services by 27%. • 66,000 condoms have been distributed by	MOH, UTT, FHI				

Progress Toward Results to Date: Major Field Activities									
Country	**Beneficiary Population/Program Area**	**Program Description**	**Program Evaluation Strategies and Tools**	**Major Results to Date**	**Partners**	**Funding Level (in thousands)**			
						<100-	**100–499**	**500–999**	**>1,000**
	and offers on-site HIV treatment as well as home-based care. 160 PHEs, 29 HIM-trained PHEs.	social norms about gender among co-workers and promote HIV testing and utilization of FP and health services. FHI is also working in the same area to train staff and strengthen FP/HIV services and integration; (2) CAC models for community mobilization; (3) integrating FP services with HIV/AIDS services; and (4) strengthening the FP services and availability at the corporate plantation health facilities through linkages with the MOH for training and commodities. ESD plans to further integrate FP and HTSP into HIV/AIDS education and counseling and improve links between PHEs and health providers.	through pre- and post-test knowledge and attitudes. ESD has provided periodic TA for (1) training in HIM, CAC, HTSP, LAM, and SDM; (2) developing the M&E strategy; (3) developing linkages with the MOH for FP services; and (4) financial support for UTT staff for data collection and supervision of activities	PHEs. • Enrollment at UTT's Care and Treatment center have increased by 20%. • Anecdotal reports that more men are accompanying their wives for FP services. • Numbers of new and repeat clients receiving FP services with HIV/AIDS services and at FP service sites are being collected.					
Field Support (Country Mission)									
Angola (2008–present)	840,000 WRA (including many refugees and internally displaced persons in four municipalities in Luanda Province.	Strengthen family planning: and expand clinical services. Strategy includes capacity-building of providers, integration of FP into all services and SDP, and community	• Quality Improvement Checklist (QI) • Client Satisfaction (CS) instrument • KAP household baseline survey conducted focusing	• Addendum to National Reproductive Health Training of Trainers' Manual developed. • 13 national-level master trainers created in the full range of FP	MOH				

Progress Toward Results to Date: Major Field Activities									
Country	**Beneficiary Population/Program Area**	**Program Description**	**Program Evaluation Strategies and Tools**	**Major Results to Date**	**Partners**	**Funding Level (in thousands)**			
						<100-	**100–499**	**500–999**	**>1,000**
	Post- conflict setting.	mobilization.	on FP/MNCH/HIV • Endline follow-up KAP planned • Well-developed M&E plan	methods. • Compendium of job aids for providers developed. • IEC materials for providers and clients developed.					
Ethiopia (2007–2008)	Underserved population living in four rural regions supporting 9,124 community-based RH agents and 3,000 HEWs	Bridge program to continue support for large-scale RH/FP community-based program; fistula repair program	• Health information system	• 289,964 new FP users; 152,223 referrals for other RH services (ANC, PCC, immunization) • 2,213,877 received RH/FP educational messages.	MOH, Pathfinder, and 46 local NGOs for the RH/FP program; IntraHealth for fistula.				
Guatemala (2006–2007)	APROFAM (local IPPF affiliate)	CSR model to help APROFAM, a local health NGO, become more sustainable through marketing its services and raising awareness among local companies of the importance of RH/FP and increasing employer investment in health services.	• Relevant Indicators created under Catalyst project		APROFAM, MOH				
Guatemala (2006–2007)		TA for RH/FP guidelines and policies		• Guidelines and policies revised					
Guinea (2007–2009)	Three regions in rural Guinea	Introduce and strengthen RH/FP services in facilities and at the community level. Program includes community	M&E plan and well-functioning HMIS with timely information exchange between	• Program reported 1,158,599 new users and over 1 million couple-years protection. • Program reported 11	MOH; ACCESS-FP; RTI; local NGOs				

Progress Toward Results to Date: Major Field Activities									
Country	Beneficiary Population/Program Area	Program Description	Program Evaluation Strategies and Tools	Major Results to Date	Partners	Funding Level (in thousands)			
						<100-	100–499	500–999	>1,000
		mobilization and community-based distribution of FP methods. Program components also include PAC and peer educators in schools.	MOH and project. ESD training HIV/AIDS service providers to offer information and refer clients for FP services	million community members reached through RH/FP education, over 8 million reached by HIV prevention messages, 2.6 million women reached with PAC messages. • 1,595 cases of early marriages canceled. • 455 providers trained in service delivery (including FP). • Timely sharing of program data between MOH and project—regional MOH taking lead on managing the MIS. • National protocols for RH/FP adapted from existing materials. • IEC materials developed for community health workers based on existing materials (August 2008).					
Kenya (2006–2007)	Refugees in two camps (Kakuma and Dadaab): focus on males and youth	Program designed to improve RH/FP and increase awareness of gender-based violence (GBV). Activities focused on refugee community	• Pre- and post-intervention knowledge and attitudes • HIM curriculum adapted for refugee	• 27 gender champions were trained in a 5-day TOT to raise awareness of the social and cultural factors that influence GBV and to	UNHCR; NCCK (National Churches of Kenya); Film Aid; Lutheran				

