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R2 Results Review



Population, Health and Nutrition Center

FY 1995

Bureau for Global Programs, Field Support and Research
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Table of Contents

I. PHNC Strategic Framework	1
Critical Functions	1
Strategic Objectives and Intermediate Results	2
II. Factors Affecting Program Performance	3
Facilitating Program Performance in FY 95 -	3
Focus and finding in the Re-engineered Agency	
Constraints to Program Performance in FY 95 -	4
Reduced funding, procurement issues	
Need to Revise Strategic Framework in FY 96	
III. Results by Strategic Objective	5
Strategic Objective 1	
Progress Toward Objective	6
Expected Progress FY 1996-1998	11
Strategic Objective 2	
Progress Toward Objective	13
Expected Progress FY 1996-1998	17
Strategic Objective 3	
Progress Toward Objective	19
Expected Progress FY 1996-1998	25
Strategic Objective 4	
Progress Toward Objective	26
Expected Progress FY 1996-1998	30
IV. Status of the Management Contract	31
Annex	32
List of Acronyms	41

**POPULATION, HEALTH AND NUTRITION CENTER
RESULTS REPORT - FY 1995**

I. G/PHN Strategic Framework

G/PHN Strategic Approach. The strategy of the Population, Health and Nutrition Center (G/PHN) is firmly rooted in the principles and guidance of the United States Agency of International Development (USAID) in the population, health and nutrition (PHN) sector. G/PHN's strategic approach contributes directly to the realization of the Agency's goal to stabilize world population and protect human health in a sustainable fashion. Building on thirty years of experience and success, this approach incorporates principles from the World Summit for Children (1990), the Cairo Program of Action (1994) and various international conferences on HIV/AIDS; and in doing so, the strategy also reflects Agency commitment in the areas of gender and women's empowerment.

G/PHN's approach focuses on improving the **availability, quality and use** of key interventions in the PHN sector. Sustainability, program integration, and gender sensitivity are important cross-cutting themes and approaches. Program **sustainability** is promoted by building host country capacity to plan, finance, manage, and evaluate programs. **Integration** is reflected in the strategic linkages among G/PHN's Strategic Objectives and Intermediate Results. **Gender sensitivity** is enhanced through a focus on the perspectives and needs of women and girls in each strategic objective area.

As shown in Table 1, G/PHN's strategic approach is captured in Strategic Objectives that support and foster the achievement of Agency Strategic Objectives to reduce unintended pregnancies, maternal mortality, infant and child mortality, and STD transmission with a focus on HIV.

Table 1. Strategic Objective Framework: Population, Health and Nutrition Sector				
Agency Goal	Stabilize World Population and Protect Human Health in a Sustainable Fashion			
Agency Strategic Objectives	Sustainable reduction in unintended pregnancies	Sustainable reduction in maternal mortality	Sustainable reduction in child mortality	Sustainable reduction in STD/HIV transmission among key populations
G/PHN Strategic Objectives	Increased use by women and men of voluntary practices that contribute to reduced fertility	Increased use of safe pregnancy, women's nutrition, family planning and other key reproductive health interventions	Increased use of key child health and nutrition interventions	Increased use of proven interventions to reduce HIV/STD transmission

Over the course of 1995, we have confirmed the appropriateness and validity of G/PHN's Strategic Objectives. While we have refined specific tactics and indicators relating to these objectives, our management contract will remain intact through the 1996-1998 period.

G/PHN Critical Functions. G/PHN implements its strategic approach by providing global leadership, research and evaluation, and technical support to the field. These critical functions, expressed in the Intermediate Results defined below, are unique to G/PHN, and define a continuum of expertise and assistance that links the operations of G/PHN with the problems and opportunities in the developing world; not only in countries served by USAID Missions but globally.

G/PHN's global leadership facilitates the achievement of all results and strategic objectives by enhancing the implementation capacity of USAID-funded field programs and by influencing the wider global community of countries, donors and non-governmental organizations. Global leadership is captured in two principal activities: policy dialogue development and resource mobilization. Appropriate policy and adequate resources are essential to achieving and sustaining programmatic impact.

In the arena of research and evaluation, G/PHN supports the development, testing and dissemination of new technologies and methodologies that address key technical problems and constraints to program implementation and sustainability in developing countries. Results of G/PHN-supported biomedical, operations, demographic, evaluation, applied, and social science research improve services and enhance the impact of population, health and nutrition programs worldwide.

G/PHN currently manages more than 80 percent of the Agency's research activities in population, health and nutrition. G/PHN plays a key role in developing new, cost-effective technologies such as the Solojet syringe and new and improved contraceptive methods. G/PHN research also identifies the underlying causes of morbidity and mortality and demonstrates the efficacy of various interventions in removing those causes; for example, G/PHN was instrumental in proving the multiple benefits derived from adequate vitamin A intake. In collaboration with Missions, G/PHN makes a significant contribution to the development of improved operational approaches.

G/PHN's technical support to the field is the critical function linking advances in research and successes in global leadership with program improvements at the country level. Technical support to the field emphasizes two principal activities: increasing the knowledge and involvement of individuals, couples, families, households, and communities in the use and support of practices and products that improve well-being, and improving the efficacy and sustainability of the systems providing essential, well valued products and services. G/PHN works with USAID Missions to ensure an appropriate fit between Global Bureau initiatives and country-specific situations, and provides a ready mechanism by which missions can benefit from the experience and knowledge that USAID has gained worldwide.

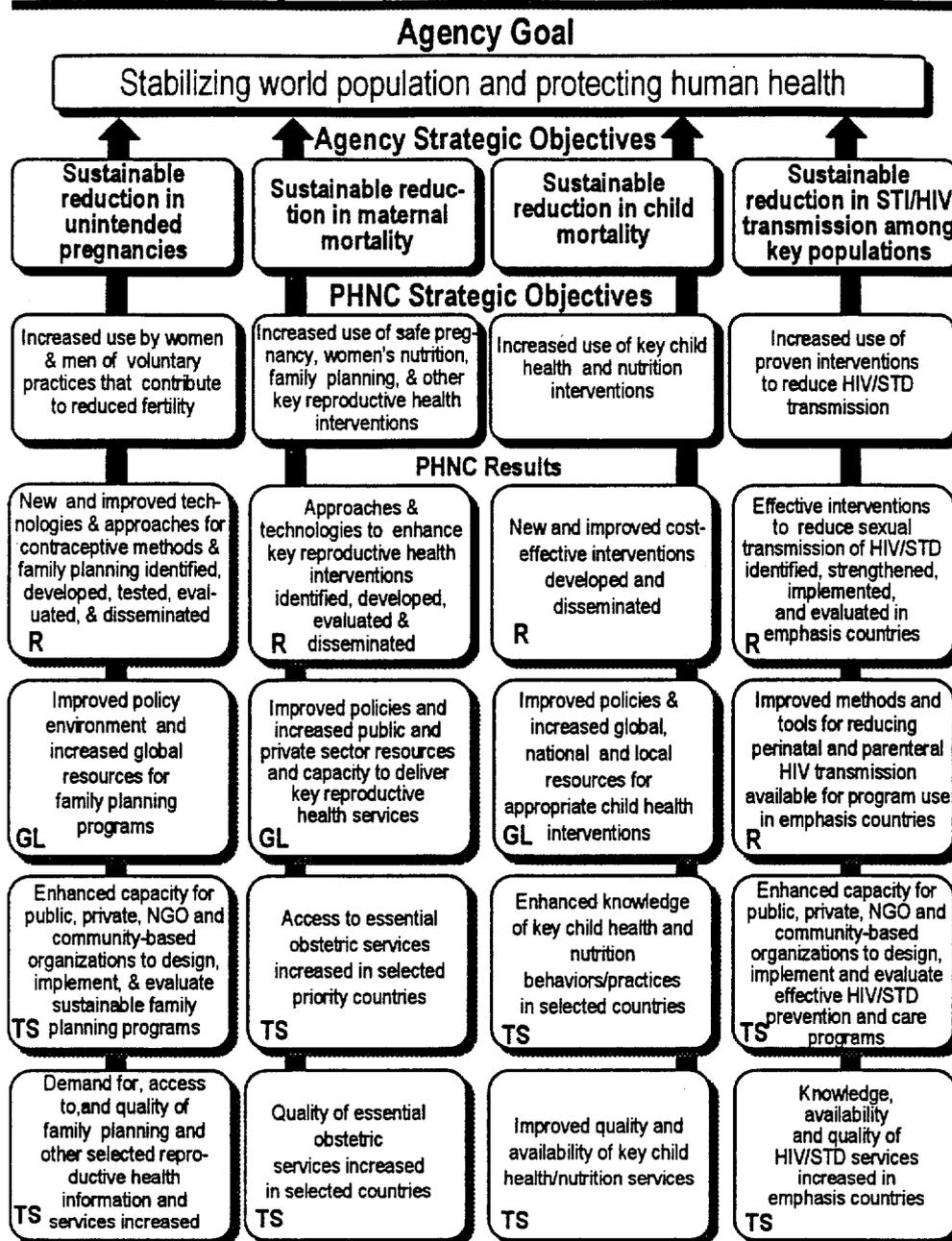
G/PHN Strategic Objectives and Results. As noted above, the G/PHN's four strategic objectives advance the attainment of the Agency's strategic objectives and goal. Although each strategic objective could be pursued independently, there are obvious relationships and synergies. For example, improvements in child survival affect fertility behavior; healthy women are more likely to bear healthy children and to be able to care for them. Improved birth spacing contributes to maternal and child health, while use of barrier methods of family planning helps prevent sexually transmitted diseases, including AIDS.

The programs implemented under each G/PHN strategic objective are neither equally mature nor funded equivalently. G/PHN has made significant long-standing investments in interventions to reduce fertility (SO #1). Comprehensive efforts to address the determinants of maternal mortality (SO #2) were initiated only in the early years of this decade. G/PHN's activities in Child Survival (SO #3) were linked in a unified program a decade ago. Finally, the HIV/AIDS program (SO #4) was created in the middle of the last decade without the benefit of any prior experience in this very challenging area. This variance in maturity and level of intensity explains, in part, the differences in program impact to date.

G/PHN's mutually supportive strategic objectives support the overarching objectives of the Agency. This is as it should be because G/PHN serves as a catalyst for identifying and promoting new and time-tested interventions, synthesizes experiences across countries and regions, and shares responsibility with Missions and Regional Bureaus for planning, implementing and monitoring PHN programs. G/PHN's technical capability, accessed through pre-positioned contractors and grantees, provides Missions with a wide range of proven expertise and experience.

G/PHN's Intermediate Results guide programs and activities and allow the G/PHN to monitor progress toward the Strategic Objectives (See G/PHN Results Framework below). G/PHN has four Intermediate Results under each Strategic Objective. These Intermediate Results document the application of the G/PHN's critical functions.

Strategic Objective Tree: PHN Center



Critical Function: R = Research & evaluation GL = Global leadership TS = Technical support

II. Factor's Affecting Program Performance

Factors facilitating Program Performance. The establishment of G/PHN in FY 95 and the delineation of its Strategic Plan and Action Plan give greater definition, focus and precision to the Agency's work in population, health and nutrition. Restructured as part of the Agency's reengineering process, G/PHN is better able to coordinate the work of the PHN sector. Some of the major changes resulting from this process included:

- Creation of a new organizational structure which consolidated the Offices of Population, Health and Nutrition and created an Office for Field and Program Support;
- Facilitation of the management, implementation and assessment of work across and within the Offices of G/PHN;
- Finalization of the Strategic Plan and the Plan of Action 1995-1997, which enabled G/PHN to define targets, choose interventions and manage programs to achieve explicit results essential to stabilizing population growth and protecting human health;
- The development and implementation of a Joint Programming and Planning Country Strategy (JPPC) that pulls together teams of Mission, Regional Bureau, and G/PHN staff to plan and allocate USAID resources effectively and efficiently to achieve country program objectives;
- Consolidation of results packages and technical intervention between the offices of Population and Health, in areas focusing on Young Adults, Breastfeeding, Research and Evaluation (MEASURE), and Quality Assurance.

In FY 95, approximately 41% of the Agency's resources were allocated to the PHN sector. Of that 41%, G/PHN managed 54% through core support, field support, buy-ins and add-ons, or Operating Year Budget transfers. Most importantly, beyond the funds, organizational restructuring, and strategic plan, the G/PHN staff has worked with Missions, the Bureau of Policy and Program Coordination (PPC), and Regional Bureaus to manage research, develop and promote policies, and design, develop, and implement programs. The work of G/PHN staff was complemented by the active commitment and responsiveness of host country professionals and other stakeholders (governments, communities, foundations, non-governmental organizations (NGOs) and private voluntary organizations (PVOs), and the partnership of other donors and international agencies. Sustained commitment from the countries and donors has been crucial to achieving the results reported below.

Factors constraining Program Performance. Although significant results were achieved in FY 95, G/PHN began to encounter a number of serious constraints to program performance that could impact negatively on future results. Major examples are discussed below.

- *Funding for Population Programs.* In FY 1996 G/PHN faces serious constraints on the level and flexibility of funding appropriated by Congress for the PHN sector. Funding levels were slashed by 35 percent for population assistance in FY 1996 compared to FY 1995. This action has reduced sector funding from \$548 million in 1995 to \$356 million in 1996. In addition, Congress is not releasing these funds until July 1996, and then only in monthly allotments of 6.67 percent of the total amount appropriated. G/PHN is cooperating with its colleagues in the field and in other bureaus of AID/W to develop a master plan for providing population funding when and where it is needed most. However, there is no question that a funding cut of this magnitude will seriously affect future progress toward results, particularly under our strategic objective related to family planning.

In this transition year, the budget allocation process is being influenced by many factors unrelated to and, at time, counterproductive to a programming effort designed to maximize results. Moreover, this year has seen a change in the financial planning of support funds to the field. The new field support budgeting process has required significant staff input and time.

