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The MEASURE Evaluation PRH Small Grants Program: Building Capacity and Informing the Field of Family Planning Research



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Cover photograph, by Jeff Kambale Mathe, showing the new auditorium at the Université Catholique du Gabon in Butembo, Democratic Republic of the Congo.

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Acronyms

AFIDEP	African Institute for Development Policy
APHRC	African Population and Health Research Center
ART	antiretroviral therapy
BHDS	Bangladesh Demographic and Health Survey
CHRIS	Center for Health Research and Implementation Support
CHW	community health worker
CPR	contraceptive prevalence rate
CTC	care and treatment center
DRC	Democratic Republic of the Congo
FP	family planning
GHI	Global Health Initiative
GIS	geographic information system
GPSDO	Gurage People Self Development Organization
HSS	health and demographic surveillance site
HTSP	healthy timing and spacing of pregnancy
LIC	low-income country
ICFP	International Conference on Family Planning
IRB	institutional review board
LIC	low-income country
MEDSAR	Medical Students Association of Rwanda
NGO	nongovernmental organization
NIMR	National Institute for Medical Research
PHE	population, health, and environment
PI	principle investigator
PPFP	postpartum FP
RFP	request for proposal
RH	reproductive health
RHSP	Rakai Health Sciences Program
TA	technical assistance
UCG	Université Catholique du Graben
UNC	University of North Carolina at Chapel Hill
USAID	U.S. Agency for International Development
WHO	World Health Organization

Introduction

Family planning (FP) is experiencing a renewed interest from the global health community. In November 2009, the first international meeting on Family Planning Research and Practices was held in Kampala, Uganda. Arising from the conference was a call for building on the evidence base and best practices in FP. Yet the opportunity to conduct this research, from both a technical and financial point of view, remains largely unattainable to those living in the very countries being studied. At the 2010 First Global Symposium on Health Systems Research held in Montreux, Switzerland, the point was made that among the health systems research studies conducted in the previous decade in low-income countries (LICs), fewer than 10% of researchers actually came from these countries.

Small grants have been viewed as one way to promote capacity and provide financial support for health research conducted in LICs. In line with the Global Health Initiative (GHI) principles, small grants support “an effective, efficient and country-led platform for the sustainable delivery of essential health care and public health programs” by giving country-based research groups the opportunity to research local FP issues then disseminate their findings directly to stakeholders so the research can inform and influence policies and programs (“Implementation of the Global Health Initiative: Consultation Document”, p. 3). Furthermore, as the U.S. Agency for International Development (USAID)’s business model undergoes scrutiny internally, with the agency’s goal of building “real incentives into the system to transition to make our projects more sustainable, to work through host-country systems and ministries or local institutions”, supporting country-led research promotes the vision of sustainability with country teams researching issues, developing strategies, and implementing solutions (Walter Pincus, “New administrator wants to change the way USAID works.” *The Washington Post*, January 24, 2010).

Background

In August 2009 discussions began about how small grants administered to local universities and nongovernmental organizations (NGOs) in LICs could contribute to Result 3 of the MEASURE Evaluation PRH Associate Award: Timely and topical analyses done for improved understanding of FP/reproductive health (RH) dynamics and evidence-based decision making. The specific aims of the small grants program were to:

1. increase the evidence-base of FP/RH research;
2. provide data use opportunities to inform programs and policies; and
3. improve the local capacity of developing country researchers and research institutions.

It was envisioned the small grants would support primary and secondary data analysis, lead to the development of a working paper, and assist with implementing data use activities. After submitting a detailed work plan and budget for the small grants program, in October 2009 USAID approved the activity and the first request for proposals was disseminated the following month (see appendix A). A six-person MEASURE Evaluation PRH Sub-grant Review Committee reviewed the initial applications, created a short list, reviewed the full proposals, and selected the final sub-grantees. After a successful first round of small grants, the process was repeated for three additional rounds. Over the course of

four years, 16 sub-agreements were signed with research organizations from 10 USAID FP priority countries. Fifteen of the sub-grantees successfully completed their research projects, as outlined below:

Table I: PRH-AA Sub-grantees, by Research Topic and Country

	Sub-grantee	Research Topic	Country
Round I	Rakai Health Sciences Program (RHSP)/Uganda Virus Research Institute	Does use of hormonal contraception influence the effectiveness of ARV therapy among HIV-infected women?	Uganda
	African Population and Health Research Center (APHRC)	Spatial analysis of contraceptive use in Kenya	Kenya
	Université Catholique du Graben (UCG)	Assessment of healthy timing and spacing of pregnancy practices among postpartum women in Butembo, Eastern DRC, and barriers to the adoption of FP	Democratic Republic of the Congo (DRC)
	Moi University School of Medicine	Investigating low uptake of skilled delivery services and postpartum FP services among women in Western Kenya	Kenya
Round II	Dire Dawa Regional Health Bureau	Assessing the integration of FP and HIV/AIDS care and treatment services in health facilities in Dire Dawa City, Eastern Ethiopia	Ethiopia
	Kintampo Health Research Centre	Improving FP service delivery to adolescents in Ghana	Ghana
	Center for Health Research & Implementation Support (CHRIS)	Intended FP use among pregnant women presenting at health facilities in rural Ghana	Ghana
Round III	Population, Health, and Environment (PHE) - Ethiopia Consortium	Establishing the effectiveness of the PHE approach for achieving FP outcomes in Ethiopia	Ethiopia
	University of Malawi College of Medicine	Using a patient-held record system to examine the determinants of FP uptake, continuation of use and provider-switching in rural Karonga	Malawi
	Health Child	Can wireless text messaging increase uptake of FP services in Uganda?	Uganda
	National Institute for Medical Research (NIMR)	Assessing the effect of quality of FP services offered in HIV/AIDS care and treatment clinics in Tanzania	Tanzania
	Medical Students Association of Rwanda (MEDSAR)	What affects the integration of men in FP?	Rwanda
Round IV	African Institute for Development Policy (AFIDEP)	What is the policy and programmatic evolution of the community-based distribution of FP in Kenya and prospects for its sustainability?	Kenya
	Eminence	Examining the gap between preferred and actual birth intervals in Bangladesh: implications for fertility and child health	Bangladesh
	WISE Toamasina	Spousal agreement on FP and effects on family well-being in Madagascar	Madagascar

One sub-grantee in Round II, the Economic Policy Research Centre, was unable to complete their research on women's empowerment and RH outcomes in Uganda. Over the course of two years,

numerous attempts were made to reach out to the principle investigator (PI) and offer any assistance needed; but, for various reasons, the PI was unable to complete the research project. The funds received were returned to MEASURE Evaluation PRH and the sub-agreement was terminated.