Progress Toward Results to Date: Major Field Activities									
Country	**Beneficiary Population/Program Area**	**Program Description**	**Program Evaluation Strategies and Tools**	**Major Results to Date**	**Partners**	**Funding Level (in thousands)**			
						<100-	**100–499**	**500–999**	**>1,000**
		champions and religious leaders through a series of trainings and community mobilization and education.	setting	increase their ability to educate and mobilize the community around the issue. • 111 gender champions were selected and trained from the camps. • 30 young male gender champions (mainly from local NGO staff) participated in a 5-day TOT using the HIM (Healthy Images of Manhood) curriculum.	World Federation (LWF); other NGOs				
Sudan (2006)	Internally displaced persons	TA to develop RH/FP policies and FP guidelines which featured FP integration into safe motherhood.		• 4,000 copies of FP technical guidelines developed and distributed. • ESD helped JSI develop to develop RH/FP Policy Framework. • With FHI provided TA for a strategy for integration of FP into HIV/AIDS interventions along transportation corridor.	FHI, JSI, MOH, UNFPA				
Field Support (USAID/Asia Near East (ANE) Regional Bureau or ESD) or WHO funds and ESD Core funds for TA for Scaling Up Best Practices (Post Bangkok)									
Afghanistan (Tier 2-WHO grant)	Child health	Zinc for child diarrhea ESD TA		• Inclusion of zinc into national IMCI guidelines	Government				
Bangladesh	Urban poor	Scaling up/extending Healthy Fertility Study	New activity	New activity	Shimantik				

Progress Toward Results to Date: Major Field Activities									
Country	**Beneficiary Population/Program Area**	**Program Description**	**Program Evaluation Strategies and Tools**	**Major Results to Date**	**Partners**	**Funding Level (in thousands)**			
						<100-	**100–499**	**500–999**	**>1,000**
(2009)	postpartum women	programmatic activities to urban areas of Sylhet.			(local NGO)				
Egypt (2008–2009) Tier 1—ANE grant	Poor women in an underserved district with 25 clinics. Population in program area: 239,000. Demonstration site (Al-Kalyoubiah).	Improvement Collaborative (quality improvement) approach model. Improving maternal and neonatal health through a package of PP and FP services. Technical training of health center staff and community health workers on postpartum care with focus on FP/HTSP and neonatal care. Model is to train providers in the clinic and community, then assign a number of houses for each CHW to visit. Each pregnant woman will be visited 5–6 times during and after pregnancy for counseling in MNCH and FP/HTSP and referred when needed to health centers. Coupling the technical intervention with the Improvement Collaborative approach may prove to be an excellent approach to move from demonstration level to scale-up.	• Baseline and endline data will be collected that measures improved CPR and reduction in infant and maternal mortality. • Main indicators include % of women visited at least 3 times; average number of visits; % of nurses trained on updated guidelines; % of women visited by nurse within 48 hours following birth; % of visited women who use FP before 40th day postpartum.	• Training guidelines for PP package developed, including detailed clinical and counseling instructions for six outreach visits by a community health worker or nurse within the first six weeks PP were developed. • Notification system set up between hospital and PHCs to alert community agents to visit the mother PP.	Save the Children, URC				

Progress Toward Results to Date: Major Field Activities									
Country	**Beneficiary Population/Program Area**	**Program Description**	**Program Evaluation Strategies and Tools**	**Major Results to Date**	**Partners**	**Funding Level (in thousands)**			
						<100-	**100–499**	**500–999**	**>1,000**
Egypt (Population Council) Tier 2 ANE Grant (June 2009)		Scaling up the provision of family planning messages in antenatal and postpartum services in Upper Egypt	• New activity	• New activity					
India (CARE) Tier 1-ANE Grant	Tribes; analysis conducted to identify underserved/ marginalized for program focus.	Scaling up community integrated management of neonatal and childhood illness (IMNCI). Community mobilization, strengthen awareness and referrals for FP.	• Formative research to identify key barriers to behavior change and messages to be emphasized in the capacity-building and communication materials (related to IMNCI interventions). • Final evaluation planned.	Trained 20 of CARE's program staff in IMNCI	MOH, ICDS, WRA				
India (Population Council) Tier 2 ANE Grant (June 2009)		Increasing postpartum check-ups and contraceptive use among young women in India.	• New activity	• New activity					
Indonesia (JNPK/MOH) Tier 1 ANE Grant (2007)	Providers and their clients who are delivering	Scaling up comprehensive obstetric and neonatal emergency care training for clinicians. Using Continuous Improvement System Tools for CEONC.		• Completion of training packages (protocols) for Comprehensive Emergency Obstetrics and Neonatal Care (CEONC) by the Indonesian Society of OB/GYNs and of Pediatricians. • Midwives set up quality improvement supervisory system for	MOH, National Clinical Training Network (JNPK)				

Progress Toward Results to Date: Major Field Activities									
Country	Beneficiary Population/Program Area	Program Description	Program Evaluation Strategies and Tools	Major Results to Date	Partners	Funding Level (in thousands)			
						<100-	100–499	500–999	>1,000
				doctors, nurses, and midwives. • Indonesia decided to introduce kangaroo mother care (KMC) as a standard practice for LBW babies. • Reduction in mortality noted from 30/3000 live births (February to July 2008) to 12/3500 live births (August 2008 to January 2009). • Decision to expand CEmOC to six other district hospitals with national scale-up planned.					
Nepal (2008) Tier 1 ANE Grant (with additional Mission field support funds)	Various	Several activities—including study tours—supported to highlight programs successfully implementing interventions incorporating best practices. Study to examine effect of BS interval on birth weight.	ESD will monitor networking and achievements relating to scale-up.	• 30% reduction in neonatal mortality and significant reduction in maternal mortality reported by MIRA.	Several local NGOs				
Nepal (2006–2008) Tier 1-ANE Grant	Young postpartum women living in poor section of Katmandu (urban area) with a population of 12,000	Community-based postpartum care program including education and support (PPFP, LAM, transition to FP). Train peer educators, mothers' groups, and	• Baseline survey (2007) of random sample of 200 married women and 100 husbands conducted. Endline survey also	Study demonstrated positive trends in HTSP/FP knowledge, LAM use, transition to another method, and FP continuation. In a sample of 341 LAM	Nepali Technical Assistance Group (NTAG) (local NGO)				