- *Procurement Issues.* G/PHN is actively participating on a Global/Office of Procurement (OP) working group to identify ways to improve the efficiency and flexibility of procurement actions that affect our ability to achieve planned results. These include development of a procurement plan, reduction/delegation of a number of administrative approvals currently handled by contracting officers, and the availability of adequate staffing in OP to handle a heavy load of actions from G/PHN. Rapid resolution of these issues will be particularly important in light of the hundreds of

additional funding actions in FY 1996 necessitated by the congressional restrictions placed on population funds.

- **Staffing and Management System Issues.** G/PHN's performance continues to be affected negatively by Operating Expense (OE) funding constraints. Staff recruitment and travel are disproportionately affected. Currently, G/PHN has 16 US direct-hire staff vacancies, which represents nearly one-fifth of our total Full Time Equivalents (FTEs). There are an additional 22 PHN vacancies in regional bureaus and mission programs. Quite often, the PHN program is the largest in a mission portfolio, but it will have the fewest available staff. Similarly, the lack of adequate travel funds has severely hampered program monitoring, technical exchange, and joint programming and planning between G/PHN and field staff.

The Management Bureau has also placed limits on the G bureau's technical and program decision-making by assuming approval authority for levels and placements in such programs as the Michigan Fellows, Population Leaders, Technical Advisors in AIDS and Child Survival, and Senior Technical Advisors in Residence. Recruitment for these non-direct hire technical staff have been frozen for nearly one year, reducing both G/PHN's and the field's access to technical expertise and placing in jeopardy the fostering of a cadre of PHN development professionals.

G/PHN is also concerned that the new management system (NMS) is not yet fully available and accessible to all staff that need to use it. To address this issue G/PHN has developed a list of staff who need access to and training in NMS software, and is taking steps to obtain this training.

- **Agency Transition.** 1995 marked a year of transition for USAID as the first U.S. Government agency to fully implement a reengineering strategy. The promise of long-term benefits carried the necessary burden of applying new systems and approaches to the work of development assistance. G/PHN participated fully in training sessions devoted to new management systems, creation of strategic objective teams, results-oriented approaches to program design and implementation, and so on. The practical outcome of reengineering has been significant change in overall vision, organizational structure, staffing, systems, and procedures, all of which have required considerable time and effort. While reengineering has reduced documentation required for programming activities, it has increased the investment in processes such as team meetings.

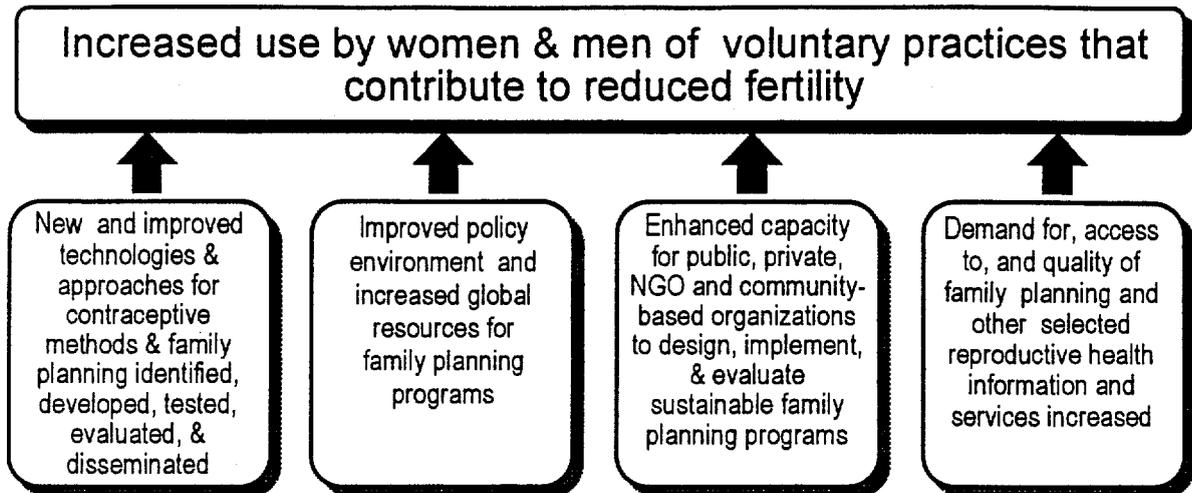
III. Results by Strategic Objective

During the past year, G/PHN has fully oriented its programs and activities toward results that will lead to achievement of the Center's strategic objectives. G/PHN has continued to focus on its critical functions (i.e., global leadership, research and evaluation, and technical support to the field), which represent the Center's comparative advantage.

Despite the many factors (described earlier) which have constrained performance, G/PHN has achieved an impressive array of results. For example, recent surveys show that the availability and use of modern contraception continues to increase significantly in countries receiving substantial technical assistance from the Center. In addition, the Center continues to provide leadership in developing new and cost-effective interventions to prevent infant and child deaths. G/PHN is also developing curricula and providing training for health care professionals on emergency obstetrical care to reduce maternal mortality. The Center is also establishing global standards of practice for STD/HIV prevention, and developing innovative systems for monitoring the spread and impact of HIV/AIDS.

A more detailed analysis of results achieved, by strategic objective, is presented below.

Strategic Objective 1:



PROGRESS TOWARD STRATEGIC OBJECTIVE

For over 30 years USAID has supported population programs in developing countries and has contributed significantly to the decline in fertility from 6.0 children per woman in 1965 to 3.4 in 1995. The primary indicator chosen by G/PHN to measure progress toward the first Strategic Objective (SO) is *modern contraceptive prevalence rate (CPR) for currently married women*. The CPR has been steadily increasing over time in developing countries and is now estimated to be over 32%, based on recent DHS data from 36 USAID-assisted countries. Although new CPR data are not available on an annual basis for all developing countries, some new data have been received that indicate continued program progress. For example data, from Morocco, Indonesia and Tanzania, will be used repeatedly as illustrative examples in the following text.

- In Morocco, modern CPR rose from 36% in 1992 to 42% in 1995;
- In Indonesia, modern CPR climbed from 47% in 1991 to 52% in 1994; and
- In Tanzania, modern CPR almost doubled, from 6% to 11% between 1991/92 and 1994.

G/PHN is also tracking trends in CPR among unmarried women and in the proportion of women aged 20-24 who had intercourse and gave birth before age 20 (indicators 2, 4, and 5). Progress against these indicators will be key markers of the success of G/PHN's new young adult initiative, which was awarded in late FY1995.

G/PHN has always been on the cutting edge of population program implementation--introducing new and improved contraceptive methods, pioneering innovative service delivery models, improving distribution channels, designing state-of-the-art communication and training strategies, providing high-quality programmatic technical assistance, and promoting the effective use of survey and evaluation data for program and policy improvements. G/PHN's results and activities reflect this leadership, recognize the close link between G/PHN and the field, and build on G/PHN's comparative advantage in research, technical and program innovations, and evaluation.

G/PHN has four results under SO 1 that together create a supportive environment and institutional framework for provision of quality family planning and other selected reproductive health services and information in order to enhance couples' and individuals' ability to freely choose the number and spacing of their children. Progress towards each result is detailed below.

Intermediate Result 1.1: New and improved technologies and approaches for contraceptive methods and family planning programs identified, developed, tested, evaluated, and disseminated

G/PHN plays a vital role in increasing the effectiveness of family planning/reproductive health (FP/RH) programs by: supporting contraceptive research and development; developing and testing innovative service delivery strategies through operations research (OR); identifying and testing new and improved tools and technologies for management, training, information, education and communication (IEC), policy, data collection, and evaluation; and transferring the resultant knowledge, strategies, technologies, and tools to health and family planning professionals around the world.

Contraceptive research and development. The improvement of existing methods and the development and adoption of new contraceptives is a process spanning many years. The research process involves identifying new leads, developing and evaluating these leads, obtaining United States Food and Drug Administration (USFDA) approval, introducing new and underutilized methods into service delivery programs, and studying existing methods in order to improve our understanding of their advantages, side effects, and appropriateness of use in a variety of developing country settings. Priority areas for contraceptive research are barrier methods and spermicides/microbicides that protect against pregnancy and STD/HIV, long-acting hormonal preparations for women and men, and better contraceptive delivery systems.

The indicator values for this result (see table) traces leads through the research process. There are currently a total of 37 leads in the pipeline: 24 are in preclinical studies or Phase I trials, 4 are in Phase II trials, and 9 are in Phase III trials, the USFDA approval process, or Phase IV trials. Of these 37 leads, some will fall by the wayside. By 1998, we expect that 20 leads will have moved to the next stage of development and two new or improved methods will have been approved by the USFDA. Five leads--two novel non-latex condoms, two new female barrier methods, and a new device for female sterilization--currently hold the most promise for early USFDA approval. Significant milestones were passed in FY 1995 on the road to USFDA approval, including:

- the clinical trial for Lea's Shield, a one-size-fits-all female barrier method, that was completed with positive results;
- a multi-center clinical trial of Femcap, another type of female barrier method, which was initiated; and
- the New Drug Application for Norplant II that was submitted to the USFDA for review.

Family planning & reproductive health strategies/subsystems, IEC, training, and other technical improvements: The second indicator for Result 1.1 covers operations research as well as new and improved tools and technologies. Currently there are eight approaches/strategies/tools being developed and evaluated; in 1998 there will be about 15 under evaluation with about 10 new approaches/tools being replicated/expanded through routine service delivery programs.

USAID's OR program is designed to pioneer the application of new ideas, to test innovative strategies to enhance access to services, improve quality, and, in general, to help programs work better. Priorities in OR include developing new approaches to link and evaluate FP and other RH interventions such as STD/HIV services and how to reach underserved populations. Examples of results in FY 1995 from OR in these areas include the following:

- Many more nurses and auxiliary birth attendants are achieving competency in the provision of a complete range of FP/RH services by using training and reference materials developed to address insufficient supervision, poor recordkeeping, and an inadequate system for client follow-up, all documented by a situational analysis in Burkina Faso.
- A pilot study at the Navrongo Health Research Centre identified significant cultural and gender barriers to family planning in the study area. As a result, a participatory, community-based distribution system that involves village chiefs, elders, and peer network leaders is being developed as part of a package of village health services.

In addition to OR, USAID supports research to identify, develop, and test new and improved tools and technologies for management, training, IEC, policy, data collection, and evaluation. Examples of results in this area in FY 1995 include:

- publication and dissemination of a series of handbooks of reproductive health indicators;
- development and field testing of a computerized model for projecting family planning training needs;
- development and field testing of interactive, computerized training modules on IUD insertion that permit family planning trainees and providers to learn at their own pace.

Intermediate Result 1.2: Improved policy environment and increased global resources for family planning programs

Experience in the field of population and family planning has demonstrated that political commitment and adequate resources at all levels are necessary in order to have effective programs. A notable outcome of the 1994 Cairo Conference on Population and Development was a commitment to translate the rhetoric of supportive population policies into action, with a focus on improved quality, access, and gender equity, and to increase the resources available for FP/RH programs. The indicators for this result track progress in the development and implementation of strategic plans, the level of resources available for FP/RH programs, and the participation of the private sector in service delivery.

All of the Agency's PHN Joint Programming Countries have development plans that include some discussion of program quality, access to services, and gender equity. G/PHN is helping to provide policy makers and program managers with the tools and information they need to implement policies and programs in accordance with these plans. Evidence of progress in this area in FY 1995 includes:

- the development and vetting of a national strategic plan in Turkey that includes plans for increasing contraceptive self-reliance;
- in two states of Northeast Brazil, the development of state-level strategic plans that include family planning within the rubric of reproductive health services to be provided;
- barriers to service access and quality were identified and addressed in national reproductive health guidelines in five countries; and
- the development of effective medical, training, and service protocols in 10 countries.

In concert with other USAID units and other donors, G/PHN seeks to increase the resources available from all sources and is working with host-country counterparts to allocate resources more effectively and efficiently. In FY 1995, USAID spent \$102.4 million, or an average of 24 cents per woman of reproductive age (WRA), in the Joint Programming Countries. In 1994, funds from all sources for family planning programs in PHN Joint Programming Countries averaged 70 cents/WRA. Data on funds from

all sources for 1995 are not available. The majority of these funds come from developing country governments and citizens themselves. For example,

- with assistance from the International Planned Parenthood Foundation (IPPF)/WHR transition project, IPPF affiliates in Latin America have introduced sliding fee scales in their clinics, thereby increasing revenues; and
- in Zimbabwe, a G/PHN-supported project worked with the government to define appropriate roles for the private sector in service provision.

Success in FY 1995 in increasing private sector participation in service provision include:

- working with insurance companies to include reimbursement for family planning; and marketing that insurance to the informal sector;
- developing a loan fund for midwives in Indonesia to launch and/or expand private practice; and
- establishing a for-profit commodity procurement organization in Brazil to replace USAID as a sustainable supplier of low-cost contraceptives.

Intermediate Result 1.3: Enhanced capacity for public, private, NGO and community-based organizations to design, implement, and finance sustainable family planning programs

USAID recognizes that the key to sustainable family planning programs is the ability of host-country organizations to design, implement, and finance those programs. Activities under this result focus on strengthening the technical and management capacity of public, private, NGO, and community-based organizations. The following are some illustrative achievements under this result:

- In the Philippines, 17 additional family planning clinics were added to the national clinical training network as a direct result of training assistance to schools of midwifery and nursing;
- In Tanzania, the improved management and training capacity of the Family Planning Unit of the Ministry of Health is reducing dependence upon donor technical assistance;
- Three African countries (Uganda, Zambia, and Tanzania) evaluated and documented the quality, coverage, and significant impact of their national IEC family planning program. Sustainability has been built through development of local expertise, design of national family planning strategies, and transfer of programming ownership to local public and private sector broadcasters;
- Training Bangladeshi Thana teams in planning, budgeting, mobilizing local resources and monitoring expenses has helped build financial sustainability at the local level.