Program Management

The small grants program was managed by the MEASURE Evaluation PRH project manager, in close coordination with the project director. Although the project manager was the primary point of contact for the sub-grantees before the contracts were issued, during their projects, and after the formal agreements had ended, many others were involved in administering and managing the program (e.g., MEASURE Evaluation Finance Department, Sub-grant Review Committee, the USAID technical advisor for MEASURE Evaluation PRH). Technical assistance (TA) was sought from others in the project according to the specific needs/requests of the sub-grantees and the expertise of other project staff.

The sub-grantees were required to submit quarterly reports to assist MEASURE Evaluation PRH with monitoring the progress of the projects. They were also asked to provide updates on dissemination activities after their contracts had closed. Activity progress and results of the small grants were communicated to USAID through MEASURE Evaluation PRH’s reporting system (e.g., quarterly, annual, and results reports).

A detailed budget for the program was drafted prior to the first round and adjusted accordingly after the conclusion of the pilot. Just over \$510,000 in total costs was spent on the program, resulting in an average cost per small grant of around \$34,000. Awards received by the sub-grantees accounted for approximately 35% of the total budget. The remaining costs of the program included administration of the grants, technical assistance, indirect costs and overhead.

Due to the high number of applications, the acceptance rate for the program was 3.8%.

Table 2: Statistics from Managing the Small Grants Program

	Round I	Round II	Round III	Round IV
Number of applications received	159	48	133	78
Number of countries represented	24	11	19	16
Average concept paper request	\$13,997	\$8,204	\$11,085	\$9,182
Number of applicants shortlisted	13	11	10	10
Number of proposals funded	4	4	5	3
Average award amount (direct costs only)	\$9,959	\$8,937	\$12,545	\$16,998

Results

Contribution to the Evidence Base of FP/RH Research

The small grants program was a successful and cost-effective way to contribute to the evidence base for FP, build local research capacity, and disseminate research findings to those directly involved in making programmatic and policy changes. The research projects fell into four key themes:

- I. Integration of FP into HIV Services
- II. Community-Based Approaches to Improving FP Service Delivery
- III. Factors Influencing the Adoption of FP
- IV. Birth Intervals and the Relationship to Proximal Determinants of Child Health

I. Integration of FP into HIV Services

Three research projects investigated the relationship between FP and HIV services.

Looking at clinical and questionnaire data from 418 HIV-positive women in Rakai, Uganda who were initiating antiretroviral therapy (ART), researchers at the [Rakai Health Services Program](#) found that injectable contraceptive use was not associated with increased risk of ART failure or poorer adherence to ART. The results are consistent with current World Health Organization (WHO) recommendations for injectable contraceptive use among HIV-positive women on ART and support the findings of previous studies.



The [National Institute for Medical Research \(NIMR\)](#) study examined the quality of FP services in the two models that integrate FP services in HIV/AIDS care and treatment centers (CTCs) in Tanzania. When looking at WHO's six dimensions of quality: effective, efficient, accessible, acceptable/patient-centered, equitable, and safe, the research team (pictured at left) found that quality of FP services was lacking in all areas in the expanded facilitated referral model, particularly with regard to service providers following the national standards for FP service provision and having the necessary equipment and supplies at the CTCs.

Researchers in [Dire Dawa Administration, Eastern Ethiopia](#) employed a cross-sectional study design to assess the unmet need for FP and barriers to use among women living with HIV and accessing HIV/AIDS health services in Dire Dawa. The study found that knowledge of FP was low in this population with more than one in 10 not having heard of an FP method. Subsequently, unmet need was high, at 36%. Nearly 25% of the study subjects were not counseled on FP methods and there seem to be limited channels of communication for health providers to inform HIV clients on the importance of FP. The findings point to poor integration of FP services into HIV care and treatment services in Dire Dawa, despite the evidence showing improved FP use among HIV clients when FP/HIV services are integrated.

II. Community-Based Approaches to Improving FP Service Delivery

Four research projects looked at community-based approaches to improving FP service delivery.

To understand unmet need for FP, it is important to examine contraceptive switching and discontinuation as desired family size declines and contraceptive prevalence rate (CPR) increases. However, conventional assessments of FP use do not always capture this. A team from the [College of Medicine at the University of Malawi](#) (at right) explored a new, prospective method for collecting FP data. Using patient-held records capturing provider data, the researchers built a prospective longitudinal data set from 8,176 women aged 15-49 living in the Karonga, Malawi health and demographic surveillance site (HSS). This allowed them to explore continuity of use and provider/method-switching, which could also be linked to an HSS database. Although 42% of married women report using FP in Malawi as a whole, this study found that 62% of women in the study had used *some* method of FP at *some* stage over the study year. However, this figure does not reflect the fact that many of these women might be using FP haphazardly and inconsistently, thus underscoring the importance of community-based distribution of FP.



A research team from [Health Child](#) investigated if mobile phone text messaging increases uptake of FP services in the Eastern Region of Uganda. The use of mobile telephone text messaging was associated with high turn up at health facilities: 75% of the women who received text messages mobilizing them to turn up at the health facility for FP sensitization meetings honored the invitation (compared to 5% in the control group). Mobile telephony was also associated with increased rates of uptake of modern contraceptive methods (39% in the implementation group compared to 14% of women in the control groups). Women in the experimental group reported that the messages they received helped them in several ways, including knowing the facilities where they could access FP services, obtaining information about FP benefits, clearing myths and misconception about FP, and gaining confidence to talk about FP.



The research team from [AFIDEP](#) (at left) aimed to document the evolution of policy and program processes related to community-based distribution of contraceptives in Kenya to determine associations of its influence on use of modern FP methods as well as determine its sustainability. Community-based interventions and the value of community health workers (CHWs) in improving access to health services

resulting in improved health outcomes in Kenya is unprecedented. Further, task shifting/sharing supply of FP methods to CHWs has been demonstrated to be safe and effective and linked to increased uptake of FP. But since the revival of community health service delivery through the *2006 Community Health Strategy*, implementation has been delayed, particularly with reinforcement of quality of care standards

The PHE approach was implemented because of evidence that integrated development programming incorporating PHE can be effective at lowering population growth rates and preserving the environment. Yet the outcomes of this intervention in Gurage Zone were never analyzed. The PHE-Ethiopia Consortium conducted the first evaluation of a PHE project in Ethiopia that used a rigorous research design and led to statistically significant results. Including data from 960 married women of reproductive age, the researchers found that overall, the PHE approach increased positive outcomes on fertility attitudes, FP use, and environmental conservation areas, while there was no significant difference in knowledge about FP. Because the findings unexpectedly revealed that there were more unwanted pregnancies in young women in the PHE site and more in older women in the non-PHE site, Gurage People Self Development Organization (GPSDO), the implementing organization, is using the data to determine why this has happened and revise their programming accordingly.



women give birth are influenced by socioeconomic factors, cultural practices, fear of HIV testing at the hospital, quality of service provided, geographical access to facilities, stigma surrounding health facilities as being unfriendly and disempowering, and more familiarity with traditional birth attendants. The

and a defined monitoring and evaluation framework. The association between increased contraceptive uptake and increased access to FP at the community level has already been achieved and a further boost in FP uptake is anticipated, which will be the first one since the repositioning of community-based FP distribution.