Progress Toward Results to Date: Major Field Activities									
Country	**Beneficiary Population/Program Area**	**Program Description**	**Program Evaluation Strategies and Tools**	**Major Results to Date**	**Partners**	**Funding Level (in thousands)**			
						<100-	**100–499**	**500–999**	**>1,000**
		private RH/FP services Program designed to measure HTSP promotion on the impact of FP use, birth spacing, and newborn outcome (birth weight). IBP Guide for fostering change	conducted. • OR study developed with control group sites. Study designed to monitor FP continuation. • Research to measure birth weight in relation to birth spacing. • ESD provides periodic TA for M&E.	users who transitioned to another modern method when LAM was no longer protective, 85% were still contracepting at one year postpartum.					
Nepal (core)	Nepal	Coordination and developing linkages between groups providing PPFP			MIRA, local NGO				
Jordan (2009) Tier 1—WHO grant	Postpartum women and post-abortion care	Two BPs selected for to scale up; use of magnesium sulfate for postpartum mothers with hypertension and the introduction of PAC in the public sector. ESD provides TA and links with URC to assist the MOH introduction and gradual expansion of previously non-existent PAC services.	• M&E plan developed	• Plans to expand activities from one to five hospitals. • Discussion underway for AA FS funding to expand PAC services throughout the country by strengthening local organization.	USAID PAC GLP/TP; WHO grant $20,000				
Pakistan Tier 1—WHO grant		WHO grant is being used to help scale up several best FP and MNCH practices (Active management of the third	WHO and ESD will monitor progress of scale-up	• AMTSL is being scaled up in over 30 districts. • USAID e-learning courses are being translated into Urdu.	WHO grant $20,000				

Progress Toward Results to Date: Major Field Activities									
Country	**Beneficiary Population/Program Area**	**Program Description**	**Program Evaluation Strategies and Tools**	**Major Results to Date**	**Partners**	**Funding Level (in thousands)**			
						<100-	**100–499**	**500–999**	**>1,000**
		stage of labor (AMTSL), EBF, ORT, ARI, FP (LAM, SDM, PAC, LAPMs)		• Plans to scale up SDM in 20 districts.					
Yemen (2008) Tier 1	(See AA for description of program BPs are being integrated into.)	Improvement Collaborative approach model. Collaborating to increase the use of evidenced-based BPs in PP care (kangaroo care, EBF, PPFP, HTSP, LAM, infection control, and Vitamin A) in Yemen's BHS program (see AAs)		• Training guidelines for the introduction and implementation of five best practices developed by BHS and country team. • TOT for 15 master trainers from Al-Sabeen Hospital. • Trained 100 clinicians from Al-Sabeen Hospital. • Media launch of the five best practices at the largest maternity hospital. • MOH issued national directive to provide Vitamin A to all women who deliver in public hospitals. 85% of women giving birth at Al-Sabeen received Vitamin A. • PP Vitamin A was added to the Essential Drugs List and distributed to all government hospitals in Yemen. • Distribution of Vitamin A for all PP women in government hospitals is					

Progress Toward Results to Date: Major Field Activities									
Country	**Beneficiary Population/Program Area**	**Program Description**	**Program Evaluation Strategies and Tools**	**Major Results to Date**	**Partners**	**Funding Level (in thousands)**			
						<100-	**100–499**	**500–999**	**>1,000**
				going to national scale.					
Field Support (USAID/Asia Near East (ANE) Regional Bureau or ESD) for Working with Religious Leaders									
Bangladesh	Young women, conservative groups	Change social norms by training RLs in HTSP							
Pakistan (A/NE FS)		Change social norms by training RLs in HTSP	ESD support: Periodic TA for training Muslim leaders, arranging study tours for the leaders, M&E.						
Yemen (Gender GLP)	Young girls, child and youth marriages, and pregnancies	Change social norms by training RLs in HTSP	ESD support: Periodic TA for training Muslim leaders, arranging study tours for the leaders, M&E.						
Associate Awards									
Burundi (2007–2010)	400,000 post-conflict beneficiaries including mothers and children, youth, marginalized "hill" (tribal) residents, urban poor, young couples, and internally displaced persons. Program area: two provinces (Muyinga and Kayanza)	Strengthen facility and community-based health care in FP/MCH through training; increase capacity of MOH management and data for decision-making; community mobilization; media to reach youth. Programmatic components include birth preparedness and maternity services, HTSP, clinical training in clinical FP methods (LAPMs), integration of FP into MNCH/PNC and HIV services, PMTCT, IMCI,	• Rapid Facility Assessment • KPC Survey 600 HHs with children <2 yrs. for HTSP/RH/FP. Annual follow-up planned to measure change. • Baseline gender assessment completed. • Comprehensive set of programmatic indicators developed—mainly focused on MCH.	• Assisted MOH in developing a checklist for health providers. • Development and distribution of clinical algorithms to manage OB complications. • Adapted/revised MOH training materials. • Developed national EPI strategy for immunizations. • Program has exceeded its 2008 targets for several key MCH-related indicators:	ACCESS-FP, MSH, PI, Chemonics, DAI (local NGO)				