In order to measure both organizational capacity and a national family planning program's ability to continue to meet its objectives with decreased or discontinued donor support, the G/PHN is spearheading the development of a sustainability index. The index will be a composite of indicators measuring resource inputs, private sector involvement, policy support, regulatory mechanisms, institutionalized systems, functional operations, technical expertise, service production and utilization, contraceptive prevalence and ultimate impact. During FY 1995, the Sustainability Index Task Force was formed. The Task Force held meetings with key stakeholders, clients and donors, identified many of the relevant indicators to be incorporated into the Index, and selected likely countries where the Index will be field tested.

Intermediate Result 1.4: Increased demand for, access to, and quality of family planning and other selected reproductive health information and services.

Responding to the high existing demand for family planning with accessible, quality, cost-effective services, as well as to the increasing demand for such services, is crucial to achieving SO 1. Result 1.4 depends heavily on and benefits from the close links between G/PHN's and USAID's field programs and the achievement of the other three results. Under this result, G/PHN provides extensive technical leadership and assistance in service delivery, training, IEC, management, contraceptive logistics, and evaluation.

Examples of broad-based achievements in FY 1995 are:

- an increase by over 1.5 million new users of family planning methods in Indonesia in the first half of the year alone;
- a 24% increase in the number of men who felt it was their responsibility to obtain family planning, and a 10% increase in the number who felt jointly responsible with their partner, in Zimbabwe;
- increased awareness of and demand for family planning among adolescents who participated in a young adult radio talk show in Kenya;
- expansion of a contraceptive social marketing and education program in Uganda that uses midwives both to sell contraceptives and to teach Ugandan men and women about reproductive health;
- development and adaptation of in-service clinical training, curricula, protocols, and guidelines in Peru, Bolivia, Kenya, Tanzania and Uganda;
- application of state-of-the-art technical guidance on best practices for service delivery such as contraceptive eligibility (developed in collaboration with WHO), and selected recommendations for use of oral contraceptives, injectables, NORPLANT, and Intrauterine Devices (IUDs);
- expansion of family planning activities by an NGO in Kenya to include other reproductive health services, such as prenatal counseling, immunizations, and STD prevention based on a successful community involvement model;
- introduction and expansion of youth-oriented services by supporting peer counseling and clinic based services, and creating health manuals for high school teachers in Brazil, Tanzania and Uganda;
- successful introduction of the contraceptive injectable, Depo Provera, into a wide variety of USAID supported programs, including the provision of over three million doses in 1995, along with appropriate technical assistance;
- implementation of a home visit program based on a woman to woman approach which in turn led to increased acceptance of condoms and pills by women, in Bihar, India;
- a 450% increase in the number of men (from 1800 to 8470) who sought out surgical contraception (vasectomy) as a method of family planning, from 1994 to 1995 in six states of Mexico;

- expansion of a USAID supported family planning program in Uganda by leveraging resources from the World Bank in order to include IEC in AIDS prevention along the shores of Lake Victoria where AIDS prevalence is among the highest in the country;
- Launch of the reproductive health program "It's My Turn" in the Philippines. The government, NGOs and private sector used multimedia channels to communicate self-care messages to women in more than 50 cities.

EXPECTED PROGRESS: FY 1996 - FY 1998 (SO1)

G/PHN anticipates progress toward SO1 for FY 1997 and FY 1998 in several areas.

Technical improvements in family planning strategies and subsystems will be made and new contraceptive products will be developed and adopted. Examples include:

- obtaining USDA approval of at least two new contraceptive methods, Norplant II and a new female barrier method;
- building upon a successful program in the Philippines, integration and scaling up of multi-channel communication activities in other priority countries to educate, inform and promote reproductive health care and family planning; and
- launching of a new results package on frontiers in operations research for reproductive health and improved service delivery.

G/PHN will provide local managers the tools and information needed to implement policies and programs with a focus on improved quality, access and gender equity, and will analyze resource needs and mechanisms to make the most efficient and effective allocation of resources. Specific examples of these activities include:

- analysis of the Service Delivery Expansion and Sustainability (SDES) mechanism in place for Mexico and Indonesia as a potential model for program implementation in other countries under conditions of USAID's reduced overseas presence;
- analysis and evaluation of the IPPF/Transition experience for increasing sustainability of family planning NGOs in Latin America; and
- follow-up on strategies for empowerment of women and increasing access to reproductive health services in Africa;

G/PHN will strengthen the technical and management capacity of organizations to design, implement and finance sustainable family planning programs, through:

- continued development and application of state-of-the art technical practices under the Maximizing Access and Quality Initiative; and
- design and implementation of a new results package on PVO service delivery.

Finally, G/PHN will continue providing technical leadership and assistance in service delivery, training, IEC, management and evaluation. Examples of anticipated achievements include:

- implementation, through close links with ongoing service delivery activities, of a new initiative to meet the reproductive health needs of young adults;

- initiation of a new results package for the PHN Center flagship breastfeeding program for impact on fertility and maternal and child health;
- evaluation of post partum family planning programs in three Latin American countries; and
- continued application of practical, mutually supportive linkages of family planning with other reproductive health services such as post abortion care.

Strategic Objective 2:



PROGRESS TOWARD STRATEGIC OBJECTIVE

This Strategic Objective represents the newest program focus in the G/PHN. Supporting the Agency objective to realize a reduction in maternal mortality, and following the direction established in Cairo at the International Conference for Population and Development in 1994, G/PHN has broadened the focus of traditional maternal and child health and family planning programs to that of reproductive health.

Each year over half a million women in developing countries lose their lives giving birth. The major causes of maternal mortality -- hemorrhage, sepsis, obstructed labor, eclampsia and the sequelae of unsafe abortion -- are preventable with known technologies. Millions more women suffer direct and long-term complications of pregnancy and delivery. USAID has been at the forefront of the global effort to support and develop programs which are designed to enhance the ability of women to:

- seek and receive care during pregnancy, delivery and postpartum, including access to affordable, high-quality family planning counseling and services;
- use emergency services, especially for labor, delivery, and the postpartum period;
- utilize antenatal and postpartum health promotion services, including micronutrient supplementation, infection prevention, immunization, and breastfeeding;
- access information and services to prevent and treat sexually transmitted diseases (STDs);
- prevent and treat the complications of female genital mutilation; and
- contribute to the design of responsive maternal and family health programs through qualitative research on services, client-centered project design and participatory evaluations.

In its role as a global leader, G/PHN has been instrumental in sponsoring and participating in a number of major initiatives for establishing reproductive health programs, including the drafting of language for the "Platform for Action" at Beijing. Research sponsored by the G/PHN serves as the basis for program design and implementation by countries and other donors. For example, a compendium of results of

USAID sponsored research, published in the *International Journal of Gynecology and Obstetrics*, spans topics ranging from the development of a rapid assessment methodology for planning Safe Motherhood Programs to a validation study of women's reporting and recall of major obstetric complications, which is essential for accurate community baseline data about complications. Since reproductive health is a new program for USAID, a part of the G/PHN effort in FY 95 was devoted to assisting the rest of the Agency, Missions as well as Regional Bureaus, with programs in this field.

Neither the indicators for measuring program performance nor the methods for their estimation are as advanced as in other program areas. However, during FY 95 a compendium of significant indicators of reproductive health programs was published following the work of over 100 leading experts from the international population and health community. This activity has been crucial for moving toward a consensus and enabling comparisons of program level data, as well as helping with the selection of indicators for this strategic objective.

In order to achieve this strategic objective, G/PHN has addressed the cross cutting issues of financing and quality. As one of the steps in assuring sufficient allocation of resources for reproductive health, prototypes have been completed for developing transparent national health accounts in Egypt and Bolivia. In the area of quality assurance, remarkable progress has been achieved with minimal external resources using a problem-solving approach which is a cornerstone of sustainable capacity-building. Illustrative successes include:

- the development of protocols for management of life threatening obstetric complications, a critical standard against which quality is measured, in Bolivia, Guatemala and Egypt;
- an increase in prenatal care coverage from 56% to 72% in a rural Niger clinic;
- an increase in compliance with prenatal anemia screening in a Chilean clinic from 5% to 65%; and
- a decrease in post-cesarean section rates in a Guatemalan hospital from 25% to 11%.

Indicators of progress toward the Strategic Objective are discussed below:

Percent of births attended by medically trained personnel

In 1994 the average percentage of women receiving antenatal care in selected maternal health emphasis countries - Bolivia, Egypt, Guatemala, Indonesia- was 70%. In those same countries the average number of births attended by medically trained health personnel was 37%. The only new data available for 1995 is from the Morocco DHS where it was found that the percent of prenatal care increased from 32% in 1992 to 45% in 1995 and the deliveries assisted by trained personnel rose from 31% in 1992 and 40% in 1995.

Met need for essential obstetric care

An important measurement of progress toward the strategic objective is the level of essential obstetric care provided to women in need of services. The met need is measured by the percentage of women with serious obstetric complications in need of essential obstetric care who reach a functioning referral center. There is international consensus that this indicator is suitable for measuring change in the ability of countries to deliver obstetric services; but the indicator has not yet been field tested. Preparation for baseline studies was carried out in 1995.

Percent of pregnant women receiving iron supplementation, immunized against tetanus, and accepting a modern contraceptive method in the postpartum period

Baselines for iron distribution ranged from 4-50% and averaged 45% for tetanus coverage and 18% for use of a contraceptive method in the postpartum period. Preparation for baseline studies where USAID will implement prenatal and postpartum care programs was carried out in 1995.

Intermediate Result 2.1: Technologies and approaches to reproductive health interventions identified, developed, evaluated and disseminated

G/PHN plays a vital role in determining the feasibility and cost effectiveness of implementing various approaches to reproductive health programs and activities in the developing world. This includes determining pregnancy outcomes as a result of direct interventions such as the provision of vitamin A supplementation or the control of STDs during pregnancy as well as determining cost effectiveness of "packages" of interventions. Activities carried out in FY 95 were as follows:

Impact of low-dose vitamin A on post partum and neonatal sepsis

- Studies to evaluate the impact of low-dose Vitamin A during pregnancy on postpartum and neonatal sepsis were initiated in Indonesia and Nepal

Models for obstetric care training

- A tool for "Diagnostic Assessment of Performance and Potential of Front Line Workers" has been developed and is ready for field testing.
- A new distance-learning model, Healthy Mother, Healthy Child, was developed for community midwives in geographically isolated areas of Indonesia.
- A streamlined approach for providing Life Saving Skills training was evaluated in the field in Indonesia.

Models to enhance access and use of essential reproductive health by young adults

- A model to promote increased young adult access to STD/FP services is being field tested in Mexico.
- Qualitative research to determine adolescent sexual and health seeking beliefs and practices, as well as their recommendations for reproductive health services, was initiated in Uganda.
- A new approach to improving food intake and iron supplementation for adolescents was started in Peru.

Costs of the provision of essential obstetric care

- A streamlined approach for antenatal care, designed to improve cost-effectiveness, was being tested in Thailand as part of a WHO-sponsored multicenter trial. It is expected that the results of this study will provide long needed direction regarding the essential components of antenatal care.
- Research to determine the costs of new and improved reproductive health interventions, including essential obstetric care, were identified in Guatemala, Bolivia and Indonesia.
- Guidelines for the assessment of the capacity of the private sector, an essential tool for understanding how to work with the private sector to increase their capability to provide reproductive health services, were successfully field tested in Kenya, Senegal, Zambia, and Tanzania and are now available for wide use.

Interventions to Improve Iron Intake

- Studies to determine the most effective approaches to improve the distribution and compliance with iron supplementation were started in Guatemala, Bolivia, Indonesia, Malawi, and India.
- The public and private sectors were brought together in Indonesia, and an agreement was reached for selected companies to provide iron supplements supplied by government to their female employees.

Intermediate Result 2.2: Improved policies and increased public and private sector resources and capacity to deliver key reproductive health services

Experience has shown that without the commitment of participants at all levels, progress toward achieving activity goals will be thwarted. This is particularly true for removing barriers to health care practices for front-line providers. Additionally, attention to health care financing and rational approaches to allocation of resources is critical.

Policies and plans for safe pregnancy and breastfeeding

- In an effort spanning several years, USAID has supported UNICEF in developing a "Baby Friendly" certification process for hospitals in 48 countries. Where USAID-trained health professionals have mobilized efforts, 3,245 hospitals have been designated "Baby Friendly," constituting 81% of the 4,000 Baby Friendly Hospitals worldwide.
- The number of countries with maternal child health and family planning policies and implementation plans for the promotion of breastfeeding increased from 5 to 22.
- Studies in Latin America demonstrated that the cost savings accrued to hospital of averting disease, such as diarrhea, through the promotion of breastfeeding is significant.
- Nigeria and Uganda have developed National Safe Pregnancy policies and plans for implementation
- Plans are in place in the Ministries of Health in Bolivia and Indonesia to improve essential obstetric care and expand antenatal care to include integration with STD services at a national level.

Breastfeeding and safe pregnancy incorporated into pre-service curricula

- The number of countries with breastfeeding in their national medical and nursing training institution curricula increased from 5 to 15.
- Adoption of a pre-service maternal/neonatal health curriculum, utilizing Safe Pregnancy principles, for nurse-auxiliaries took place in Bolivia.

Intermediate Result 2.3 : Access to essential obstetric services increased in selected countries

Data show that in geographical areas with high maternal mortality, 70-90% of those births occur at home: a place where life threatening complications cannot be adequately treated. Improving both the demand and the availability of appropriate services is essential to improving access to care.

Data for the indicators which measure progress toward increased access are difficult to collect. The percent of adults with knowledge of complications related to pregnancy and childbirth; the percent of adults with knowledge of the location of essential obstetric services; and the number of priority countries with systems in place to monitor essential obstetric care are new indicators for the reproductive health program and data are not yet available. However, considerable progress has been made for acquiring

sound baseline data. Based upon validation studies which were carried out in FY 95, baseline and community diagnosis tools were developed and are ready to be implemented in Bolivia and Indonesia.