Researchers from the [PHE-Ethiopia Consortium](#) used quantitative and qualitative data to evaluate the effectiveness of the PHE community-based approach for achieving FP and fertility outcomes in Gurage Zone of South Ethiopia. There was no significant difference in CPR in the intervention and non-intervention woredas (i.e., districts), which is likely due to the confounding effect of the Meskel holiday, during which a large-scale campaign promoted FP that resulted in a culture of FP use by the community. However, a subgroup analysis of CPR excluding recent new acceptors showed that PHE woredas had a significantly higher CPR as compared to non-PHE woredas. Within this sub-group, women in the PHE woredas were over four times more likely to use an FP method during the study period compared with women in the non-PHE woredas.

III. Factors Influencing the Adoption of FP

Seven research projects looked at factors that influence the adoption of modern FP methods.

Despite the fact that 92% of Kenyan women receive antenatal care, only 44% of births occur with a healthcare professional in a facility. Moreover, 26% of women have an unmet need for FP. Researchers from [Moi University School of Medicine](#) conducted a study to examine how women choose where to deliver and how they arrive at their postpartum FP decisions. The results found that decisions pertaining to where

findings illustrate that FP practices are determined by spousal and extended family support, literacy, and access to accurate information about FP, fear of side effects, costs of FP methods, and religion.

A team from the [Center for Health Research & Implementation Support \(CHRIS\)](#) (at right) conducted a survey among pregnant women attending antenatal clinics in a rural district in Ghana's Central Region to explore predictors of their willingness to adopt postpartum FP (PPFP). The findings show that 84% of women consider PPFP acceptable and 70% expressed a willingness to adopt a method after delivery. Perception of male partner and societal approval, knowledge of FP methods, past experience with the use of



injectables, number of times the women had been pregnant, and whether the pregnancy was unwanted or unexpected are the major determinants of the willingness of a pregnant woman to adopt PPFP.

In a country where the CPR stands at 7%, researchers at [Université Catholique du Gabon \(UCG\)](#) in Butembo, DRC, aimed to assess the extent of knowledge, attitudes, and practice of FP among women who had just delivered. The study also attempted to assess birth spacing, how well couples are following healthy timing and spacing of pregnancy (HTSP) guidelines, and to what extent HTSP is being promoted in postpartum units. The findings reveal that knowledge and attitude toward FP among this cohort is high (76% and 80%, respectively), however, fertility awareness is low (35%) as is knowledge about FP methods among teenage mothers. About one-fifth of the women (21%) had an unmet need for spacing and about one-third had an unmet need for limiting pregnancies (31%). Most healthcare workers in Butembo have poor knowledge of FP and do not discuss HTSP nor counsel on or provide FP to women after delivery.

[MEDSAR's](#) study sought to understand what affects the integration of men in FP in Rwanda, mainly in villages of Southern Province and Kigali City Province, and what can improve male involvement. Factors that facilitate the integration of men in FP include radio talks, FP trainings at healthcare facilities and at the community level, community health worker visits to families, and FP counseling in health centers integrated with different RH services, though the lack of a defined calendar for FP services to men impedes service delivery. The main factor encouraging men to take a role in FP issues is concern over family size and the financial needs accompanied with it. However, they face barriers to use such as misconceptions about side effects of FP methods, staunch religious beliefs, wives willing to continue having children, a pronatalist culture, and few male-focused methods available. Despite sensitization programs in healthcare facilities, male participation is still low, and some men believe it is a woman's issue and/or do not believe in FP, even forbidding their wives from practicing it. However adolescents and young men are more motivated to use condoms and are more receptive to FP.



To complement earlier studies about the relationship between family dynamics and FP use and FP use and family well-being, researchers from [WISE Toamasina](#) (at left) explored if there is a relationship between family influence on FP use and family well-being. With data collected from 768 couples in the Vatovavy Fitovinany region of Madagascar, the findings reveal that 57% of couples talk to, discuss, and agree with each other on FP decisions; 20.8% of couples talk to, discuss,

and agree with extended family on FP decisions. Among the couples having FP discussions, nearly all (96%) said they first discuss this issue before seeking advice from others such as parents, in-laws, friends, and neighbors. There is evidence that while both spousal dynamics and extended family influence are associated with FP use, spousal dynamics show a stronger relationship. Analyses regarding well-being were inconclusive overall but suggest that spousal dynamics may also have a greater association with well-being than extended family influence.

Using quantitative and qualitative data, a research team from the [Kintampo Health Research Centre](#) aimed to understand the FP needs of adolescents (10-19 year olds) in central Ghana, as well as the societal and healthcare perspectives on FP services for adolescents. Marital rates among adolescents in the study area (19.1% for females and 6.7% for males) were above national figures, as were pregnancy and birth rates. The most commonly used methods were the condom followed by the rhythm method, however, most females stated their future FP preferences to be injectables and pills. The general attitude is that FP is good and has several benefits for adolescents, with few respondents thinking otherwise. But adolescents stated many obstacles in accessing FP care, including poor attitudes and discrimination from healthcare providers, the community seeing adolescents practicing FP as spoilt, the perception that FP could corrupt the young population, concerns about healthcare worker approaches to care delivery, and perceived complications of FP.

The findings from Moi University's research on low uptake of skilled delivery and postpartum FP services were widely disseminated in Western Kenya with great interest taken from government staff, local community leaders, traditional birth attendants, researchers, and diverse organizations working in RH in the study sites. Two interactive stakeholder meetings were held in the study areas; one in rural Bunyala District where Port Victoria is located, and one in urban Eldoret, at the Moi Teaching and Referral Hospital. During the meetings, participants discussed the study findings and possible strategies to help achieve the United Nation's Millennium Development Goals 4 and 5. Port Victoria District Hospital invited the researchers to come back to the hospital to share the findings with the healthcare providers from all cadres. Because the findings stirred quite a bit of dialogue, additional meetings were requested in Eldoret and Port Victoria with the National RH Departments where the findings and recommendations were again presented and discussed. The paper was presented in Washington DC at the George Washington University Research Day and at the 8th Annual Tropical Institute of Community Health Scientific Conference in Kisumu, Kenya.