Progress Toward Results to Date: Major Field Activities									
Country	Beneficiary Population/Program Area	Program Description	Program Evaluation Strategies and Tools	Major Results to Date	Partners	Funding Level (in thousands)			
						<100-	100–499	500–999	>1,000
		nutrition, water and sanitation, EMOC, immunizations, and strengthening HMIS. Capacity-building in development of health information systems, data management and use. Models being tested/adapted include Positive Deviance/Hearth; Performance Assessment Improvement (PAI), and Health Watch Framework.		number of people trained in MNCH, number of deliveries with skilled attendants, number of children <12 months who received DPT3. • TOT taught 56 health providers and health promotion technicians to train TBAs on danger signs and making referrals. • 67 TBAs trained on dangers signs and referrals. • Basic EmOEC trainings for 71 health providers. • Data analysis training for 20 staff.					
Jordan (2009)	Pending	AA project proposal was requested by Mission, with funds set aside. This is pending agreement with national partner.	• New activity	• New activity					
East Africa (DRC/ Burundi) (2009)	Refugees and unsettled populations	Models will be developed for RH/FP/GBV.	• New activity	• New activity					
Kenya–APHIA II NE province (2007–2012) [Core funds for FP]	Nomadic, refugees in NE (Garissa) Province	Multifaceted program supported mainly through PEPFAR is designed to provide integrated FP, HIV, MNCH services at both facility and community levels to a	• Most at-risk sub-populations identified who are most at risk for HIV. • Assessments conducted at 80	• PMTCT services provided for 30,000 clients. • Clinical and community-level trainings for 800 skilled and semi-skilled	MOH, Magwanza (a local NGO for people with HIV/AIDS), SUPKEM (Muslim				

Progress Toward Results to Date: Major Field Activities									
Country	Beneficiary Population/Program Area	Program Description	Program Evaluation Strategies and Tools	Major Results to Date	Partners	Funding Level (in thousands)			
						<100-	100–499	500–999	>1,000
		neglected region. Goal is to increase service access and use and promotion of healthy behaviors among those at high risk for HIV. Innovations include VCT in alternative settings ("moonlight" services), community-based VCT, and treatment involving HIV+ volunteers and providers, and involving religious leaders to provide use of health services. Program is providing palliative care to children. Program is also introducing SDM.	facilities to map out RH/HIV services and resources available to identify gaps in services. • Studies conducted: Human Resources for Health and Sexual Networks Study.	providers (PMTCT, VCT, TB/HIV, care of orphans and vulnerable children (OVCs)). • Educational outreach in HIV prevention to over 150,000. • Sub-grants executed to 20 local organizations providing OVC support. • Targets for promoting abstinence/being faithful achieved. • 65% of at-risk population reached through outreach activity involving uniformed personnel and civil servants to promote behavior change and condom use. • 80% of benchmark met for support to orphans and vulnerable children. • Over 200,000 reached through community education about prevention of HIV/AIDS. • Over 40,000 received counseling and testing. • Over 30,000 receiving palliative care for HIV. • Over 14,000 OVCs being served.	orphanages)				

Progress Toward Results to Date: Major Field Activities									
Country	Beneficiary Population/Program Area	Program Description	Program Evaluation Strategies and Tools	Major Results to Date	Partners	Funding Level (in thousands)			
						<100-	100–499	500–999	>1,000
				• Over 17,000 on ART • North Eastern Province (NEP) district that is piloting SDM training for couples who are referred to health service providers by Muslim leaders and their community neighbors, there is increasing demand for this method by couples; 95% of new SDM acceptors had never previously used FP.					
Kenya-APHIA II Nairobi Province (2009)	Men, women, and children in Nairobi Province	Expand availability of quality, sustainable, HIV/AIDS and TB prevention, treatment, care, and support along with integrated RH/FP services.	• New activity	• New activity					
Kenya-APHIA II Central Province (2009)	Men, women, and children in Central Province	Expand availability of quality, sustainable, HIV/AIDS and TB prevention, treatment, care, and support along with integrated RH/FP services.	• New activity	• New activity					
Yemen (2006–2009)	Underserved women, children, and youth in five northern and eastern governorates	Basic Health Services (BHS) Project designed to improve MCH through multifaceted approach	• Baseline KAP study in five governorates. • Facility assessments completed in 78	• National curriculum/protocol revision • IEC materials	Deliver				

Progress Toward Results to Date: Major Field Activities									
Country	Beneficiary Population/Program Area	Program Description	Program Evaluation Strategies and Tools	Major Results to Date	Partners	Funding Level (in thousands)			
						<100-	100–499	500–999	>1,000
		involving establishment of mobile teams to provide health services to over 125,000 clients; refurbishing and equipping health facilities; training providers including midwives in RH/MCH; supporting distribution of supplies; supporting midwives association; mobilizing community outreach workers, and disseminating health education messages through religious leaders and midwives.	districts. • Conducted 2 TOT workshops for 34 trainers in RH/MCH. • TOT conducted for 20 male and female religious leaders (including six from central level and representatives from all five governorates). • Service statistics will be used to assess uptake of services.	developed (flipchart, TOT curriculum for FP service provision). • MOH has asked Oxfam, GTZ and World Bank to use mobile team approach. • MOH has added incentives to retain providers in rural areas by providing housing. • MOH has changed how it recruits midwives selected for long-term training—they are now selecting them from rural areas and assigning them to work in their home regions (rather than requiring them to work in urban areas).				