Intermediate Result 2.4: Quality of essential obstetric services increased in selected countries

G/PHN takes a rigorous approach to promoting and measuring quality. This includes assisting in the development of national and institutional standards against which to measure quality of care. The goal is to develop realistic standards based upon cost effective public health approaches. Essential to the institutionalization of quality assurance programs is the use of data to help determine and assess achievements of quality care.

Indicators for this result are also new, therefore, complete data are not yet available. The indicators include: the *number of facilities adopting prototype systems for (a) recording and aggregating complications by cause (b) monitoring admission-interval for hemorrhage and (c) monitoring case-fatality rates*. Progress for FY 95 progress was made in the following areas:

- Technical and policy work got underway in Guatemala, Bolivia, and Indonesia to incorporate necessary information into current data collection systems which offers a more feasible approach than attempting to make massive changes in the health information systems.
- In Guatemala, changes were made in the delivery records to incorporate new information, such as protocols for management of life threatening obstetric complications, like those which have been drafted in Bolivia and finalized in Guatemala and Egypt.
- Prototype validation studies for obstetric complications, "community diagnosis" to determine community needs and understanding, situation analysis for reproductive health service delivery capability, training needs assessment, and baseline studies for indicators not included in DHS was developed as a means of measuring quality of care.

EXPECTED PROGRESS: FY 1996 - 1998

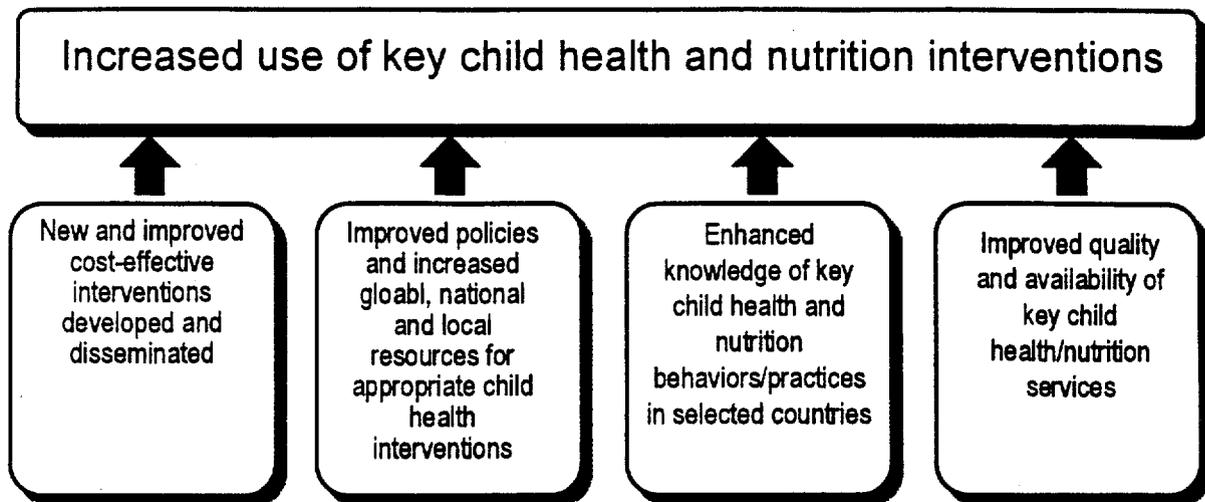
It is expected that the next few years will see the finalizing and validation of a number of research studies on technologies and approaches initiated in FY 94 and 95. These results will lead to enhanced G/PHN activities for reproductive health and improved maternal and child health. Priorities for FY 1997 and FY 1998 include the following:

- An increase in the understanding of cost effectiveness of behavior change approaches.
- Improved policies for resources allocations, removal of barriers to service provision, and quality assurance. Detailed clinical protocols will have been developed/improved as standards for preventive maternal/newborn care and the management of obstetric emergencies; these will be used as the standards against which to measure quality.
- Sustainable community models for resources to access essential obstetric care including effective transportation to and from facilities, appropriate fees, and adequate supply of drugs and blood will have been tested and implemented in selected priority countries.
- Streamlined approaches to competency-based training and distance learning will be available and implemented in priority countries.
- Additional and improved Safe Pregnancy and Reproductive Health policies, such as the "Mother Friendly Workplace" policy, and implementation plans will be in place.

- Participation of NGOs for the provision of care will be increased.
- Using the tools for the community diagnosis currently being field tested, interventions such as utilization of mass media and interpersonal communication, will be put in place.
- Collaboration between professional associations and Ministries of Health to set standards of care will be increased in priority countries.
- Monitoring systems used for measuring incidence of pregnancy complications, timeliness of care, and case-fatality ratios as reflections of quality of care which directly contribute to the reduction of maternal mortality will be in place and local capacity for program evaluation will be improved in selected priority countries and ultimately available globally.

It is expected that the results of these efforts will generate a greater willingness and ability for increased local and national resources for reproductive health activities, as well as an increase in demand for and provision of reproductive health services.

Strategic Objective 3:



PROGRESS TOWARD STRATEGIC OBJECTIVE

G/PHN's child survival program develops and applies cost-effective, sustainable interventions to reduce and prevent the principal causes of illness and death in infants and children. G/PHN brings to the field new and improved interventions, actively identifies and promotes policies that favor improved child health and nutrition, and contributes, through its partnerships with field missions and regional bureaus, to the development and implementation of state-of-the-art child survival programs. G/PHN synthesizes experiences across countries to improve child survival globally.

G/PHN's performance indicators at the SO level track Child Survival interventions concerning prevention and treatment of illness on a global scale. For these indicators, changes cannot be measured annually and therefore new global data are not available. However, DHS surveys completed in 1995 in two USAID-assisted countries identified the types of improvement that are seen globally when longer term trend data are aggregated. Compared to preceding DHS surveys, the 1995 surveys revealed:

- The *proportion of fully immunized children under one year of age* in Morocco increased from 63% in 1992 to 85%; in Guatemala, the *proportion of fully immunized children under age one* increased from 25% in 1987 to 43%.
- In Morocco, the *proportion of children with diarrhea episodes treated with ORS or appropriate home fluids* increased from 17% in 1992 to 33% in 1995. In Guatemala, the proportion increased from 16% in 1987 to 22% in 1995.

The four Intermediate Results under this Strategic Objective reflect G/PHN's areas of special expertise and comparative advantage in supporting the Agency's global child survival program. For 1995, G/PHN has identified the following results and highlights.

Intermediate Result 3.1: New and improved cost-effective interventions developed and disseminated.

G/PHN is USAID's principal focus of technical leadership in identifying, evaluating and introducing new approaches for the prevention and treatment of childhood illness and malnutrition, and developing, testing and introducing improved, lower-cost tools and technologies. In the past, products of G/PHN-supported research -- such as oral rehydration salts and the development of low-cost treatment for infant and child pneumonia -- have been key elements of improving child health, nutrition, and survival.

Indicators for this Intermediate Result represent selected -- not comprehensive -- examples of improved technologies and approaches to dealing with key child health and nutrition problems. For these and other such major causes of child mortality and ill health, G/PHN has determined that lack of such technology or an improved approach represents a critical constraint to improved child survival. During 1995, important progress was made to develop and evaluate several critical technologies and methods, including:

In immunization programs and vaccine development regarding ARI and malaria:

- *Vaccine Vial Monitors (VVMs)*, developed and evaluated over several years, show whether vaccines are impotent due to excessive exposure to high temperature. In 1995, UNICEF required that VVMs be provided on all polio vaccine purchased for worldwide immunization activities. During 1996-98, the monitors will be adapted for use on measles vaccine.
- Studies of pre-filled, single-use syringes were conducted in Bolivia and Indonesia to deliver tetanus toxoid to women of reproductive age and hepatitis B vaccine to newborns. These syringes were found by health workers, including traditional birth attendants, to be easier to use than conventional syringes, and to be more acceptable to mothers.
- A G/PHN led, multi-donor supported, field trial of a vaccine against *Hemophilus influenzae* type b showed a 95% effectiveness of this vaccine.
- Two *malaria vaccines* based on different parasite stages were produced and underwent pre-clinical safety and immunogenicity studies in preparation for human trials.

In nutrition including micronutrients:

- Important research in Indonesia showed that administration of vitamin A at birth (50,000 IU) decreased infant mortality by 64%.
- To follow up on the potentially important finding of one study indicating a protective effect of vitamin A on HIV transmission to newborns, a trial has been initiated in Zimbabwe to examine the effect of providing vitamin A to HIV+ mothers and their infants at birth on reducing the transmission of HIV to those infants through breastmilk (which accounts for approximately 1/3 of the total mother-to-infant transmission).

Regarding diarrhea:

- A dietary management treatment for persistent diarrhea -- which causes up to one-third of diarrhea deaths and does not respond to rehydration alone -- was tested in health facilities in 6 countries, found to be 90% effective, and incorporated into global policy. Multi-center trials were begun of a new formulation of ORS that improves fluid absorption in the 10 per cent of children where the standard solution is ineffective.

To bring environmental health issues to the fore:

- G/PHN trained Indian planning institutions to perform comparative environmental health risk assessments. One assessment identified motor vehicle emissions, indoor cooking stoves, and contaminated water as high risk factors for children resulting in a commitment by the institutions involved to prepare an environmental management plan.
- In Tunisia, a methodology to enable municipalities to plan and implement environmental health programs in poor, urban areas with full community involvement was successfully implemented. Lessons learned are now being applied in Jordan and Egypt.

To improve the approach to treating children in need:

- A new *integrated approach to treating the major illnesses of children* in health facilities resulted in the USAID/WHO/UNICEF-supported initiative for "Integrated Management of Child Illness." During 1995, using a preparatory guide produced in collaboration with the Africa Bureau, G/PHN worked with health authorities and policy-makers in six countries to introduce this approach and begin a systematic process of integration of their child survival programs.

Intermediate Result 3.2: Improved policies and increased global, national, and local resources for appropriate child health interventions.

G/PHN has focused on developing and improving policies supportive of child health services and to increasing overall resources for child health and nutrition. The specific indicators for this Intermediate Result focus on *developing sustainable financing for countries' vaccine supplies*. Activities in this area include assisting countries in developing and implementing approaches to increase financial support for child survival services in general, as well as applying strategies that result in increased participation of private sector entities in the production, promotion, and delivery of child health and nutrition-related goods, services, and information.

During 1995, G/PHN assisted countries to reformulate policy, mobilize private sector resources, make more efficient use of diminishing government resources, and increase access to affordable vaccines, drugs and micro-nutrient supplements. Pertinent examples are as follows.

To further efforts at sharing the cost of child survival programs:

- The Vaccine Independence Initiative (VII) expanded in 1995, with new agreements in Ghana, Tanzania, Burundi and the South Pacific Islands. These nations now purchase a portion of their childhood vaccines with their own resources and have agreed to regularly increase the amount of their vaccine needs that they purchase. During 1995, several additional donors joined the VII, making this USAID-initiated scheme a self-sustaining mechanism for supporting countries' child immunization efforts.
- Technical assistance in health financing and cost analysis to national governments in multiple countries (including Ethiopia, Eritrea, Niger, Tanzania, Kenya, Egypt, Bolivia, Paraguay, Ecuador, the Dominican Republic, Jamaica, Poland and the Central Asian Republics of Georgia, and Moldova), resulted in the development of national financing strategies and health expenditure tracking systems that have improved the capacity of governments to monitor and analyze financial resources. In several of these countries, pilot cost-recovery programs have generated resources to improve the quality of care and availability of drugs.

To improve the delivery of services:

- Policy dialogue led to the formulation or revision of national policies and plans to introduce more cost-effective child health strategies in over 20 USAID assisted countries. Examples include

assistance in the formulation of disease control policies that helped to avert 80 per cent of the 3,000 predicted cases and 160 predicted deaths from the diphtheria epidemic in Moldova, and that guided successful polio eradication efforts across the Central Asian Republics. G/PHN also assisted five of the NIS countries to revise their childhood immunization schedules and their policies on contraindications to immunization, saving these countries an estimated \$4 million over the next five years.

- In 1995, in partnership with the Africa Bureau, G/PHN launched the Africa Integrated Malaria Initiative. This initiative will apply the results of past program and policy research in malaria prevention and treatment to address this major cause of infant and child mortality in Africa. Between FY 1996-1998, three African countries will have developed appropriate national protocols and initiated program activities for diagnosis and treatment of children with malaria and for household level prevention.

To broaden the partnership working toward better child survival:

- Partnerships with PVOs and NGOs have increased access, efficiency and, quality of child survival goods and services. For example, G/PHN assisted Nigeria and Indonesia to develop innovative private sector approaches to improving maternal health status, pregnancy outcome, and child survival. G/PHN also provided assistance to PVOs and NGOs in Ecuador, Haiti, Honduras, India, Indonesia, and Bangladesh to improve the quality of private sector health programs and services. In Kenya, Tanzania, Senegal and Zambia, nationwide assessments of private sector involvement were completed and discussed with national leaders.
- G/PHN took a leading role in inducing the private sector to support micronutrient interventions. As a result of assistance to the Government of Indonesia in coordinating NGO activities and commercial private sector initiatives, industry in that country has for the first time invested in micronutrient supplementation and nutrition education among women factory workers. In addition, a greater proportion of micronutrient activities has been shifted to the commercial private sector through food fortification of sugar with vitamin A (Bolivia, Central America, Philippines), of wheat with iron (Sri Lanka, Philippines), and of salt with iodine (Eritrea, Nicaragua).
- G/PHN also continued to lead the global child survival effort in increasing the role of commercial organizations in providing appropriate child health products. In Bolivia, G/PHN cooperated with commercial producers and international organizations to develop and launch a national ORS marketing campaign. In the Central America region, G/PHN projects initiated work with major multinational and national producers of soap and chlorine to promote their products for improvement of household health.