Moi University Research Team



IV. Birth Intervals and the Relationship to Proximal Determinants of Child Health

One research project investigated the gap in preferred and actual birth spacing.

Using data from the 2011 Bangladesh Demographic Health Survey (BDHS), researchers at Eminence studied the existing gap between actual and preferred birth intervals to examine the relationship between birth intervals and child health, fertility variation, and other proximal determinants of birth spacing. For the last birth, the actual birth intervals were found to be 64.9 months and 57.6 months in urban and rural areas, respectively, revealing an increase over the length of the previous interval as reported in the BDHS 2011 in both areas. The difference between actual and preferred birth intervals is greater in the urban areas than the rural areas when the median length of the birth interval is more than 24 months. For median intervals less than 24 months, the difference between the actual and preferred birth interval is insignificant. Child mortality was found to be higher when the birth interval is less than 24 months, with the proportion gradually decreasing when the interval is 24 months and over. Although there is little change in the under-nutrition status of children if the preferred birth interval prevails, shorter birth intervals might influence children's under-nutrition through its association with preterm births and low birth weight. The analysis found that mothers with primary or higher education generally prefer fewer children and have longer birth intervals than mothers with no education.

Provision of Data Use Opportunities to Inform Programs and Policies

All of the small grants research manuscripts were turned into working papers and shared directly with USAID/Washington and technical staff at other offices, as appropriate (e.g., the U.S. Centers for

Disease Control and Prevention, USAID Missions, in-country health bureaus). In addition, two-page research briefs (appendices B, C, D, and E) were developed for four of the research projects. The manuscripts and briefs were disseminated through various channels ranging from meetings with local health facility or regional health office staff to oral presentations at large international conferences. The range of dissemination channels and activities, by sub-grantee, is outlined in table 3.

Several of the PIs recently submitted or are planning to submit their research for journal publication (particularly among the last round of small grants); therefore, the number of journal publications may increase in 2014.

Table 3: Small Grants Dissemination Activities

Sub-grantee	Journal Publications to-date	Presentation at Intl. Conference	Presentation at Regional Conference	Presentation at University Research Event	Local Dissemination Workshop	Local Stakeholder's and/or Technical Meeting	Final Report Sent to Stakeholders	Research Brief Developed	Posted on PRH-AA Website	Posted on Another Website (or blog)	Data Used for Additional Research & Analysis
Rakai	X	X							X		
APHRC					X				X		
UCG	X	X			X		X		X		
Moi University			X	X	X	X	X		X		
Dire Dawa							X		X		
Kintampo		X			X		X	X	X		
CHRIS	X				X		X	X	X		X
PHE-Ethiopia		X	X		X		X	X	X	X	
U. of Malawi		X		X		X			X		
Health Child		X	X			X			X		X
NIMR			X			X		X	X		
MEDSAR		X		X				X	X		
AFIDEP		X				X	X	X	X		
Eminence							X		X		
WISE Toamasina						X	X		X		

Local Capacity Improved for In-Country Researchers and Research Institutions

Arguably the most successful aspect of the small grants program was the extent to which this program provided young, emerging, and/or under-funded organizations or researchers the opportunity to conduct research, receive high-quality technical assistance, and develop and implement a data dissemination plan. Although all of the PIs had conducted research, their level of experience varied greatly. Furthermore, there were gaps in their research capacity that this program helped to address. Dr. Jeff Mathe, the PI for UCG, explained:

Jean Christophe Rusatira, a medical student with MEDSAR when the sub-grant was awarded, was interested in FP/RH and wanted to focus on research. This sub-grant created the opportunity for Rusatira to be the PI for a research project and build his technical writing skills, research experience, and reputation. Following the conclusion of MEDSAR's research project Rusatira wrote, "I am now part of the team that is working on medical education and research development, composed of senior and junior doctors and medical students. (It is designed) to improve interaction amongst health professionals, and it is a good team for different researches. It has been such a great experience for all my team mates to be part of this research and we all have learned a lot!" Their efforts were recognized on May 5, 2013, when the National University of Rwanda awarded MEDSAR "Best Student Research Project" at an annual Research Day celebration. As the PI, Rusatira was granted a scholarship to present the findings at the International Conference on Family Planning (ICFP) in Ethiopia, November 2013 (below). Through this experience, he was selected to be a member of the youth delegation and is now involved in FP 2020 as a youth advocate.



Personally, this research was an opportunity for me to build up my research skills especially in two areas: the analysis plan and the dissemination plan. In my past research experiences, I wasn't using them, but to fulfill the requirements of this grant, I had to. With no experience, I had to do some personal readings to make sure I knew what to do. If this opportunity wasn't there, then I wouldn't have got these new important skills, which are part of good research. So in my future research, I will now make sure that these areas (a detailed analysis plan, as well as a dissemination or data use plan) are well documented in the preparatory phase. Most of the time, we just sit on findings and do nothing about them. This research has opened my mind for the future.

Justin Murashani, PI from NIMR, and Aisha Dasgupta PI from the University of Malawi College of Medicine both expressed what a new and positive experience it was for them to be responsible for leading a research project from start to finish, from writing the concept paper and proposal to applying for ethics approval, managing the sub-grant, handling logistics, protocol design, planning, implementation and supervision of field-work, meeting reporting requirements, data management and cleaning, analysis, write-up, and dissemination. Ahmed Mohammed from the PHE-Ethiopia Consortium reinforced their sentiments:

As the program officer, I coordinated the research, and in so doing I benefited a lot. I developed my capacity how to conduct research and I have also developed my skill in research proposal writing, data analysis, reporting, etc.

Organizations also benefited from the exposure this research provided as well as the opportunity to build the organization's research portfolio. For instance, the small

grant awarded to APHRC provided an opportunity for the organization and PI to develop the capacity to utilize spatial data for research studies, thereby enabling other staff at the center without experience in geographic information systems (GIS) to build their capacity in conducting this type of study. The PI gave a training seminar to research staff at APHRC to demonstrate the use of GIS data for spatial analysis and its applicability to various projects in the Nairobi Urban Health and Demographic Surveillance System.

This was the first research grant awarded to CHRIS. The work gave them visibility through their collaborations with the University of Cape Coast and Ghana Health Services, particularly the Family Health Division and the institutions where the study was conducted.