APPENDIX P. MATRIX OF INTEGRATED ACTIVITIES: CORE, FIELD SUPPORT, AND ASSOCIATE AWARDS

Core-Funded Activities												
Integrate RH/FP Through NGO Corporate Partnerships												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers	X		X	X	X	X					X	
Men												
Postpartum women												
Refugees/IDPs												
Religious leaders												
Youth												
Participate in the Development of the Family Planning Global Resource Package												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Postpartum women												
Refugees/IDPs												
Religious leaders												
Service providers	X	X				X				X	X	
Women of reproductive age	X					X				X	X	
Youth												
HTSP Tools and Materials												
	Themes											

Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Factory workers												
Men												
Postpartum women	X					X				X	X	
Refugees/IDPs												
Religious leaders	X					X				X	X	
Women of reproductive age	X					X				X	X	
Youth	X					X				X	X	
Postpartum FP Framework and Toolkit												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Postpartum women	X			X		X	X	X		X	X	
Refugees/IDPs												
Religious leaders												
Youth												
Nepal Urban Poor Postpartum FP Project												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Postpartum women	X			X		X	X			X	X	
Refugees/IDPs												
Religious leaders												
Youth	X			X		X	X			X	X	
HTSP for Young Married Women in Northern Nigeria												

	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Postpartum women												
Refugees/IDPs												
Religious leaders												
Service providers		X		X		X				X	X	
Youth				X		X				X	X	
FP/MNCH Integration in Burundi												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants	X					X		X				
Factory workers												
Men	X					X	X	X		X	X	
Postpartum women	X					X	X	X		X	X	
Refugees/IDPs	X					X	X	X		X	X	
Religious leaders												
Women of reproductive age	X					X	X	X		X	X	
Youth												
Integrate RH/FP and HIV in Kenya												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
					X	X		X			X	
Children/infants												
Factory workers												

Men												
Postpartum women												
Refugees/IDPs												
Religious leaders												
Youth												
Provide TA in RH/FP Service Delivery, Health Partnerships, and Workplace Productivity												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers	X		X	X	X	X		X			X	
Men	X		X	X	X	X		X			X	
Postpartum women												
Refugees/IDPs												
Religious leaders												
Service providers	X	X	X	X	X	X		X			X	
Women of reproductive age	X	X	X	X	X	X		X			X	
Youth												
Provide TA to Pathfinder International Ethiopia and Other Partners to Strengthen the Capacity of Health Extension Workers												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Postpartum women												
Refugees/IDPs												
Religious leaders												
Service providers	X	X				X	X			X	X	
Youth												

Strengthen Institutional Capacity of the Yemen Midwives Association												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Postpartum women												
Refugees/IDPs												
Religious leaders												
Service providers	X	X		X		X	X	X		X	X	
Youth												
Youth-Friendly Post-Abortion Care												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Postpartum women												
Refugees/IDPs												
Religious leaders												
Service providers	X	X				X			X		X	
Youth	X					X			X		X	
Safe Age of Marriage Yemen												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants	X			X		X						
Factory workers												
Men	X	X		X		X					X	
Postpartum women												

Refugees/IDPs												
Religious leaders	X	X		X		X					X	
Youth	X	X		X		X					X	
Religious Leaders in Northern Nigeria												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: youth
Children/infants												
Factory workers												
Men												
Postpartum women												
Refugees/IDPs												
Religious leaders	X	X				X					X	X (youth)
Youth												
Asia Middle East Bureau Field Support												
AME Religious Leaders Activity												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men	X			X		X					X	
Postpartum women												
Refugees/IDPs												
Religious leaders	X			X		X					X	
Youth												
Scaling Up High Impact Best Practices												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants	X					X		X		X	X	

Factory workers												
Men												
Postpartum women	X					X		X		X	X	
Refugees/IDPs												
Religious leaders												
Service providers	X	X				X		X		X	X	
Women of reproductive age	X					X		X		X	X	
Youth												
Angola Muiji wa Dissanze Project Field Support												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants	X			X	X	X						
Factory workers												
Men	X	X		X	X	X						
Postpartum women	X	X		X	X	X	X	X		X	X	
Refugees/IDPs												
Religious leaders												
Service providers	X	X		X	X	X	X	X		X	X	
Women of reproductive age	X	X		X	X	X	X	X		X	X	
Youth	X	X		X	X	X	X	X		X	X	
ESD Guinea Field Support												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: Primary HC
Children/infants						X		X				X
Factory workers												
Men						X					X	
Postpartum women						X	X	X		X	X	
Refugees/IDPs												

Religious leaders												
Service providers		X				X	X	X	X	X	X	X
Women of reproductive age						X	X	X	X	X	X	X
Youth		X				X	X	X	X	X	X	X
Strengthening Capacity of the UN Agencies to Provide RH/FP Services to Refugees Field Support												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men	X			X	X	X	X	X		X	X	
Postpartum women	X			X	X	X	X	X		X	X	
Refugees/IDPs	X			X	X	X	X	X		X	X	
Religious leaders	X			X	X	X	X	X		X	X	
Service providers	X	X		X	X	X	X	X		X	X	
Women of reproductive age	X			X	X	X	X	X		X	X	
Youth												
Ethiopia Fistula Project Field Support												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Postpartum women	X			X	X			X			X	
Refugees/IDPs												
Religious leaders												
Service providers	X	X		X	X			X			X	
Women of reproductive age	X			X	X			X			X	
Youth												

Ethiopia RH/FP Project Field Support												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants	X			X	X	X		X				
Factory workers												
Men	X	X		X	X	X					X	
Postpartum women	X	X		X	X	X	X	X		X	X	
Refugees/IDPs												
Religious leaders												
Service providers	X	X		X	X	X	X	X	X	X	X	
Women of reproductive age	X	X		X	X	X	X	X	X	X	X	
Youth	X	X		X	X	X	X	X	X	X	X	
South Sudan Field Support												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Ministry of Health	X	X				X				X	X	
Postpartum women												
Refugees/IDPs												
Religious leaders												
Youth												
APHIA II North Eastern Province Associate Award												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: TB; OVC support
Children/infants					X			X				X