To strengthen national policies:

- In four USAID-assisted countries, G/PHN-supported research by host country investigators led to major policy improvements for child survival. In one example in Mexico, a dietary product initially developed for treatment of malnourished children with diarrhea was also demonstrated to be effective in treating child malnutrition from other causes; the President of Mexico declared use of this product to be the national standard for preventing and treating child malnutrition, and large scale commercial production has been begun.
- In response to national concern about environmental toxins potentially contaminating mothers' milk in Kazakhstan, G/PHN supported research on levels of radioactive and toxic materials in breastmilk of a scientifically selected sample of mothers. These studies documented the general absence of harmful substances from milk samples, leading the Kazakhstan Ministry of Health and National Academy of Sciences to promote breastfeeding nationally as the safest and most nutritious food for infants.

- Policies promoting environmental sanitation have been adopted and supported by PAHO and UNICEF and are presently being promoted in El Salvador and Guatemala. In El Salvador, the first National Sanitation Commission is now in place and CARE's LAC regional water supply and sanitation program has been refocused onto health outcomes, peri-urban sanitation and institutional strengthening.

Intermediate Result 3.3: Improved preventive and care-giving practices and behaviors related to child health and nutrition.

Nearly all G/PHN health and nutrition programs call for communications and related interventions to promote behavior change, principally in the health behaviors of child caretakers (mothers, fathers and other child caretakers), but also in health services personnel and policy/decision makers. Work underway is based on two decades of experience.

Indicators for this Intermediate Result reflect families' knowledge related to two of the many important child health areas -- diarrhea and pneumonia -- where appropriate knowledge and behavior by families are critical to improved health and survival. G/PHN's cutting edge work in this area is intended to develop and apply effective behavior change approaches and capabilities in USAID-assisted countries, recognizing the key role of appropriate practices and behaviors in all child health and nutrition areas from breastfeeding and feeding to acceptance of immunization to recognition, home care, and care-seeking for illness. Results achieved in this area during 1995 include:

- National IEC capabilities were strengthened in Russia, Bolivia and Eritrea. In Russia, with participation of 160 representatives from federal and regional institutions and 64 oblasts, modern communications strategies were developed and applied to address the diphtheria epidemic and to raise immunization levels for polio and other diseases. In Eritrea, as a result of an IEC needs/capabilities assessment, a national health communications policy was developed, and incorporated into the country's health plan. In Bolivia, 40 national and district level program managers, as well as health educators and community mobilizers from 6 regions, were trained in social marketing as part of Bolivia's health reform and decentralization agenda, under which social marketing and communication are seen as contributing to increased community demand for and use of health services.
- Guides for program implementors on conducting behavioral research and designing educational messages for child caretakers in the area of breastfeeding were developed and tested. In Latin America, strategic planning was conducted in collaboration with PAHO to improve the community support system for exclusive breastfeeding promotion.
- A set of communications modules and materials developed by G/PHN communications projects is being field tested in West Africa, Peru and the NIS. A manual for counseling and group facilitation and a guide for trainers and supervisors for breastfeeding promotion has also been developed.
- Behavior change activities in many cases reached beyond the specific site where they were carried out. For example, in Niger, previously vertical child health counseling messages delivered to mothers were integrated into clinical training materials, and health providers were trained to use the new combined counseling approach as part of a pilot project in two districts; recommendations from this trial will be used to formulate IEC policies related to Integrated Management of Child Illness (which includes both diarrhea and ARI). In Bangladesh, a USAID-supported home gardening activity "went to scale", reaching more than two million rural Bangladeshis in the past year; production of fruits and vegetables has been increased and has extended availability year-round, improving household diets and providing additional income, particularly among women who are the primary managers of the gardens.
- Local NGOs and communities in select countries have increased their capacity to identify high-risk environmental health related behaviors and to design and implement programs to change behavior

to achieve a health impact. In Ecuador, a community-based approach was successfully used to change hygiene behavior associated with cholera; in Zlatna, Romania, community-based approaches were used to identify actions to reduce children's exposure to lead emissions from nearby smelter plants; and, in Jamaica, Haiti and Peru, the capacities of local NGOs were strengthened to carry out environmental health projects in poor, urban areas.

Intermediate Result 3.4: Improved quality and availability of key child health/nutrition services.

G/PHN increases access and improves the quality of child health and nutrition services by supporting the delivery of targeted, cost-effective interventions to enhance the service delivery capacities of health care systems in USAID-assisted countries. This work is most frequently carried out in close working partnership with USAID country missions and regional bureaus.

Performance indicators represent selected examples of improved capabilities of health facilities, availability of key drugs and commodities, and application of important elements of quality improvement such as adoption of standardized guidelines and adoption of quality assurance approaches. G/PHN's work in support of improved quality and availability of child survival services include these and a broad range of related interventions aimed at improving the effectiveness and efficiency of countries' child health and nutrition services. Examples of results achieved during 1995 include:

Specific results relating to the availability of services include:

- In 1995, G/PHN efforts strengthened health system planning organization and management in over 30 countries. For example, in Bangladesh, a step toward polio eradication was taken when 85% of targeted children received polio vaccine during a mass immunization effort. In the five Central Asian Republics of the NIS, health system managers and workers unfamiliar with decentralized management and modern vaccine management and cold chain procedures received training and assistance that helped them effectively immunize over 1.5 million children, respond to the diphtheria epidemic, and mount polio eradication campaigns that achieved 97% coverage.
- As a result of collaborative efforts by G/PHN and other international organizations, the number of countries with established program guidelines for prevention and treatment of micronutrient deficiencies has increased from 8 in 1984 to 18.
- G/PHN assisted the effective production, procurement, and distribution of drugs, vaccines, and food/nutrition commodities. For example, in Nepal, G/PHN supported efforts to increase the delivery of vitamin A capsules in 32 of the poorest districts in the country, reaching an estimated 1.4 million children. In cooperation with WHO's Division of Diarrhoeal and Respiratory Diseases, G/PHN developed a training program aimed at improving the integrated management of drugs and commodities essential for the treatment of sick children in primary health care facilities.
- Access to health services through innovative private sector partnerships was expanded. In Nigeria, where the public sector system has become substantially dysfunctional, G/PHN projects helped identify and assist private sector channels that deliver immunization and essential health services to large numbers of children in the country's densely populated urban areas. In Indonesia, in partnership with the Government of Indonesia and the World Bank, private sector providers of child health services were brought into cooperative relationships with public health authorities.
- Local NGOs in Peru, Haiti and Jamaica have increased capacity to improve the quality and availability of key primary preventive environmental health services, such as water supply, sanitation and solid waste.

Examples of G/PHN's efforts to improve the quality of services include:

- G/PHN provided critical technical assistance to USAID Missions and collaborating sponsors of Title II programs in six countries (India, Guatemala, Honduras, Ethiopia, Eritrea, and Mozambique) on ways to incorporate food security goals in USAID and PVO programs.
- G/PHN continued its leadership in applying quality assurance techniques to improve child health services, especially in primary level facilities. For example, in Niger, the staff of rural health facilities applied quality assurance methods to improve the correct treatment of diarrhea and ARI from 20% to over 60%, and of malaria from 33% to 83%. In Indonesia, G/PHN leveraged substantial World Bank project resources to develop and implement a large scale quality assurance program as part of the government's new health sector development project. Quality assurance programs also resulted in a 42% decrease in cholera fatality rate in Guatemala.
- The monitoring, evaluation, and surveillance capabilities related to child health and nutrition of a number of countries were improved in 1995. For example, in Bangladesh, G/PHN projects assisted in mounting a nation-wide nutritional surveillance system to improve monitoring and to strengthen the government and organizational response to food security and nutritional deficits following recurrent monsoons, flooding, and other disruptions in food production and availability.

EXPECTED PROGRESS: FY 1996 - FY 1998

During 1996-98, research and evaluation will continue in the development of:

- new vaccines for malaria and ARI ;
- cost-effective technologies for service delivery;
- improved methods to assess and increase the effectiveness of child survival programs.

Among the more important results anticipated in the coming years are:

- additional field trials, to be carried out with NIH and WHO, of the vaccine against child pneumonia (*Streptococcus pneumoniae*); and
- the testing of the new malaria vaccines in humans.

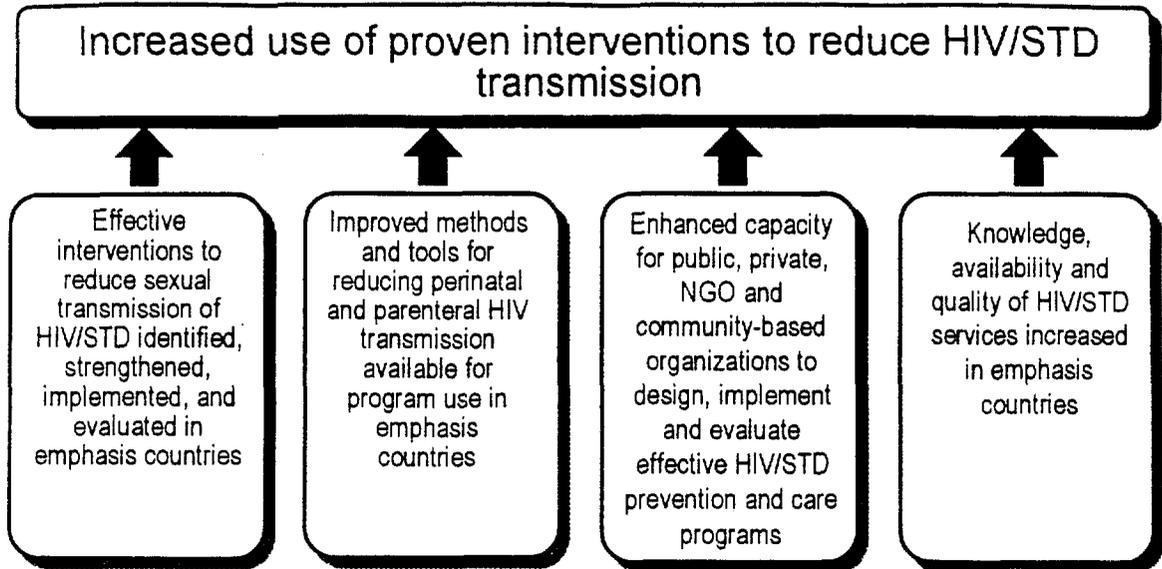
Research conducted in the 1996-98 period will also:

- strengthen at least 20 LDC institutions; and
- provide 80-100 LDC researchers with the skills to carry out independent research activities.

During 1996-98, progress toward improving policies, increasing resources and capacity building will be achieved through the following:

- vaccine supply plans will be developed and purchase of vaccines through the Vaccine Independence Initiative or similar revolving funds will be instituted in 5 additional countries;
- commercial private sector investment in micronutrient initiatives and in production, promotion, and distribution of ORS and other child health products will be accomplished in 10 countries; and
- G/PHN will have assisted host country governments in additional priority countries to implement cost-recovery and health financing approaches that support equitable expansion of child survival programs.

Strategic Objective 4:



PROGRESS TOWARD STRATEGIC OBJECTIVE

Close to 20 million people have been infected with the HIV virus since the beginning of the epidemic. By the year 2000 this total could double to 40 million, further undermining health, economic growth and political stability at the national level in high prevalence countries. The spread of HIV is aggravated by unsafe sexual activity, low use of condoms, and high prevalence of other sexually transmitted diseases (STDs) which increase the efficiency of HIV transmission. Women are becoming infected at faster rates than men, due to high levels of undiagnosed STDs among women and their greater biological, cultural and socioeconomic vulnerability to HIV infection. The number of HIV infections among women is expected to double from seven million in 1994 to 14 million by the year 2000.

USAID has emerged as the global leader in addressing the HIV epidemic, committing more than \$700 million for prevention activities since 1986 and establishing global standards of practice for the prevention of HIV. In close collaboration with the Missions, Regional Bureaus, and other international donor organizations and national governments, G/PHN sponsored activities in over 42 countries.

Computer simulation modeling of the epidemic has enabled G/PHN to begin estimating the impact of interventions. For example:

- In Kenya, for instance, it has been estimated that through condom promotion alone, over 110,000 HIV infections and over 1.3 million other STDs were averted between 1991 and 1994.
- Implementation of a 100 % condom use policy in commercial sex establishments in Thailand resulted in reductions of the monthly STD incidence from 13 % to 0.3 % per month. Surveys in Thailand also demonstrate a dramatic reduction of new HIV infections in military recruits, a proxy indicator for the general population of sexually active young men.

Comprehensive data collection systems for tracking the pandemic and the impacts of interventions are complex, and USAID is playing a key role in their development. For example:

- G/PHN staff and implementing agencies collaborate closely with WHO/UNAIDS on the development and testing of core Prevention Indicators for tracking progress of HIV/AIDS control programs at the national level.

- G/PHN is also sponsoring development of new evaluation tools, such as the Evaluation Project's manual of indicators for HIV/STD project monitoring and AIDSCAP's *Avert*, a simple spreadsheet model that will permit policy makers in other countries to estimate the financial benefits of HIV/STD prevention.

USAID's work on HIV/AIDS between 1986 and 1992 centered on identifying the best ways to respond to the problem in HIV emphasis countries. The resulting "USAID comprehensive strategy" for HIV/AIDS prevention, care and support is comprised of three principle and three supporting approaches.

Principle approaches:

- behavior change communications;
- condom supply and logistics;
- improved STD case management;

Supporting approaches:

- behavioral research;
- evaluation and monitoring; and
- policy dialogue

Key elements of the strategy are tracked through SO level indicators.

G/PHN supports quality Condom Social Marketing (CSM) projects and helps to ensure that adequate condom supplies reach areas where they are most needed. At the SO level, indicators track both *progress in increasing demand* for condoms and *success in meeting this increased demand*.

- In 1995, the total volume of condoms shipped was 314,118,000, an increase of 71% over 1994.
- CSM achieved a rate of 1.66 condoms per sexually active male (SAM) in HIV/AIDS emphasis countries, a 56 % increase over 1994 levels.