As a result of Health Child's study they were able to build on their MEASURE Evaluation PRH-funded research by following up with the women who had accepted modern contraceptives after a period of nine months and asking them additional questions. The follow-on study is titled, "Profile of Contraceptive users in Jinja District: Opportunities for scaling up and continuation."

When needed, the sub-grantees received extensive TA from the MEASURE Evaluation PRH program manager with in-depth feedback on interview questionnaires; support with reviewing and editing draft manuscripts, research briefs, or presentations; guidance on dissemination plans; and assistance with requesting reimbursement in compliance with UNC requirements. The comprehensive TA not only provided a mentorship opportunity to the PIs to build their capacity, it also resulted in higher quality research papers and presentations and more timely payments.

Lessons Learned

There were several lessons learned along the way in administering and managing the small grants program. These include the following:

Be explicit in the request for proposals (RFP) about the eligibility criteria and objectives of the small grants program. Several concept papers were automatically rejected for various reasons (i.e., not from a USAID priority country; budget was exceptionally high; the organization was a field office for a large, international NGO; proposed research exceeded the timeline for the small grants; the topic had little to do with FP). Before each successive round of the program, the RFP was reviewed and if necessary, the eligibility criteria was clarified to more specifically target the groups intended for the program. This may be one reason why the number of applications was highest for the first round.

If possible, coordinate the RFP announcement with an existing dissemination opportunity. For the first round of small grants, the RFP coincided with the ICFP, where copies of the RFP were disseminated in addition to the electronic announcement. Because of the timing of the RFP for the third round, the announcement made it into MEASURE Evaluation's *MONITOR*, an electronic newsletter that is sent to over 10,000 individuals. The numbers of concept papers received in Rounds I and Round III were 159 and 133, respectively, compared to 48 and 78 in Round II and Round IV, respectively, where the RFP announcement did not coordinate with a wider dissemination event.

Prioritize applicants who have an established relationship with a sister organization, university, mentor, or other support network. Few research organizations are working in isolation. Taking advantage of these pre-existing relationships meant that additional TA could be provided to the sub-grantee external to the organization (and proposal budget), which generally increased the quality of the research and final manuscript. Logistically, these third parties tended to have reliable internet connections and be in the same or nearby time zone, thus facilitating communication between MEASURE Evaluation PRH and the sub-grantee.

Recognize that in-country research priorities do not always match global research priorities. With each round of small grants, we reviewed one or more concept papers that were well-written, thoughtful, and of high quality but which addressed a FP research topic that was not a USAID priority. For example, over the course of the program we reviewed several concept papers from Nigeria discussing the neglected FP needs of handicapped women. Although the authors presented compelling arguments for why more research is needed in this area, it was not a topic we were able to fund. Additionally, there were many proposals that made a case for why particular research was needed locally, but that would not have substantially increased general knowledge on the topic.

Conduct due diligence about organizations to get a sense of an organization's credibility and reputation. Prior to making our final sub-grantee selections, we attempted to gather as much information as we could, both online and from colleagues, about the organizations during the shortlist period. We also took into consideration other factors that would give us a sense of how the researchers operated, such as how responsive they were to emails about their proposal and how thoroughly they addressed our questions and comments.

As appropriate, assist the applicants/sub-grantees by providing templates for requested items. Templates were provided to the applicants for the proposals and to the sub-grantees for the quarterly reports and requests for payment. This made it easier to review documents, clearly convey what information was needed, and process the paperwork with minimal back and forth.

Select applicants with varying levels of capacity. Some small grant recipients required very little TA and conducted relatively high level analysis. The scientific level of research proposed by these experienced individuals and organizations could not necessarily be matched by newer organizations or younger researchers. However, the research grants provided the less experienced teams an opportunity to “learn by doing” with the result of a completed research study, a working paper or publishable manuscript, and interaction with stakeholders. This proved to be an invaluable experience for many of the sub-grantees, as expressed in follow-up emails to MEASURE Evaluation PRH. We aimed to balance each round of the small grants program with teams that were lower capacity and expected to require more TA with teams that were higher capacity and expected to require less TA.

Encourage the selected sub-grantees to seek institutional review board (IRB) approval/waiver as soon as possible. Receiving final IRB approval significantly delayed some of the research projects. Notifying the applicants as soon as they are selected and encouraging them to immediately address the IRB approval/waiver requirement helps to mitigate delays.

Take into account the time it takes to administratively process the contracts. In some instances, it took nearly two months to process the sub-agreements and payments due to many anticipated and unanticipated administrative procedures and delays. It is critical to factor in this lengthy process when developing timelines.

Use various means of communication to stay in close contact with the sub-grantees and establish an effective working relationship. Regular communication with the sub-grantees was essential for adhering to timelines and ensuring all terms of the agreement were met. In addition to email, we found phone calls, Skype conversations, and in-person meetings (when feasible) to be effective in maintaining close contact with the research team and helping the projects stay on-task and on-time.

Invest the time to provide as much technical support as needed. Providing extensive feedback to some of the less-experienced researchers over the entire span of their project paid off in higher quality proposals, manuscripts, and dissemination materials, in addition to building their research capacity.

Set aside a small amount of funding to provide financial assistance to those given the opportunity to present their research findings at an international conference. There were 13 instances where we were notified by a sub-grantee that their abstract had been accepted at an international conference. The project was able to provide limited financial support for conference participation in just two of the instances. Subsequently, because of lack of funding, some of the researchers missed out on an exciting opportunity to disseminate their research findings to an international audience.

Prior to each new round of small grants, evaluate the program and make the necessary adjustments. We used the time before beginning a new round of small grants to review the RFP, revise timelines, adjust the budget, and modify the management of the program, as needed, based on the lessons learned from the previous round(s).

Conclusion

MEASURE Evaluation PRH's small grant program proved to be an effective strategy for increasing the evidence base in FP/RH, improving research capacity in developing countries, and providing data use opportunities. With 94% of sub-grantees achieving the terms of their agreement, the program was deemed an overall success by both USAID and the MEASURE Evaluation PRH project. Our recommendation is to promote the small grants program as a viable approach to filling local FP/RH research gaps and providing hands-on research experience for those working in areas where promotion of evidence-based FP practices is a priority.

Appendix A: Small Grants to Support Research in Family Planning: Request for Proposals

The MEASURE Evaluation Population & Reproductive Health Associate Award (PRH) is pleased to announce its fourth round of requests for proposals for its small grants program to increase the evidence base in family planning (FP). The primary objectives of this program are threefold:

- 1) To **support research** efforts of developing country researchers and research institutions to provide needed information that informs FP policy and programmatic decision-making.
- 2) To **increase use of existing data** that informs local and/or global FP programs. Such data sources may include the DHS, SPA, BSS, and high-quality, country-specific data.
- 3) To **increase use of research findings** by policy and programmatic decision-makers not traditionally involved in the research process.