Factory workers												
Men												
Nomadic pastoralists					X	X	X	X			X	X
OVC					X			X				X
PLWHA					X	X		X			X	X
Postpartum women												
Refugees/IDPs												
Religious leaders					X	X	X	X			X	X
Youth					X	X	X	X			X	X
Burundi MCH Project Associate Award												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: Polio; Hygiene and sanitation
Children/infants	X					X		X			X	X
Factory workers												
Men												
Postpartum women	X					X		X		X	X	X
Refugees/IDPs												
Religious leaders												
Women of reproductive age	X					X		X		X		X
Youth												
Basic Health Services Project Yemen Associate Award												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: Mobile services
Children/infants												
Factory workers												

Men												
Postpartum women	X					X	X	X			X	X
Refugees/IDPs												
Religious leaders	X					X	X	X			X	X
Service providers	X	X				X	X	X	X		X	X
Women of reproductive age	X					X	X				X	X
Youth	X					X	X	X			X	X
Scaling Up FP/MNCH Best Practices AME Field Support: Subgrant Details												
Facilitating Synergies to Scale-Up Maternal and Newborn Best Practices in Nepal: Mother and Infant Research Activities												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: Advocacy
Children/infants												
Factory workers												
Men												
Postpartum women												
Refugees/IDPs												
Religious leaders												
Service providers	X			X				X			X	X
Women of reproductive age												
Youth												
Other: NGO and government stakeholders	X			X				X			X	X
Scaling Up Community IMNCI Through Government Child Health Programs in Chhattisgarh State, India: Care India												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: IMNCI
Children/infants	X							X				X
Factory workers												
Men												

Postpartum women	X							X				X
Refugees/IDPs												
Religious leaders												
Service providers	X	X				X						X
Women of reproductive age	X							X				X
Youth												
Improving Maternal and Neonatal Health Through a Package of PP and Family Planning Services: Save the Children/Egypt												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: Advocacy
Children/infants												
Factory workers												
Men												
Postpartum women	X							X		X	X	
Refugees/IDPs												
Religious leaders												
Service providers	X	X						X		X	X	
Women of reproductive age												
Youth												
Other: MOH	X							X		X	X	X
Scaling Up Comprehensive Essential Obstetric and Neonatal Emergency Care Training for Obstetricians, Pediatricians, Nurses, and Midwives in Indonesia: Jaringan Nasional Pelatihan Klinis (JNPK)												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: Supportive supervision
Children/infants												
Factory workers												
Men												
Postpartum women												
Refugees/IDPs												

Religious leaders												
Service providers	X	X						X				X
Women of reproductive age												
Youth												
Other: MOH	X	X						X				
Collaborating to Increase the Use of Evidence-Based Best Practices in Postpartum Care for Mothers and Infants in Yemen: MOPHP Yemen												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: Advocacy
Children/infants	X							X				
Factory workers												
Men												
Postpartum women	X					X		X		X	X	
Refugees/IDPs												
Religious leaders												
Service providers	X	X				X	X	X		X	X	
Women of reproductive age												
Youth												
Other: MOH	X	X										X
Scaling-Up of Healthy Fertility and Postpartum Family Planning Rural Experiences in Urban Areas of Sylhet, Bangladesh: Shimantik												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other: Advocacy
Children/infants												
Factory workers												
Men												X
Postpartum women	X					X	X	X		X		
Refugees/IDPs												
Religious leaders												X
Service providers	X	X				X	X	X		X		

Women of reproductive age	X					X	X	X				
Youth												
Increasing Postpartum Check-Ups and Contraceptive Use Among Young Women in India: Population Council/India												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men												
Postpartum women	X					X	X	X		X	X	
Pregnant women	X					X	X	X		X	X	
Refugees/IDPs												
Religious leaders												
Service providers	X	X				X	X	X		X	X	
Youth												
Scaling Up the Provision of Family Planning Messages in Antenatal and Postpartum Services in Upper Egypt: Population Council/Egypt												
	Themes											
Populations	BPs	Capacity Building	CSR	Gender	HIV	HTSP	SDM/ LAM	MNCH	PAC	PPFP	RH/FP	Other
Children/infants												
Factory workers												
Men	X					X		X			X	
Postpartum women	X					X	X	X		X	X	
Pregnant women	X					X	X	X		X	X	
Refugees/IDPs												
Religious leaders	X					X	X	X			X	
Service providers	X	X				X	X	X		X	X	
Youth												

APPENDIX Q. BANGKOK BPPE ESD-FUNDED OR TA-SUPPORTED ACTIVITIES

Bangkok BPPE ESD-Funded or TA-Supported Activities (Provided by ESD)			
Grantee/Country	**Grant/Agreement Title**	**Start-Up Date**	**Planned Completion Date**
Care/India	Scaling up community IMNCI through government child health programs in Chhattisgarh state of India	02/01/08	12/31/09
MIRA/Nepal	Facilitating synergies to scale up maternal and newborn best practices in Nepal	01/01/08	12/31/09
Save the Children/Egypt	Improving maternal and neonatal health through a package of PP and family planning services	03/15/08	12/31/09
JNPK/Indonesia	Scaling up comprehensive essential obstetric and neonatal emergency care training for obstetricians, pediatricians, nurses, and midwives in Indonesia	02/15/08	02/14/10.
BHS/Yemen on behalf of Yemen MOHP	Collaborating to increase the use of evidence-based best practices in postpartum care for mothers and infants in Yemen (KMC, immediate and exclusive breastfeeding, postpartum FP-HTSP-LAM, neonatal infection prevention, distribution of Vitamin A)	01/01/08	12/31/09
BHS/Yemen on behalf of Yemen MOHP	Expanding the implementation of evidence-based best practices for healthier mothers and infants in Yemen	02/01/2009	6/30/2010
Shimantik	Scaling up healthy fertility and postpartum family planning rural experiences in urban areas of Sylhet.	03/01/2009	6/30/2010
Population Council/Egypt	Scaling up the provision of family planning messages in antenatal and postpartum services in Upper Egypt	6/1/2009	6/30/2010
Population Council/India	Increasing postpartum check-ups and contraceptive use among young women in India	6/1/2009	7/15/2010