G/PHN promotes the implementation and use of a sequence of seven steps, from surveillance and drug sensitivity studies to retraining health providers, to improve STD prevention and case management in HIV emphasis countries. The indicator that will be used to measure progress in this area is the *proportion of people presenting with STD complaints at health facilities who are treated according to national standards*. Data for this indicator is not yet available on a large-scale representative basis, but in the future will be obtained in HIV emphasis countries from facility-based surveys. Available, project-level data suggest that only about 10% of clients presenting with an STD in developing countries are treated according to established national guidelines.

G/PHN supports development of interventions to increase condom use by men and women in conjugal relations as well as in higher risk, "casual" sexual relations. Baseline data from the DHS indicate that consistent use in conjugal relations is extremely low (less than 1%). Limited data also indicate that the prevalence of condom use by males with casual partners is considerably higher than with regular, conjugal partners, but is still very low. Innovative, targeted interventions involving outreach and skills-building approaches are being tested to promote behavior change in these and other high risk situations.

G/PHN is also leading the development of more sensitive, standardized instruments to monitor intervention program impacts on adoption of lower risk sexual behaviors with specific types of partners (e.g. spouse v. acquaintance v. CSW). Currently, DHS data lack sufficient scope and consistency across countries to provide adequate indicator data.

Intermediate Result 4.1: Effective interventions to reduce sexual transmission of HIV/STD identified, strengthened, implemented and evaluated in emphasis countries.

Since 85% of HIV infections are acquired sexually, the development of new and/or improved methods and technologies to prevent transmission of HIV/STD, and to detect and treat other STDs which increase HIV risk, is a cornerstone of G/PHN's efforts. Recent technological developments supported by G/PHN include:

- A low cost, rapid, simple "dipstick" test for detecting HIV antibodies now being produced in Argentina, Cameroon, India, Indonesia, Thailand, and Zimbabwe;
- A "plasma separator card", now in production, which allows syphilis testing using a simple fingerstick sample, and provides test results (at 20-50 cents per test) within 20 minutes so that the patient can be treated immediately, if infection is present;
- Female controlled barrier methods, including the female condom and viricide/spermicides which are currently undergoing acceptability studies with women in high risk groups and the general population;

G/PHN is also collaborating with WHO to conduct a definitive, three year study in four countries to determine the cost effectiveness of high quality, pre-and post-test personal risk reduction counseling. Recruitment into the randomized clinical trial has been successfully completed, and both USAID sites (in Tanzania and Kenya) have begun follow-up protocols. Preliminary results are expected within a year.

New approaches are being tested to reach beyond STD clinic patients to increase awareness and understanding of STDs and their impact on reproductive health. DHS data demonstrate that knowledge of treatable STDs is quite low, even in countries with extremely high awareness of HIV. G/PHN supports training and operations research to improve awareness of local health beliefs, communication between STD physicians and their clients, and the effectiveness of IEC materials. For example:

- In 1995, a rapid ethnographic assessment package, the *Targeted Intervention Research model (TIR)*, was field tested in Ethiopia, Senegal, Zambia and the Philippines. This tool will be disseminated in all HIV emphasis countries to improve the speed and quality of developing locally appropriate interventions;
- G/PHN collaborated closely with the WHO Global Program on AIDS to develop and disseminate guidelines for syndromic management of STDs, which reduces misdiagnosis and treatment with inappropriate or ineffective drugs in clinics without adequate laboratory facilities. In 1991 only one of the HIV/AIDS emphasis countries had adopted these guidelines. As of 1995, ten of the countries had done so on a national or regional level, and another two were using the guidelines in pilot sites.

Intermediate Result 4.2.: Improved methods and tools for reducing perinatal and parenteral HIV transmission available for program use in emphasis countries

G/PHN has focused primarily on reducing the sexual transmission of HIV. There are, however, many country settings where reducing perinatal and parenteral transmission are becoming crucial for avoiding epidemic spread. Reducing HIV transmission to women is the best way to prevent mother-infant transmission and the following are examples of G/PHN's progress toward reducing this form of transmission:

- G/PHN-sponsored activities, such as the AIDSCAP Women's Initiative, have provided global leadership in research and advocacy for women's empowerment for HIV/STD prevention.
- G/PHN encouraged partners such as WHO and NIH to investigate intrauterine and perinatal transmission, and transmission through breast-feeding.
- G/PHN research funds have been directed to identify methods of reducing transmission during delivery (vaginal irrigation) and post delivery (vitamin A supplementation).

Within the prevention community G/PHN advocates for safe blood supply, and prevention of nosocomial or other occupational exposure to infection. G/PHN contributed to the development and testing of a protocol for blood pooling which radically cuts the cost of anonymous unlinked blood screening in blood banks, thus improving the sustainability of this crucial health service.

Intermediate Result 4.3: Enhanced capacity for public, private, NGO and community-based organizations to design, implement and evaluate effective HIV/STD prevention and care programs

This intermediate result is being met through global leadership in resource mobilization and policy dialogue, and through the development of effective mechanisms to support public, private and NGO capacity-building.

- G/PHN played a lead role in defining the structure and functions of UNAIDS, the new, joint- and co-sponsored project that will integrate the HIV/AIDS activities of the UN agencies and the World Bank, which replaced the WHO Global Program on AIDS in 1996.
- In 1995, G/PHN led the formation of a consortium of 12 US domestic NGOs which developed and publicized a 12 workshop symposium to provide information and raise the profile of HIV/STD issues at the Beijing Conference's NGO Forum.
- G/PHN convened the Third USAID HIV/AIDS Prevention Conference in August of 1995 to focus US and international attention on eight persistent challenges for the next decade: community participation and sustainability; the prevention-care continuum; new product development; behavior change communication strategies; costs and types of HIV counseling; integration of HIV/STD into reproductive health services; evaluation and monitoring; and ethics and human rights. The conference drew participants from 51 countries, and its new, participatory format was widely acclaimed.

Building local capacity is critical to the transfer of skills and technology that ensure local program effectiveness and sustainability. G/PHN provides training, technical assistance and network support that enables dedicated indigenous organizations to improve services, professionalize administrative systems, and plan for future needs, including fund-raising, training and recruitment. The following are examples.

- In Haiti, the proportion of clinicians providing proper treatment for common STDs increased from 10% to 69% in one national PVO. The adoption of syndromic management guidelines resulted in a 50% decrease in laboratory costs for a USAID-sponsored coalition of 10 NGOs in the rural, Central Plateau region.
- In Tamil Nadu, India, a small grants program enabled NGOs to develop innovative vehicles for reaching high risk populations at low cost. One \$3,000 grant supported an NGO in developing and producing 35 street dramas, each reaching some 250 people, for a unit cost of \$0.34 per person. Another \$3,000 grant to an NGO supported six issues of a Tamil language newsletter reaching an estimated 15,000 people with accessible information about HIV/STD, at a cost of \$0.20 per person.
- The International HIV/AIDS Alliance (of which G/PHN is a key partner) strengthened the capacity of over 100 NGOs in 12 countries to expand prevention, care and support services and thereby increased community participation in HIV/AIDS policy formulation and implementation.
- AIDSCAP provided training in management, financial administration, MIS, and other technical areas to strengthen 140 organizations in 1995 making a total of 240 organizations since 1991.

Intermediate Result 4.4: Knowledge, availability and quality of HIV/STD interventions increased in emphasis countries

The success of USAID's comprehensive prevention strategy depends upon the knowledge, availability and quality of HIV/STD interventions at the country level. In 1995 G/PHN supplied HIV/STD expertise to interested Missions through the Joint Programming and Planning Teams, and through centrally managed projects. These activities continue to disseminate and refine the USAID comprehensive strategy of HIV/STD control.

G/PHN's IEC programs have raised awareness of HIV in emphasis countries, though further work is needed to promote large-scale behavior change. DHS data indicate that less than 30% of male and female respondents can identify two correct means of avoiding/preventing HIV infection, even in countries with almost universal "awareness" of HIV.

Awareness and knowledge often are not enough to effect change in sexual risk behavior. In many cases, assessment of personal risk, developed through interpersonal communication and counseling, is a critical factor in motivating personal behavior change. In 1991, 11 countries were employing some form of person-to-person education for "high risk" behaviors. By 1995, G/PHN had been instrumental in raising the number to 20 emphasis countries implementing these programs and 19 extending these activities to vulnerable groups within the general population, such as students, youth and women.

EXPECTED PROGRESS: FY 1996 - FY 1998

The following is a list of some of the major accomplishments that G/PHN expects to achieve between now and FY 1998 toward the reduction of STD/HIV transmission:

- G/PHN will support the continuation of the Agency's global leadership and field support in HIV/STD prevention. Special focus will be on implementing a comprehensive strategy for prevention of sexual transmission and G/PHN will continue to support the international/multilateral response through a grant to the United Nations Programme on HIV/AIDS (UNAIDS).
- CSM projects to increase demand for and use of condoms will achieve a ratio of 2.0/SAM by 1996 and 2.7/SAM by 1998. Condom shipments are expected to fall to 150 million in 1996, due to the success of several USAID missions in securing commitments for condom procurement from other bilateral donors. Increases in generated demand, however, are expected to restore the upward trends in subsequent years, reaching a target of 200 million condoms per year by 1998.
- Over the next three years, it is expected that in 19 USAID-assisted countries, 90% of all NGOs funded through the G/PHN HIV/STD portfolio will have essential management systems and skilled staff persons, and 85% of the Alliance-assisted NGOs will have strategic plans articulated for HIV/AIDS prevention and services.
- Through the application of local behavioral research, and through innovative uses of established IEC systems, such as targeting social norms and stigma associated with HIV/STDs, G/PHN expects to bring *correct knowledge of HIV prevention* methods up to 40% in 1998, and to 50% in the year 2000 in HIV emphasis countries.
- By the year 2000, G/PHN will increase the *proportion of people presenting with STD complaints at health facilities who are treated according to national standards* to 40% in those clinical settings supported by USAID.

In addition to the anticipated achievements noted above, G/PHN will intensify efforts to encourage greater participation of people living with HIV/AIDS in the design, implementation and evaluation of prevention activities. During 1996, G/PHN will be the fulcrum of an international consultative process to redesign the G/PHN HIV/AIDS portfolio for the next decade. The redesign involves a sequence of regional, technical and community consultative meetings and reviews that began in 1995 with the 3rd USAID HIV/AIDS Prevention Conference. This participatory process is intended stimulate new thinking about key issues and promising opportunities in HIV/STD prevention and care, and to engage all Agency operating units, customers, partners and stakeholders in implementing the Agency's newly "reengineered" participatory design process. At the same time, the process will build global consensus on intervention priorities and on G/PHN's optimal role in the expanded global response. The new G/PHN strategic objective and results framework will be available by the fall of 1996, enabling G/PHN to enter the 1997 fiscal year with a fresh and shared vision of G/PHN's leadership role in HIV/STD prevention and care for the next 5-8 years.

IV. Status of the Management Contract

As substantiated above, G/PHN's strategic objectives are clearly focused on achieving the Agency's goal of *stabilizing world population and protecting human health in a sustainable fashion* and the Agency's four objectives of reducing unintended pregnancies, maternal and child mortality, and STD/HIV transmissions. The four Strategic Objectives and their sixteen Intermediate Results have not changed in any way since they were submitted in the Strategic Plan of December 1995, and remain the basic framework guiding and informing G/PHN's activities.

Furthermore, G/PHN's strategic framework is increasingly recognized as a useful tool enhancing efficiency and effectiveness in Managing for Results. Application of this instrument during 1995 has resulted in many valuable learning experiences for G/PHN staff. Correspondingly, application of the tool has appropriately resulted in a few modifications and refinements of the indicators selected to measure progress toward the objectives and intermediate results. These changes are noted in the commentaries that accompany each of the tables in the Annex. In a few cases, original indicators were replaced by others that more precisely measured the results G/PHN is trying to accomplish. In other cases, indicators were slightly reworded to better conform to standard methodologies currently being applied. In one case (SO4), two related indicators concerning condom usage were elevated from the Intermediate Results level to the Strategic Objective level because of their power to assess both demand for safer sex practices and actual behavior change. None of the movements or refinements of indicators altered G/PHN's Action Plan in any way; rather, the changes enhanced abilities to receive valuable feedback from the field.

For many of the survey-based indicators, new baselines have been calculated to include pre-1995 data not available when original baselines were submitted. In most cases, baseline changes moved in the desired direction indicating pre-1995 progress. For some indicators, the change was large enough to warrant making changes to targets. These changes are also noted in the table commentaries.

Lastly, it should be noted that the targets and expected progress articulated in this report are predicated on the availability of adequate funding levels. Obviously, if funding is significantly cut in any or all areas, this will necessitate and a reconsideration of priorities and planned results.

Annex 1

General notes for G/PHNC performance indicator tables

During 1995, performance indicators for G/PHNC's strategic objectives were developed, extensively reviewed and revised. The following tables do not list all G/PHNC performance indicators. Rather, the tables and accompanying notes in Annex 1 provide a status update by including only those indicators for which:

- (a) progress can be shown over the calendar year 1995;
- (b) a new baseline value has been calculated, and/or;
- (c) new (replaced/revised) indicators were selected for which baselines have not been previously published.

In cases where performance indicators are based on Demographic and Health Survey data, baselines have been recalculated to reflect the availability of data from several surveys conducted in 1994-95, most notably Morocco, Tanzania and Indonesia. In the coming year, Demographic and Health Surveys will provide new data for an additional set of countries including Brazil, Egypt, Guatemala, Haiti, Nepal, Malawi, Peru, Uganda and Zambia.

Table are numbered as closely as possible to the system used in the G/PHNC Action Plan (June 1995) to allow for comparability.

Other notes regarding the performance indicator tables:

- at the intermediate results level, the most distant target value (year 2000) was omitted from the table for formatting reasons;
- for all DHS-based indicators, baselines have been revised to take into account data not available when baselines were calculated for the G/PHNC Action Plan;

the current full complement of countries with Demographic and Health Surveys data (N=48) account for 75 percent of the population of all developing countries (excluding China).