The small grants are intended to support primary and secondary data analysis – especially national program or policy evaluation – and data use activities based on research findings. Small grant recipients are expected to produce a publishable manuscript and complete a data use activity.

Eligibility

Eligible candidates include country or regional academic institutions or centers, non-profit and for-profit research organizations, parastatals, and research-focused NGOs. All candidates must be from USAID's FP priority countries (see list on page 3). Eligible candidates must be seeking to build their research and/or data use capacity. Those representing regional/field offices for international NGOs are ineligible for this funding opportunity. Also, proposals for project evaluations will not be eligible.

Eligible research proposals will use appropriate and rigorous methods to respond to a question of interest to stakeholders in the country or region being studied. Potential topic areas are listed on page 3. Proposals should also include data use activities and/or products that help ensure the use of research findings by appropriate stakeholders, which may include: the development of a short briefing paper with recommendations and a presentation of the key actionable findings from the analysis; holding a workshop for policymakers and/or program decision makers to discuss key findings and the implication of these findings for policies and programs; organizing a meeting with national or regional level staff from the ministry of health to discuss the research findings and develop an action plan based on the findings; etc.

Eligible proposals should be comprised of a team of at least two people. The team should have previous research experience, particularly in FP specifically, or reproductive health in general.

Small Grants Awards

The base amount for a small grant is US\$6000, which is intended to cover basic research expenses for a **nine-month** timeline. However, the total amount of the grant will be based on proposed budgets and is expected to be higher, so as to cover the costs of the planned data

use activities. Additional funding may also be provided for research projects that include supplementary data collection. Travel to national or regional conferences to present the research findings may be requested. Funds will be paid in three installments – at the onset of the proposed study, after receipt of the first draft of a working paper, and after completion of the final working paper and other products related to the use of the findings (bulletins, action plans using the findings, etc.)

Proposals will be assigned a technical advisor at MEASURE Evaluation PRH who will provide technical assistance for data analysis, editing drafts, and/or data utilization, as needed. Final working papers will be posted on the MEASURE Evaluation PRH website.

Application Procedure

To apply, please submit the following in English:

- brief cover letter;
- 2-3 page concept paper clearly summarizing the background/context, research questions, scope of analysis, description of dataset, and proposed data use activities;
- budget;
- curriculum vitae of key personnel; and
- names and contact information of three references.

Concept papers are due by **November 12, 2012**. All candidates will be notified by November 26, 2012. Short-listed candidates will then be requested to submit a detailed research proposal (5-10 pages) with the following sections – background, research question(s), data collection/methodology, analysis, plan for using findings to inform programmatic and/or policy decision-making, composition of research team, description of how the sub-grant will build research capacity, and budget. This detailed proposal will be due by December 11, 2012. After all candidates are notified, selected candidates will be required to submit proof of institutional or country review and approval, if applicable.

Selection

Proposals will be assessed on:

- 1) The degree to which the proposal demonstrates a conceptual understanding of FP research and the related literature.
- 2) A good fit between the research question(s) and proposed data to be used in the study.
- 3) The degree to which the proposed research methods are appropriate and rigorous.
- 4) Evidence that the research findings are needed for program or policy decision-making at the country, regional, or international level and/or will make a significant contribution to the existing literature on FP.
- 5) The ability of the research to inform practice and policy for underserved populations.
- 6) The relevance of the proposed work to current and future FP public policy discussions.
- 7) Prior experience working with proposed (or similar) data.
- 8) The feasibility and appropriateness of data use activities to the proposed research question(s).
- 9) The degree to which the small grant will build on the current capacity of the organization to conduct research and encourage data use.

10) Realistic budget and timeline based on the proposed research topic and available MEASURE Evaluation PRH funds.

Suggested Research Topics & Methods

Priority will be given to proposals that address the suggested research topics and/or methods.

- Reaching underserved populations (e.g. addressing FP needs of youth and adolescents; the poor; displaced populations; etc.)
- Exploring strategies to reduce poverty and inequality through targeted FP service delivery mechanisms
- Integrated FP services (e.g. postpartum FP; FP as a component of postabortion care; FP integrated with immunization services; etc.)
- Healthy timing and spacing of pregnancies tools, approaches, and practices
- Addressing gender in FP, specifically, the effectiveness of gendered-focused interventions on FP/reproductive health outcomes
- Understanding provider and FP user behavior
- Evaluating FP programs or policies (e.g. community-based distribution, contraceptive security, long-acting & permanent methods, behavior change communication, etc.)
- Evaluating population-health-environment programs
- Utilizing innovative rapid data collection methods
- Assessing mHealth, e-Health, and emerging technologies as they relate to FP
- Mapping or spatial analysis of FP data

USAID FP Priority Countries

Afghanistan	Liberia	Philippines
Bangladesh	Madagascar	Rwanda
Democratic Republic of Congo	Malawi	Senegal
Ethiopia	Mali	South Sudan
Ghana	Mozambique	Tanzania
Haiti	Nepal	Uganda
India (Uttar Pradesh State)	Nigeria	Yemen
Kenya	Pakistan	Zambia

Contact Information

Please send inquiries and applications to:

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Appendix B: MEDSAR Research Brief



Dominic Chavez, World Bank

Involving Men in Family Planning Programs and Services

Background

Several studies have shown that male engagement can improve access to and use of family planning (FP). But despite the Rwandan Ministry of Health's expanded focus on couple counseling in FP, male involvement in FP is still poor in both the household and healthcare settings.

The Medical Students' Association of Rwanda (MEDSAR) was awarded a small grant from the MEASURE Evaluation PRH project to investigate the barriers to integrating men into FP programs in Rwanda. The research team conducted one-on-one interviews with 96 community health workers (CHWs) and 24 nurses in 24 healthcare facilities in Rwanda's Southern and Kigali City Provinces. Focus group discussions were conducted with men and women, all parents either married or not, at each of the healthcare

facilities. To read the full study see:

www.measureevaluation.org/publications/wp-13-132

Findings

In many healthcare facilities there is no defined calendar for FP services for men apart from free condom distribution. Because HIV/AIDS discussions have dominated the sexual education agenda, less attention has been directed at FP awareness efforts among men. Furthermore, some consider condom use inappropriate in families.