APPENDIX R. ESD COMMUNITY ACTIVITIES

Description of ESD Community-Based Activities (Provided by ESD)					
Name of Project	**COTR/ Technical Advisor**	**BOP/EOP**	**Description of Community-Based Activities**	**Countries**	**IP**
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provide TA to Business for Social Responsibility on the HER Project, a factory-based peer health education program. RH/FP included in health education. In Pakistan, one participating factory has decided to provide FP at the factory clinic.	Pakistan, Egypt	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to the Federation of Muslim Women's Associations in Nigeria (FOMWAN) to raise awareness and mobilize the community on FP/HTSP needs of young married women, using the community action cycle. ESD is also working with FOMWAN and religious leaders who are conducting outreach on HTSP through sermons and counseling sessions.	Nigeria	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to Burundi MCH Project to integrate HTSP into community-based activities, including training CHWs and TBAs in HTSP and incorporating HTSP messages into community health education sessions.	Burundi	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	With APHIA II NEP, provided training on RH/FP, HTSP, safe motherhood, and HIV/AIDS to mothers groups. Group members are expected to share information learned with family and friends in their community.	Kenya	Pathfinder, MSH, IntraHealth, Meridian

Description of ESD Community-Based Activities (Provided by ESD)					
Name of Project	**COTR/ Technical Advisor**	**BOP/EOP**	**Description of Community-Based Activities**	**Countries**	**IP**
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Trained Peer Health Educators (PHEs) at Unilever Tea Tanzania using ESD's Healthy Images of Manhood manual, which includes information on RH/FP, HIV/AIDS, and GBV, among other topics. PHEs conduct one-on-one and couples counseling sessions, group education sessions, and referrals to facilities for RH/FP, VCT, CTC, ANC, and other services. ESD also trained PHEs using the community action cycle to mobilize the community for collective action around FP services, including services for people living with HIV/AIDS.	Tanzania	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	With Phulki, a Bangladeshi NGO that provides day care in factories, integrated HTSP messages into day care centers in two factories.	Bangladesh	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to conduct a performance assessment report of high and low-performing Health Extension Workers. Also provided TA to decentralize access to long-acting FP methods at the health post level of the Health Extension Program in two woredas of Oromiya Region.	Ethiopia	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Trained private midwives from the Yemen Midwives Association in business skills so they are able to open private practices in their isolated communities. This included adapting a community mapping tool from Afghanistan to identify clients.	Yemen	Pathfinder, MSH, IntraHealth, Meridian

Description of ESD Community-Based Activities (Provided by ESD)					
Name of Project	**COTR/ Technical Advisor**	**BOP/EOP**	**Description of Community-Based Activities**	**Countries**	**IP**
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provide strong M&E and TA support to a Safe Age of Marriage Project in two rural districts where community educators conduct outreach on the issue of child marriage and health risks associated with early pregnancy and child-bearing.	Yemen	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to the Nepali Technical Assistance Group to conduct community mobilization activities on HTSP in the postpartum period. Urban poor and postpartum women were visited monthly for six months and were provided counseling on topics including HTSP and LAM. Additional TA was provided on community mobilization activities and support to mothers groups around HTSP, including follow-up study of the effects of the intervention on FP behavior and pregnancy outcomes over a 2–3-year period.	Nepal	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to Population Services Training Center to engage religious leaders through training on RH/FP, safe motherhood, HTSP, among other topics, from the Islamic perspective.	Bangladesh	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to Save the Children, Egypt to implement home visits for postpartum women, made by nurses and Raedat Refiat. Visits include counseling and referral for FP.	Egypt	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to SHIMANTIK, a Bangladeshi NGO, to implement a project that aims to scale up healthy fertility and postpartum FP, applying earlier rural experiences to	Bangladesh	Pathfinder, MSH, IntraHealth, Meridian

Description of ESD Community-Based Activities (Provided by ESD)					
Name of Project	**COTR/ Technical Advisor**	**BOP/EOP**	**Description of Community-Based Activities**	**Countries**	**IP**
			urban areas of Sylhet.		
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to Care/India to integrate prevention and management of neonatal and childhood illness into an ongoing community IMCI program.	India	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to ESD Angola on development of curriculum to train community agents in RH/FP/HTSP.	Angola	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Designed intervention and provided TA on workplan development for the Flexible FP/GBV Services in Transition Situations Project. Planned activities in DRC include community-based distribution of DMPA.	Burundi, DRC	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Engaged religious leaders through training on RH/FP/HTSP from the Islamic perspective to incorporate into sermons and counseling and support community activities around these health issues. Developed a Preachers Guide and RH/FP brochures to share with the community.	Yemen	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Engaged religious leaders, male champions, and NGO workers through training on RH/FP/HTSP/GBV in Kakuma and Dadaab refugee camps to support healthy RH/FP behaviors.	Kenya	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to Pop Council Egypt as they scale up the provision of FP messages in ANC and PPC services in upper Egypt, including postpartum home visits.	Egypt	Pathfinder, MSH, IntraHealth, Meridian