STRATEGIC OBJECTIVE 1: INCREASED USE BY WOMEN AND MEN OF VOLUNTARY PRACTICES THAT CONTRIBUTE TO REDUCED FERTILITY.

#	Selected Performance Indicators	1994 Baseline	1995 Data	Target 2000	Target 2005
1	Modern CPR for currently married women	30.9%	32.1%	36.8%	42.0%
2	Modern CPR for unmarried women	2.9%	3.1%	4.7%	5.9%
3	Median duration of exclusive breastfeeding (months)	1.2	-	2	3
4	% of women who gave birth < 20	39.2%	38.4%	34.8%	31.2%
5	% women who had intercourse < 20	54.5%	51.4%	36.3%	21.3%

INTERMEDIATE RESULT 1.1: NEW & IMPROVED TECHNOLOGIES AND APPROACHES FOR CONTRACEPTIVE METHODS AND FAMILY PLANNING IDENTIFIED, DEVELOPED, TESTED, EVALUATED AND DISSEMINATED

#	Selected Performance Indicators	1994 Baseline	1995 Data	Target 1996	Target 1998
1	# of new & current contraceptive leads/methods under dvlpmt or evaluation and/or advancing to the next stage. ¹	37_0_0	37_0_0	37_5_1	37_20_2
2	# of FP/RH strategies/ subsystems, IEC, training & other tech. imprvmts. under dvlpmt. or evaluated.	8 under dvlpmt.0 eval	8_0	10_0	15_10

INTERMEDIATE RESULT 1.2: IMPROVED POLICY ENVIRONMENT AND INCREASED GLOBAL RESOURCES FOR FAMILY PLANNING PROGRAMS

1	# of Cs with strategic plans reflecting public health principles, quality, access, and gender equity in FP/RH formulated & in effect	under development	-	TBA	TBA
4	Resources for FP/RH in USAID Priority Countries per WRA	\$0.70	\$0.24	?	?
6	Share of service delivery by LDC private sector	41.8	43.1	44.5	47.3

INTERMEDIATE RESULT 1.4: DEMAND FOR, ACCESS TO AND QUALITY OF FAMILY PLANNING AND OTHER SELECTED REPRODUCTIVE HEALTH INFORMATION AND SERVICES INCREASED

1	Mean desired family size	3.4	3.3	3.2	3.1
4	Mean # of modern methods known by WRA	4.6	4.7	5.1	5.4
5	% of women who can travel to a source within half an hour	66.5%	67	69	71
6	Median length of using a temporary modern contraceptive method (months)	28.4	29	30	31

¹ Categories for contraceptive products: (a) under development, (b) evaluation, (c) moving from one stage to another

Commentary on SO1 Performance Indicators Table

For all DHS-based indicators included in the R2 table the "current" data supplied is an estimate based on the projection of values from an average annual rate of change that was derived from those DHS countries that have had more than one survey.

SO 1.1 Modern contraceptive prevalence rate for currently married women [of reproductive age].

- Original Baseline: 31.6%. Recalculated Baseline: 30.9% 1994. (N = 36 countries)

SO 1.2 Modern contraceptive prevalence rate for currently unmarried women [of reproductive age].

- Original Baseline: 3.0%. Recalculated Baseline: 2.9% (N = 36 countries)

SO 1.3 Median duration of exclusive breastfeeding (months)

- Original Indicator: Proportion of women fully breastfeeding for six months [after last birth]
- Original Baseline: 24.6%. Recalculated Baseline: 1.2 months (N = 25 countries)
- Targets adjusted according to Recalculated Baseline.

SO 1.4 Proportion of women [20-24 years old] who have had a birth before age 20.

- Original Baseline: 36.5%. Recalculated Baseline: 39.2%
- Targets adjusted commensurate with recalculated baseline.

SO 1.5 Proportion of women [20-24 years old] who have had sexual intercourse before age 20.

- Original Baseline: 60.7%. Recalculated Baseline: 54.5% (N = 29 countries)
- Targets adjusted commensurate with recalculated baseline.

IR 1.1 Number of new contraceptive products in each of the following categories

- Original Baseline: Original reporting scheme consisted of 13 steps. A simplified scheme has been adopted that counts movement thru 6:
 - a = Preclinical studies in progress or completed (formerly a & b)
 - b = Phase 1 trials in progress or completed (formerly c & d)
 - c = Phase 2 trials in progress or completed (formerly e & f)
 - d = Phase 3 trials in progress or completed (formerly g & h)
 - e = FDA approvals in progress or completed (formerly k & l)
 - f = Phase 4 trials in progress or completed (formerly i & j)

IR 1.2 Number of FP/RH strategies/sub-systems, IEC, training and other technology improvements under development or evaluated.

- Original Indicator(s): This indicator was originally divided into 3 different indicators separating (1) strategies & sub-systems, (2) major findings, and (3) service delivery programs incorporating OR results. Because of considerable overlap in categories, indicators were combined in the table.

IR 2.1 (& 2.2) Number of countries with strategic plans reflecting (1) public health principles, (2) quality, (3) access, and (4) gender equity in family planning/reproductive health formulated and in effect.

- Original Indicator(s) = (1) Number of countries with formal population policies, and (2) Number of countries where population concerns are integrated into national development plans.
- New Baseline: PRB files were used to classify countries into three ordinal categories: (1) having all the above qualities, (2) having 1-3 qualities, (3) having none of these qualities.

IR 2.4 Resources for family planning and reproductive health in USAID priority countries pr WRA

- Indicator has been revised to (1) resources per woman of reproductive age in the 15 Joint Programming Countries.

IR 4.1 Mean desired family size

- Original Baseline: 3.4 (unchanged after recalculation, N = 35 countries)

IR 4.4 Mean number of modern methods known by women of reproductive age.

- Original Baseline: 4.4. Recalculated Baseline: 4.6 (N = 35 countries).
- Targets adjusted commensurate with baseline.

IR 4.5 Percent of women who can travel to a source [of family planning services/products] within half an hour

- Original Baseline: 66.3. Recalculated Baseline: 66.5% (insignificant change, N = 20 countries).
- Targets not adjusted due to insignificant change.

IR 4.6 Median length of using a temporary modern contraceptive method

- Original Baseline: 23.4 months. Recalculated Baseline: 28.4 months (N = 12)
- Targets adjusted commensurate with baseline.

**STRATEGIC OBJECTIVE 2: INCREASED USE OF SAFE PREGNANCY, WOMEN'S NUTRITION, FAMILY PLANNING,
AND OTHER KEY REPRODUCTIVE HEALTH INTERVENTIONS.**

#	Selected Performance Indicators	1994 Baseline	1995 Data	Target 2000	Target 2005
1	% of women attended during pregnancy by medically trained personnel	70%	71%	80%	86%
2	% of births attended by medically trained personnel	37.7%	38.7	44%	51%
3	% of women with serious obstetric complications receiving emergency obstetric care	4%	--	8%	15%
4	% of pregnant women receiving iron supplements in selected priority countries	4%	--	8%	20%
5	% pregnancy women receiving at least 2 doses of Tetanus Toxoid	45.1%	--	--	--
6	% of women using a modern contraceptive method in post-partum period	18.3%	18.7%	20.8%	22.8%

INTERMEDIATE RESULT 2.1: APPROACHES AND TECHNOLOGIES TO ENHANCE KEY REPRODUCTIVE HEALTH INTERVENTIONS IDENTIFIED, DEVELOPED, EVALUATED AND DISSEMINATED/AVAILABLE¹

	Selected Performance Indicators	1994 Baseline	1995 Data	Target 1996	Target 1998
1	Impact of low-dose vitamin A on post-partum & neonatal sepsis	1 @ E	2 @ E	1 @ E	1 @ A
2a	Models for obstetric care training	3 @ D	3 @ D 1 @ E	1 @ E	1 @ E
2b	Models to enhance access & use of essential RH services by young adults	3 @ I	3 @ D	2 @ D	1 @ E
2c	Cost of the provision of essential obstetric care	2 @ D	2 @ D 1 @ A	1 @ E	1 @ E
2d	Interventions to improve dietary intake of iron	2 @ D	2 @ D	1 @ E	1 @ E

INTERMEDIATE RESULT 2.2: IMPROVED POLICIES AND INCREASED PUBLIC AND PRIVATE SECTOR RESOURCES AND CAPACITY TO DELIVER KEY REPRODUCTIVE HEALTH SERVICES

1a	# of countries w/ policy & implementation plans in place for safe pregnancy	1	2 - P&IP 2 - P	2	3
1b	# of countries w/ policy & implementation plans in place for breastfeeding promotion	6	22	25	28
2a	# of countries w/ health training institutions incorporating a curriculum for Life Saving Skills	<3	3	3	4
2b	# of countries w/ health training institutions incorporating a curriculum for breastfeeding promotion	5	15	17	20

The scheme for technologies and approaches is defined as: I = Identification Stage, D = Development stage, E = Evaluative Stage, A = Availability of technology or approach.

Commentary on SO2 Performance Indicators Table

SO 2.0.1 % of women attended during pregnancy by medically trained personnel for reason related to pregnancy in selected priority countries.

- Original baseline (72%). Recalculated baseline (70%) based on priority countries: Bolivia, Egypt, Guatemala, Indonesia, Morocco, Zambia. Indonesia only 55% vs 67% with additional countries added.

SO 2.0.2 % of births in selected priority countries attended by medically trained personnel.

- Original baseline(37.7%). Recalculated baseline (37.7%) based on priority countries: Bolivia, Egypt, Guatemala, Indonesia, Morocco, Zambia.

SO 2.0.3 % of women w/ serious obstetric complications receiving em obstetric care in selected priority co.

- Referred to as "met need " indicator. Baseline data: 4%.

SO 2.0.4 % of pregnant women receiving iron supplements in selected priority countries

- Original baseline studies range from 4-50%. DHS data from 4 regions in India showed an average of 50%.

SO 2.0.5 % of pregnant women who have received at least 2 doses of tetanus toxoid.

- Original indicator was % of births at high risk due to maternal age, parity or spacing. Revised for 2 new indicators
- New indicator
- New Baseline '94 based on WHO data: Bolivia, Egypt, Guatemala, Honduras, Morocco, Zambia (45%)

SO 2.0.6 % of women using a modern contraceptive method in the post partum period.

- New indicator.
- New Baseline '94 data from Bolivia, Brazil, Colombia, DR, Egypt, Indonesia, Jordan, Morocco, Paraguay, Philippines, Peru, Turkey (18.3%).

IR 2.1.1 Models for evaluating the impact of low dose vitamin A on post-partum/ neonatal sepsis

- Baseline: 1 study. Current data: 2 studies at evaluative stage

IR 2.1.2.a Approaches/models for obstetric care training

- Baseline: 3 models at developmental stage. Current data: 3 continue w/ devel.; 1 at evaluative stage

IR 2.1.2.b Approaches/models to enhance access/use of essential RH services by young adults

- Baseline studies identified moved into developmental stage

IR 2.1.2.c Approaches evaluated on costs of the provision of essential obstetric care

- Baseline data: 2 studies at developmental stage. Current data: 2 at development, 1 guideline for assessing private sector costs available.

IR 2.1.2.d Approaches evaluating interventions to improve dietary intake of iron

- Current data includes progress at the developmental stage

IR 2.2.1.a # of priority countries with policies and implementation plans in place for safe pregnancy

- Basline based on Nigeria and Uganda. Current data includes Bolivia and Indonesia.

IR 2.2.1.b # of priority co w/ policies and implementation plans in place for breastfeeding promotion

- Baseline: Bolivia, Cameroon, Colombia, Indonesia, Nicaragua, Uganda. Current countries: Bolivia, Cameroon, Colombia, DR, Ecuador, Egypt, El Salvador, Guatemala, Honduras, Indonesia, Kenya, Nicaragua, Rwanda (draft), Senegal (draft), Uganda, Zambia

IR 2.2.2.a # of selected priority co w/ competency-based training for selected RH interventions incorporated into national curricula for life saving skills

- Baseline countries: Nigeria, Uganda. Current data: Bolivia.

IR 2.2.2.b # of selected priority co w/ competency-based training for selected RH interventions incorporated into national curricula for breastfeeding promotion.