Nearly 90% of the healthcare providers believed that men are not committed to practicing FP since they rarely accompany their wives to the facilities or show up for FP outreach or services. Women have few options when their husbands do not want them

to use FP, and there is no program or policy to help in such a situation; an outdated law requires mutual consent among couples in order to obtain contraceptives.

Men often view FP in relation to their financial situation. They are aware that bigger families are expensive; however, lack of education, religious beliefs, and cultural attitudes interfere with FP acceptance. For example, in Rwandan society children are considered a treasure or power for the family, thus encouraging larger families. Men may avoid using FP because they are trying for a boy, based on the cultural priority placed on sons. Some Rwandan proverbs and the fact that women primarily raise the children reinforce the belief that FP is a women's issue.

Both the CHWs and healthcare providers felt they needed more training on FP counseling and methods, especially vasectomy. Misinformation and rumors about FP (both urban and rural) prevent men from practicing FP and can influence their decision to prohibit their wives from using contraception. Men who understand and appreciate the role of FP are motivated to use it, but in the absence of many options for male-focused methods, men get discouraged and leave FP to women.

Recommendations

Factors that have facilitated the integration of men in FP through other RH services include: key

selection of counselors knowledgeable about FP counseling and methods; decentralizing the healthcare system through CHWs; and offering basic FP training to healthcare providers and CHWs. A variety of other factors could positively influence the integration of men in FP:

- Involve more officials in FP programs;
- Set a permanent plan of action involving men in FP integrated into different RH services;
- Make FP counseling after each hospital birth a standard practice;
- Increase the number of staff trained in FP and structure job roles and responsibilities to allow the trained staff to actively provide FP services;
- Rotate FP staff among RH units;
- Provide a variety of FP methods so CHWs and healthcare providers have enough commodities to provide FP services at the community level;
- Establish joint FP programs between healthcare providers and CHWs working in communities;
- Implement regular supervision for FP services;
- Support more FP talks and awareness building of FP programs, particularly in rural areas;
- Focus on FP education, starting from youth, to prevent unwanted pregnancies and instill a culture of FP;
- De-stigmatize male involvement in FP by using testimonies from men and couples who have had successful FP experiences;
- Provide supportive advice and counseling for men interested in FP;
- Create a policy change to allow equal access to FP for men and women, thereby giving women more agency about their healthcare.



<http://www.measureevaluation.org/prh>

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Appendix C: CHRIS Research Brief



Jonathan Ernst, World Bank

Factors Influencing the Adoption of Postpartum Family Planning

Background

Pregnancy and the immediate postpartum period are considered opportunistic times for counseling women on adopting a modern family planning method. In spite of various interventions to promote postpartum family planning (PPFP), uptake in sub-Saharan Africa has remained very low, particularly in rural areas. The Centre for Health Research and Implementation Support (CHRIS) was awarded a small grant from the MEASURE Evaluation PRH project to study women attending antenatal care in Ghana to explore factors that influence their willingness to adopt PPFP. The research team interviewed 1,914 pregnant women in rural and semi-rural health facilities in the Central Region of Ghana, a region with some of the most

adverse FP indicators in the nation. To read the full study see: www.measureevaluation.org/publications/wp-10-117

Findings

The findings showed that the vast majority of women (84%) in the Mfantseman District of the Central Region consider PPFP acceptable and are willing to adopt a method after delivery. However their willingness depends on a number of important factors. The more times a woman had been pregnant and if she was carrying an unwanted or unexpected pregnancy made her more likely to choose PPFP. On the other hand, PPFP was less likely if one of more of previous

Appendix D: NIMR Research Brief



Wayne Hoover, MEASURE Evaluation

Quality of FP Programs in HIV/ AIDS Care and Treatment Clinics

Background

Mounting evidence shows that many people with HIV have an unmet need for family planning (FP). Providing FP services in HIV care and treatment clinics (CTCs) can increase access to FP among women and couples living with HIV. However, the potential health benefits of integrated services remain largely undocumented.

There are two models of FP/HIV integration in Tanzanian health facilities. The facilitated referral model screens clients at risk for unintended pregnancies, educates clients on FP methods, records referrals to an FP clinic, and accompanies clients to the FP clinic. The expanded facilitated referral model provides all the above services in addition to providing short-acting FP methods.

The National Institute for Medical Research (NIMR)-Muhimbili was awarded a small grant from the MEASURE Evaluation PRH project to evaluate the quality of FP services provided in the two models and assess the extent to which provision of FP services in CTCs meets established national standards for FP service delivery.

The study involved eight health facilities offering FP in CTCs in Morogoro and Iringa, Tanzania. The study included 200 HIV-positive clients ages 18–49 attending the CTCs and 16 providers from the health facilities.

To read the full study see:

www.measureevaluation.org/publications/wp-13-136

Findings

Based on WHO's six dimensions of quality of care, the quality of FP services within CTCs was lacking for many criteria. Although 76% of all providers asked their clients about their reproductive goals, more than 62% did not ask if their client had any other reproductive health concerns/problems. Around 59% did not ask their client whether they knew/had heard about FP methods and 60% had not asked their client which FP method they are interested in and what they may know about that method. Furthermore, there is a significant shortage of health providers compared to client load, as well as a lack of refresher trainings, which compromise the effectiveness of services provided.

Poor resource allocation and a shortage of supplies impacted efficiency. Also, restocking took a long time which strained service delivery. The provision of FP methods to HIV+ clients was sporadic and few HIV+ clients were referred for FP services. Although 80% of the CTC clients were repeat clients, the services were not particularly accessible; they traveled long distances and 58% queued for over an hour to see a provider. Providers also lack adequate skills and access to on-the-job training for FP.

The services were found to be acceptable/patient-centered with nearly all (96%) of the respondents reporting satisfaction with the client-provider interaction. However, only 41% of the respondents were given a FP pamphlet to read at home and most mentioned that the content was on knowledge of how to prevent HIV infection.

The largest gap in equitable service provision was shown with gender. Overall, 89% of female clients accessed FP services as compared to 11% of their male counterparts and fewer men were counseled on dual protection than women (60% versus 72%, respectively).

World Health Organization's (WHO) Quality of Care Criteria for Health Service Delivery

- Effective
- Efficient
- Acceptable/patient-centered
- Equitable
- Accessible
- Safe

The study found that most of the CTCs had safe, reliable, functioning equipment. This helps make the work of service providers simpler and reduces inefficiencies. Effort is still needed to enable the facilities have a wide variety of equipment to avoid contamination and ensure the safety of the clients and providers.

Recommendations

There is a general need for more human resources of different cadres at the CTCs. Although some providers are following the procedure manual for service provision, there is still a need to carry out continuous trainings and disseminate knowledge and information to the providers.