Description of ESD Community-Based Activities (Provided by ESD)					
Name of Project	**COTR/ Technical Advisor**	**BOP/EOP**	**Description of Community-Based Activities**	**Countries**	**IP**
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to Pop Council India as they work to increase postpartum check-ups and contraceptive use among young women in India, including home visits.	India	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Provided TA to ESD Guinea on intervention design and workplan development, including support for CBD activities started under the PRISM project.	Guinea	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Developed a community-based strategy on the integration of FP into HIV/AIDS care and treatment services. With TA from ESD, the strategy is being implemented with mothers groups in the North Eastern Province Kenya and with Peer Health Educators at Unilever Tea Tanzania, using the community action cycle.	Kenya, Tanzania	Pathfinder, MSH, IntraHealth, Meridian
TOOLS					
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Mobilizing Muslim Religious Leaders for RH/FP at the Community Level: A Training Manual—developed through work in Egypt and Yemen and used in Kenya, Bangladesh, and Nigeria and will be used in Pakistan.	Kenya, Nigeria, Bangladesh, Pakistan	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Healthy Timing and Spacing of Pregnancy Trainer's Reference Guide—used with local NGOs FOMWAN and NTAG for community outreach.	Nigeria, Nepal	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Healthy Images of Manhood: A Training Manual for Working with Young Men—developed for use in Tanzania with Peer Health Educators at Unilever Tea (UTT) and will be used at three sites in Kenya.	Tanzania, Kenya	Pathfinder, MSH, IntraHealth, Meridian

Description of ESD Community-Based Activities (Provided by ESD)					
Name of Project	**COTR/ Technical Advisor**	**BOP/EOP**	**Description of Community-Based Activities**	**Countries**	**IP**
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Youth-friendly post-abortion care job aids—currently being tested in Kenya.	Kenya	Pathfinder, MSH, IntraHealth, Meridian
ESD	Maureen Norton; Rushna Ravji	09/05–10/10	Community Health Worker RH/FP/GBV Flip Chart—job aid developed for use with Somali refugee population in North Eastern Kenya.	Kenya	Pathfinder, MSH, IntraHealth, Meridian

APPENDIX S. KNOWLEDGE ORGANIZATION AND COMMUNICATION ACTIVITIES

Global Level:

- Organizing and/or participating in BPPEs where the focus is dissemination of P/BPs and developing country-level workplans/strategies for introducing/scaling up relevant activities (Appendix J).
- Sponsoring country-level participation in national and international-level BPPEs. including:
  - ESD core funds sponsored MOH personnel from different countries to the Bangkok and Senegal PEs.
  - ESD leveraged funds from USAID Missions and other organizations (WRA and WHO) for their participation and sponsorship of other country-level personnel.
- Funding South-to-South study tours for country-level persons to see P/BPs in action and learn from other countries:
  - Twenty-two religious leaders (18 male), MOHPN, and Ministry of Religious Affairs persons from Yemen went to Egypt to learn from the TAHSEEN Religious Leaders Model.
  - Yemeni health providers have been sent to Tunisia to learn from their mobile health teams program.
  - Seven Yemeni midwives were sent to Uganda to learn from the Uganda Private Midwives organization.
  - Religious leaders from Jordan and Pakistan went to Egypt to learn from the TAHSEEN RL model, as the RL activities in Jordan have recently been reactivated as a result of MOH and bilateral program interest.
- Using core funds for small grants to local organizations to cover the costs of organizing and implementing meetings for advocacy and information exchange:
  - HTSP Champions Chairpersons (e.g., Medical Women Association of Tanzania (MEWATA).
  - Country-level task forces for working with religious leaders.
  - Country-level networking group for cross-learning on PPFP services for urban/periurban areas (MIRA, Nepal).
  - Budget for prefecture-level MOH to organize meetings toward developing community worker networks linked with the health system (Guinea).
  - Policy advocacy to high-level government decisionmakers, including legislators, for incorporation of HTSP messages into guidelines and policies (local NGO in Nepal).
- Developing briefs and a Promising and Best Practices Series that summarize various P/BPs and situations where they are most relevant.
- Developing/participating in virtual knowledge materials/events:
  - The ESD website has links to, or copies of, key materials for users.

  - Created a "Health NGO-Corporate Partnerships Community" on the International Best Practices Initiatives website for the Tanzania Training Workshop participants to exchange lessons learned and promising practices in corporate-NGO-government partnerships and communicate about follow-up Training Workshop activities.
  - Participated in videoconferences organized by Johns Hopkins in collaboration with the ACCESS-FP project.
  - Web-based HTSP-related activities (see next bullet).
- An HTSP Community of Practice has been formed and information-sharing occurs via:
  - Quarterly meetings in Washington DC.
  - Internet posting and sharing hard copies of tools.
  - Maintaining an activity matrix for tracking progress in HTSP roll-out.
  - Semi-annual E-updates.
- ESD is testing CD-ROM-based learning and has developed text and CD-ROMS for sharing education related to:
  - HIV/Integration in Zimbabwe Summary Brief to accompany CD.
  - TAHSEEN Summary Brief and CD titled "An Integrated Model for Success."
- Presentations at international meetings (Appendix M) and USAID/CA groups (Appendix N) to share experiences and promote P/BPs, including HTSP.
- National level-revision of RH/FP guidelines and policies (Sudan, Guinea) and in-service training (Angola) to include LAM, SDM, HTSP, guidance for integrating FP awareness and information within MCH and HIV services, and, where relevant, supervision and commodity management guidance (Facilitating development of Infection Control Guidelines for S. Sudan)
- Developing and sharing generic job aids for counseling related to RH:
  - Counseling cards and guidelines for Youth and PAC; counseling guides for HTSP.

For more information, please visit
http://www.ghtechproject.com/resources.aspx

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