- Current countries: Bolivia, Brazil, Cameroon, Colombia, DR, El Salvador, Egypt, Ecuador, Honduras, Kenya, Mexico, Nicaragua, Pakistan, Peru, Uganda

STRATEGIC OBJECTIVE 3: Increased use of key child health and nutrition interventions

#	Selected Performance Indicators	1994 Baseline	1995 Data	Target 2000	Target 2005
1a	Prevention: % of children fully immunized by age 1	40%	see text	45%	51%
1b	Prevention: children age 6-60 mos. receiving vitamin A supplementation	23%	-	45%	65%
1c	Prevention: infants < 4 mos. of age exclusively breastfed	45%	-	51%	58%
2a	Treatment of illness: % of children < 5 rcvng ORS or RHF or IFs for diarrhea	55%	-	72%	89%
2b	% < 5 yrs. with ARI symptoms taken to health facility	16%	-	26%	35%

INTERMEDIATE RESULT 3.1: NEW AND IMPROVED COST-EFFECTIVE INTERVENTIONS DEVELOPED AND DISSEMINATED¹

	Selected Performance Indicators	1994 Baseline	1995 Data	Target 1996	Target 1998
1a	Technologies: ARI vaccines	1 @ E	1 @ D	1 @ E 1 @ A	5 @ E 3 @ A
1b	Technologies: Malaria vaccines	1 @ E	same as 1994	9 @ I 5 @ D 5 @ E	11 @ I 7 @ D 7 @ E
1c	Technologies: Vaccine vial monitors (measles)	1 @ E	1 @ A	1 @ E	1 @ A
1d	Technologies: Malaria diagnostic kit	1 @ E	1 @ E	1 @ E	1 @ D
2a	Approaches: ICM of the sick child	1 @ D	1 @ D	1 @ E	1 @ E, A
2c	Approaches: integrated supervision	None	1 @ I	1 @ I	1 @ D
2d	Approaches: increase availability of impregnated bednets	None	1 @ I 1 @ D 1 @ E	1 @ I	1 @ D

INTERMEDIATE RESULT 3.2: IMPROVED POLICIES AND INCREASED GLOBAL, NATIONAL, AND LOCAL RESOURCES FOR APPROPRIATE CHILD HEALTH INTERVENTIONS

1a	# of countries financing child vaccines from national budget	41	41	51	61
1b	# of countries meeting vaccine self-financing levels	38	39	40	45

INTERMEDIATE RESULT 3.3: ENHANCED KNOWLEDGE OF KEY CHILD HEALTH AND NUTRITION BEHAVIORS/PRACTICES IN SELECTED COUNTRIES

1a	% of caretakers w/ correct knowldg of: a. the symptoms of ARI needing assesemnt	33%	na	36%	40%
1b	approp. trtmt of diarrhea Incl. knowldg of (1) care-seeking, (2) increased fluids, and (3) continued feeding	(1)25% (2)50% (3) 40%	na	(1)30% (2)55% (3)50%	(1)40% (2)60% (3)60%

INTERMEDIATE RESULT 3.4: IMPROVED QUALITY AND AVAILABILITY OF KEY CHILD HEALTH/NUTRITION SERVICES

2d	# of countries w/ key health commodities available at affordable prices thru comerial outlets & private providers: micronutrient supplementation	Unk.	3	-	-
3a	# of sel. Cs w/ prgrm guidelines in place for: micronutrient deficiencies	8	18	19	22
3c	# of countries w/ QA techniques incorporated into pre-service & in-service training	4	5	-	-

¹IDEA scheme is used for reporting progress in S.O. 3.1 (technology and approaches): I for Identified, D for Developed, E for Evaluated, A for Available.

Commentary on SO 3 Performance Indicators Table

SO 3.0.1a. Prevention: Percent of : a) children fully immunized by age 1.

- Original Baseline: 40%. Recalculated Baseline: 39.7%, 1994. (N=23 countries).
- Current Data: For the narrative there is new data for individual countries. Guatemala in 1987 reported 24.7% coverage; in 1995 it was 42.6%. In Morocco coverage was 63.4% in 1992 and 85% in 1995.
- Targets adjusted commensurate with recalculated baseline.

SO 3.0.1c Prevention: Percent of c) infants less than 4 months of age exclusively breastfed.

- Original Baseline: 40%. Recalculated Baseline: 44.8%, (N= 21 countries).
- Targets adjusted commensurate with recalculated baseline.

SO 3.0.2a Treatment of illness: Percent of a) children under age five receiving ORS, recommended home fluids, or increased fluids for diarrhea.

- Indicator revised to include increased fluids.
- Original Baseline: 46%. Recalculated Baseline: 55%, (N=66 countries)
- Targets adjusted commensurate with recalculated baseline.

SO 3.0.2b Treatment of illness: Percent of b) children under age five with cough and difficult breathing taken to a health facility

- Indicator revised from children with pneumonia given appropriate antibiotic treatment.
- This indicator was changed from a quality of care indicator to a caretaker behavior indicator.

SO 3.0.2c Treatment of illness: Percent of c) children under age five receiving standard diagnosis and treatment of malaria (in Africa)*

- This indicator was deleted in September 1995.

IR 3.1.1 Technologies evaluated: a) ARI vaccines

- Original Baseline: 1 vaccine @ E, Recalculated Baseline: 1 vaccine @ D.

IR 3.1.1 Technologies evaluated: b) malaria vaccines

- Original Baseline: 1 @ E, Revised Baseline: 7 vaccines @ I, 4 vaccines @ D, 4 vaccines @ E.
- Targets revised commensurate with recalculated baseline.

IR 3.1.1 Technologies evaluated: c) vaccine vial monitors (measles)

IR 3.1.1d Technologies evaluated: d) malaria diagnostics

- Indicator should be changed to read "diagnostic kit" because lead disease of kit has not been determined from among the diseases (Malaria, Hep B, TB, STD's) addressed by technology, according to CTO.

IR 3.1.2a Approaches evaluated: a) integrated case management of the sick child

- Current Data: Integrated Case Management being developed in four countries: Madagascar, Mali, Zambia, and Ethiopia.

IR 3.1.2c Approaches evaluated: c) integrated supervision.

IR 3.1.2d Approaches evaluated: d) methods to increase availability of impregnated bednets.

IR 3.2.1a Number of countries financing child vaccines from national budget.

- Original Baseline: 47 countries, Revised Baseline: 41, based on UNICEF figures.

IR 3.4.2d Number of selected countries where key health commodities are available at affordable prices through commercial outlets and private providers: d) micronutrient supplements

- Indicator changed from iron and mineral supplements, taking into consideration Vitamin A and iron social marketing programs.

IR 3.4.3a Number of selected countries with program guidelines in place for :

a) micronutrient deficiencies.

IR 3.4.3c Number of selected countries with program guidelines in place for: c) quality assurance techniques incorporated into pre-service and in-service training

- Intermediate result should be reworded to: Number of selected countries with c) quality assurance techniques incorporated into pre-service and in-service training.
- Original Baseline: 20. Revised Baseline: 4. Revised according to program information to reflect those countries with a formal quality assurance program underway.

STRATEGIC OBJECTIVE 4: INCREASED USE OF PROVEN INTERVENTIONS TO REDUCE HIV/STD TRANSMISSION

	Selected Performance Indicators	1994 Baseline	1995 Data	Target 2000	Target 2005
1.	Condom Social Marketing (CSM) annual sales per male population, 15- 54, in select HIV emphasis countries	0.93*	1.66*	1.8	2.0
2.	Total volume of USAID shipped condoms to HIV emphasis countries. These are by definition USAID purchased .	183.87 million	314.118 million	150 million	200 million
4a.	In HIV E-Cs, sex-specific gen. pop. rate of reported condom use in: in-union partner relations	15 - 31% M 3-5% F	* 9-12% M 4-7% F	2 point increase	5 point increase
4b.	In HIV E-Cs, sex-specific gen. pop. rate of reported condom use in: casual relations	<10% M - F	31-60% M 17-38% F	5 point increase	15 point increase

INTERMEDIATE RESULT 4.1: EFFECTIVE INTERVENTIONS TO REDUCE SEXUAL TRANSMISSION OF HIV/STD IDENTIFIED, STRENGTHENED, IMPLEMENTED AND EVALUATED IN EMPHASIS COUNTRIES

	Selected Performance Indicators	1994 Baseline	1995 Data	Target 1996	Target 1998
1.a	Technologies evaluated and available: Female barrier methods	1@I 1@D 1@E	1@I 2@E	1@I 1@E 1@A	1@D 1@E 1@A
1c	Technologies evaluated and available: STD Diagnostics	1@I 2@D	2@D 1@E	2@E 1@A 1@I	2@A 1@E 1@D

INTERMEDIATE RESULT 4.2: IMPROVED METHODS AND TOOLS FOR REDUCING PERINATAL AND PARENTERAL HIV TRANSMISSION AVAILABLE FOR PROGRAM USE IN EMPHASIS COUNTRIES

1	Technologies evaluated and available to reduce perinatal HIV transmission: a. vitamin A prophylaxis for PNT b. vaginal irrigation	1@I 1@D	1@D 1@E	1@D 1@E	1@E 1@A
2	Technologies evaluated and available to reduce parenteral HIV transmission: a. blood pooling b. TBD*	1@I	1@A	1@I	1@A

INTERMEDIATE RESULT 4.3: ENHANCED CAPACITY FOR PUBLIC, PRIVATE, NGO AND COMMUNITY-BASED ORGANIZATIONS TO DESIGN, IMPLEMENT AND EVALUATE EFFECTIVE HIV/STD PREVENTION AND CARE PROGRAMS.

1	1. % of NGOs funded by PHNC for HIV/AIDS prevention and care with: a. staff person(s) with technical skills b. essential management systems and skills c. HIV/AIDS strategic objectives or planning complete	a. 0% b. 0% c. 0%	a. 12% b. 28% c. 10%		a. 90% b. 87% c. 85%
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INTERMEDIATE RESULT 4.4: KNOWLEDGE, AVAILABILITY AND QUALITY OF HIV/STD INTERVENTIONS INCREASED IN EMPHASIS COUNTRIES.

2	% of population aware of treatable STDs	20%	57-73% M 18-45% F	25%	65% M 40% F +
3	% of population with correct knowledge of HIV/AIDS prevention	range 26%-66%	27% M 29% F	30% M 35% F	40% M 45% F

Commentary on SO 4 Performance Indicators Tables

SO 4.0.1 The volume of condoms sold or distributed per population age 15-49 in HIV emphasis countries (previous indicator number 4.4.7)

- Original: General urban population access to condoms in HIV emphasis countries. Replaced due to insufficient data. To be considered when regular data collection method established.
- Recalculated Baseline: .93 based on HIV emphasis co except DR (data forthcoming).

SO 4.0.2 Total volume of USAID shipped condoms to HIV emphasis countries.

- Original indicator: Originally at 4.4.6. "Total annual volume of condoms sold or distributed". Baseline was 507.7 million.
- Baseline redefined establishing a new figures of 183.87 million.

SO 4.0.4.a In HIV emphasis countries, sex specific general population rate of reported condom use in in-union partner relations.

- Original Baseline: <1%. New DHS recal w/ 93-94 DHS in Burkina Faso, Haiti (men only), Kenya, Tanzania, Zimbabwe. Figures are ranges of data. Co used diff time interval from last intercourse. # of partners used as proxy of partner type. Single partner under So 4a and 2+ partners under 4b.

SO 4.0.4.b In HIV emphasis countries, sex specific general population rate of reported condom use in casual relations.

- Original Baseline: (10% M, no data for F). Recalculation: DHS (1) women from Kenya, Tanzania, Zimbabwe and (2) Kenya, Burkina Faso, Zimbabwe and Haiti for men.

IR 4.1.1 a and c Effective Technologies for: (a) female condoms (b) safe and effective vaginal microbicide (c) rapid, simple, low-cost STD diagnostics.

- Original Baseline split into 2 (a) female barriers (c) STD diagnostics
Current Data: (a) Evaluation of nonoxynal 9 compound now in evaluation stage. One at Identification stage (c) STD diagnosis for GC in devel. stage. Test for syphilis available.

IR 4.2.1 Technologies evaluated and available for: (a) vitamin A prophylactics for reduced perinatal HIV transmission (b) vaginal irrigation for reduced perinatal HIV

- Revised wording: Technologies evaluated and available to: (a) reduce perinatal HIV transmission and (b) reduce parenteral HIV transmission.
- Current Data: (a) Vitamin A prophylactic devel. (b) vaginal irrigation at eval.

IR 4.2.2 Technologies evaluated and available to reduce parenteral HIV transmission: (a) blood pooling (b) TBD

- Revised wording now breaks into a second indicator for technologies. Current: (a) blood pooling available (b) an approach for decreasing parenteral transmission to be determined.

IR 4.3.1a.b.c. Portion of indigenous NGOs funded by G/PHN for HIV/AIDS preven't and service organ w/: (a) staff with HIV/AIDS tech skills (b) essential mngt skills sys (c) SO or plan complete.

- Revised wording. New targets/baseline by AIDSCAP. External eval of AIDS Alliance in progress, data forthcoming. Original Baseline: (a) 10% (b) 15% (c) 2%. Recal baseline (a)12% (b)28% (c)10%

IR 4.4.2 Percent of the population aware of treatable STDs

- Original Baseline: 20% Based on DHS III HIV/AIDS modules in Kenya, Malawi, Tanzania, Uganda, Zimbabwe. Current data: women 18-45%, Men 57-73% in FY95. Targets revised for 95 DHS male survey and STD data. Since few co with commitment to STD control, program effort will focus on increasing # of co in program and on raising baseline knowledge in selected co. DHS data represent national pop whereas USAID STD intervention focuses on limited geographic areas.

IR 4.4.3 Percent of the population with correct knowledge of HIV transmission

- Original Baseline: 75 %. Recalculated baseline from median proportion of respondents HIV em co w/ DHS 93-95: Burkina Faso, Kenya, Zimbabwe, CAR (median % by gender).

LIST OF ACRONYMS

AIDS	- Acquired Immunodeficiency Syndrome
AIDSCAP	- AIDS Control and Prevention Project
ARI	- Acute Respiratory Infection
CPR	- Contraceptive Prevalence Rate
CSM	- Condom Social Marketing
CSW	- Commercial Sex Workers
DHS	- Demographic and Health Survey
FP	- Family Planning
FTE	- Full-Time Equivalents
FY	- Fiscal Year
G/PHN	- Global Bureau, Center for Population, Health and Nutrition
HIV	- Human Immunodeficiency Virus
ICM	- Integrated Case Management
IEC	- Information, Education and Communications
IPPF	- International Planned Parenthood Foundation
IUD	- Intrauterine Device
JPPC	- Joint Programming and Planning Country
LDC	- Least Developed Country
NGO	- Non-governmental Organization
NMS	- New Management System
OE	- Operating Expense
OP	- Office of Procurement
OR	- Operations Research
ORS	- Oral Rehydration Salts
PHN	- Population, Health and Nutrition
PPC	- Bureau of Program and Policy Coordination
PVO	- Private Voluntary Organization
QA	- Quality Assurance
RH	- Reproductive Health
RHF	- Recommended Home Fluid
SO	- Strategic Objective
STD	- Sexually Transmitted Disease
UNAIDS	- United Nations Joint Programme on AIDS
USAID	- United States Agency for International Development
USFDA	- United States Food and Drug Administration
WHO	- World Health Organization
WRA	- Women of Reproductive Age