There is a need to supply equipment and supplies to CTCs given the noticeable deficiencies at most health facilities.

More effort is needed to encourage men to come for health lessons at the health centers.

Governments should put more effort into sensitizing health providers to recognize the importance of providing integrated services at the CTCs. This should go hand in hand with finding the best ways to train health providers as well as stock all the needed supplies and equipment necessary for providing integrated FP/HIV services.



<http://www.measureevaluation.org/prh>

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Appendix D: AFIDEP Research Brief



Curt Carnemark, World Bank

The Evolution of Community-Based Distribution of Family Planning in Kenya

Background

Family planning (FP) has been increasingly acknowledged for its health, economic and environmental benefits. However, about a quarter of married Kenyan women (mostly poor and residing in rural areas) would like to delay the next birth or stop childbearing altogether but are not using any form of contraception. Task-shifting specific services to trained volunteers (community health workers or CHWs) was initiated in Kenya in the early 1980s as a solution to the health workforce crisis and insufficient number of health facilities. The community-based distribution (CBD) program stalled in the late 1990s, affecting FP uptake, but was rejuvenated in the 2000s. The African Institute for Development Policy (AFIDEP) was awarded a small grant from the MEASURE Evaluation PRH project to evaluate these policy and program changes.

To read the full report, see:
www.measureevaluation.org/publications/wp-14-144

Findings

Kenya has a conducive policy and legal framework for implementing the CHW program with the community as the foundation of the national health system. CHWs supply clients with short-term FP methods—pills and condoms. Recently CHWs trained to administer injectable contraceptives were authorized to do so in marginalized areas only. Since April 2013 the governance structure of the CHW program has been modified and improved with the establishment of standards and tools to guide recruitment, training and allocation of CHWs; community advocacy and mobilization for the CHW program; and data from the community captured in the national health information system. A number of further improvements are underway, including revising the policy framework that guides implementation of the CHW program, developing implementation guidelines for service delivery, and establishing quality of care standards for training and supervision of CHWs.

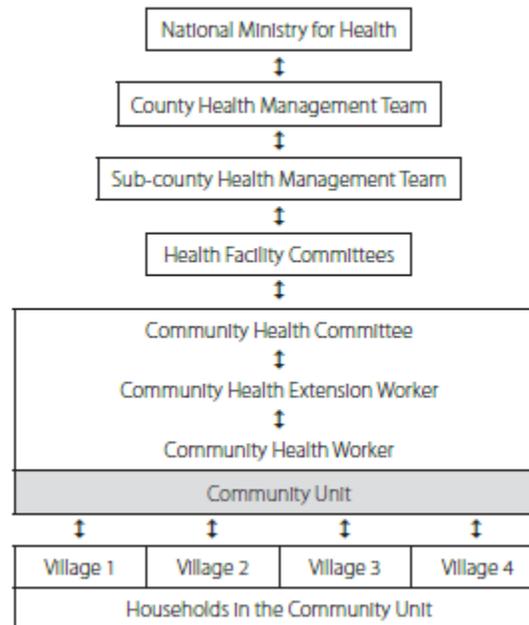
Notably, program implementation began after the release of the most recent Kenya Demographic and Health Survey in 2008/09, making it impossible to determine if there is an association between the CHW program and FP uptake in Kenya. However, a UNICEF/Ministry of Health (MoH) evaluation in 2010 found that the CHW program is successful in promoting and improving access and utilization of FP in Kenya. Despite this, some existing challenges put the sustainability of CBD of FP and the CHW program at risk, including:

- CHW training on FP is supplementary, not mandatory;
- too much reliance on external support for financial resources, resulting in poor retention of CHWs and sporadic payment-for-performance incentives;
- frequent FP commodity stock-outs due to inaccurate requisitions by CHWs;
- irregular monthly supervisory meetings of CHWs because of long distances to health facilities;
- delivery of community health services by various implementing partners in silos; and
- uncertainty if county governments will prioritize delivery of FP services and products.

Recommendations

The findings of this assessment highlight the need for the MoH to take decisive action to secure the sustainability of the program. Induction trainings on the policy framework and roles of county level leadership and administration would support harmonized and efficient delivery of community health services. Targeted evidence-based advocacy to relevant government officials that demonstrates the centrality of FP uptake to reducing maternal deaths and broader development benefits would help secure financial resource for the FP and CHW programs. The Community Health Strategy Unit should seek to gather supportive evidence including documenting service delivery gaps

Governance of Community Health Service Delivery



that are being filled by the CHW program and its cost-effectiveness/economic benefits in order to advocate for it. At the community level, the MoH should mobilize community participation in the CHW program as well as FP acceptability, targeting men and youth in particular. To ensure that quality of care standards for community service delivery are adhered to as well as to motivate and retain CHWs, the following should be enforced: financial remuneration consistent with CHWs' scope of work, mentoring and supportive supervision of CHWs, regular updating of the CHW training curriculum and job aids, refresher trainings of CHWs, and consistent availability of CHW supplies (commodity security). Finally, the MoH should participate in knowledge sharing forums to learn lessons and contextualize them for the improvement and sustainability of Kenya's CHW program.

Appendix F: Timeline for a Round of Small Grants

TASK	MONTH																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Draft RFP and review internally	█																	
Submit RFP to USAID/OPRH for review	█																	
Receive USAID's feedback and approval to proceed	█																	
Disseminate RFP	█																	
Concept papers submitted by interested applicants		█	█															
Concept papers reviewed and first shortlist created			█															
Shortlist notifications and rejections sent out			█															
Proposals received from shortlisted applicants				█														
Proposals reviewed and second shortlist created				█	█													
Shortlist sent to USAID for approval					█													
Receive USAID's approval					█													
Notifications of award sent out					█													
Rejections sent out					█													
Specifics gathered from sub-grantees and sent to Finance for drafting contracts					█	█												
Contracts sent to sub-grantees from UNC						█												
Signed contracts returned from sub-grantees							█	█										
Contracts signed by UNC								█										
Fully executed contracts sent to sub-grantees								█										
First tranche of funds wired								█	█									
Sub-grant projects underway									█	█	█	█	█	█	█	█	█	
First quarterly report sent to UNC by sub-grantees										█								
Second quarterly report sent to UNC												█						
Draft manuscripts submitted and reviewed at UNC															█	█		
Last tranche of funds wired																█		
Manuscripts finalized and sent to copy-editor to be turned into working paper																█	█	
Working paper (WP) sent to USAID for approval																	█	
USAID approves WP; WP is posted online																	█	█