CARE

Final Report of the Population and Family Planning Expansion (PFPE) Project

December 1999

CARE

PFPE: Population and Family Planning Expansion Project
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Acronym List

ADRA	Adventist Development and Relief Agency
BSQ	CARE's Basic Service Questionnaire
MoRR	Management of Reproductive Risk
CEDPA	Center for Development and Population Activities
CIDA	Canadian International Development Agency
CO	Country Office
CS	Child Survival
DFID	Department for International Development
ENABLE	CEDPA Project
EOC	Emergency Obstetric Care
FP	Family Planning
H&P	Health & Population
HIV	Human Immunodeficiency Virus
MH	Maternal Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non Governmental Organization
NH	Neonatal Health/Newborn Health
PFPE	Population and Family Planning Expansion Project
PIR	Project Implementation Report
PLA	Participatory Learning and Action
PVO	Private Voluntary Organization
RH	Reproductive Health
STI	Sexually Transmitted Infections
TA	Technical Assistance
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund

Timeline of CARE's Institutionalization of Family Planning/ Reproductive Health[1]

1945
CARE was founded to provide relief assistance to survivors of World War II.

1946
President Harry S. Truman places his CARE package order in May, sending relief parcels to European heads of state. Every president since Truman has endorsed CARE.

1949
CARE begins work in the developing world with child nutrition programs in India.

1954
President Dwight D. Eisenhower honors CARE at a White House Ceremony. Under Eisenhower, the U.S. government began the "Food for Peace" partnership with CARE to feed the hungry.

Section I

Introduction

This document constitutes the final report of the eight-year (1991-1999) Population and Family Planning Expansion (PFPE) Project implemented by CARE and funded by the Office of Population of the U.S. Agency for International Development (A.I.D.).

CARE International is one of the world's largest private relief and development agencies. CARE operates in over 60 developing countries, serving an estimated 30 million people annually. CARE's programs include health and population, income generation, agricultural and natural resource management, education, food distribution and emergency relief.

Prior to 1990, CARE had virtually no family planning activities. In 1989-90 CARE launched a family planning initiative and subsequently entered into a dialogue with A.I.D. A dialogue which culminated in the signing of the PFPE agreement in 1991. The agreement covered a period of 5 years from May 1, 1991 to April 30, 1996 with a budget of $25.8 million. The project was subsequently extended through June 30, 1999 precipitating an increased budget ceiling to $33.7 million.

The goals of PFPE were:

- to enhance the freedom of individuals in developing countries, especially sub-Saharan Africa, to choose the number and spacing of their children; and
- to encourage a population growth rate consistent with each country's goal for economic and social development.

1961
President John F. Kennedy establishes the Peace Corps and asks CARE to train volunteers and to help manage its first projects.

1970
CARE USA's Board of Directors raised the issue of FP as a key program area to be addressed by CARE.

1974
CARE begins environmental programming in response to a major drought in the Sahel in Africa.

Mid-1970s
A policy on FP is endorsed by the Board, and a memo is sent to country offices recommending their participation in family planning programs.

The stated purpose of the PFPE Project was to expand the use and availability of voluntary family planning services and to improve the quality of services delivered.

The three operational objectives were to:

1. develop CARE's institutional capacity to design and implement family planning programs;
2. establish new new models of family planning service delivery which draw upon CARE's existing work in other sectors; and
3. increase access to family planning information, services and supplies for developing world couples, especially in rural and other hard-to-reach areas.

In keeping with the stated objectives, the PFPE agreement envisioned a two-track strategy. The first track focused on building technical capacity within CARE's headquarters, regional level and country offices. The second track capitalized on CARE's extensive infrastructure of projects and programs by incorporating family planning into CARE's existing operations.

The PFPE agreement also specified outputs to be achieved at the institutional and field levels *(see table 1).* All of the PFPE objectives and projected outputs have been exceeded. This has been documented through the PFPE annual reports, the Final Evaluation of the CARE PFPE Project, an extensive case study of CARE's family planning and reproductive health experience[1] and A.I.D. annual management reviews. Major Accomplishments include:

- All 38 CARE country offices have addressed FP/RH issues in multi-year plans;
- 1.1 million new and 4 million continuing FY users reached with information or services;
- A portfolio of 59 FP/RH projects in 32 countries;
- A committed core of FP/RH professional staff; and
- A FP/RH programmatic framework integrated into CARE's broader development approach.

As agreed, USAID was expected to provide $17.1 million in core funding, with an additional $8 million from USAID Mission buy-ins expected. CARE was expected to provide $7.1 million in match funds producing total of $32.9 million. With the 1996 extension the USAID budget ceiling rose to $39 million, as did the CARE match to $10.1 million.

Table 1: Summary of PFPE Objectives and Accomplishments

Phase I: 1991-1995		Phase II: 1996-1999	
Objectives	**Accomplishments**	**Objectives**	**Accomplishments**
16 pilot projects designed	10 projects (revised under the Big Country Strategy)	**2 new PFPE projects; 2 new non-PFPE projects**	Philippines/PFPE Bangladesh/UNICEF Philippines/WMC Ghana/Gates
All projects evaluated	Baseline surveys on all projects; 8 MTE in 1993; 7 FE in 1996	**All projects evaluated**	6 MTE in 1997
6 Local NGOs assisted	27 NGOs assisted	**Continued assistance to local NGOs**	Over 35 NGOs assisted
8 FP service delivery models tested	5 models tested by 1995	**Test and document role of Pop Programming in CARE's HHLS framework**	Developed and tested Health security framework
2,697,000 CYP (765,500 revised in project designs)	1,125,324 CYP distributed	**Total to be delivered**	3,454,947CYP distributed
Population Unit Created	Operational with 6 staff members as of 1995	**Continued development of the population unit**	Operational with 5 staff technical staff
20-30 overseas COs receive TA	21 COs received TA	**22 overseas COs receive TA**	30 COs received TA
7.1 million raised by other donors	9.1 million	**10.1 million raised total**	17.2 million raised total
Collaborative relationships with 10 Pop/RH organizations	17 partners	**Collaborative relations established in each PFPE country project**	All PFPE projects are part of a RH network in country

The focal point of this final report is primarily lessons learned over the past eight years. Section II focuses on the process of institutionalizing family planning (FP) and reproductive health (RH) at CARE, so as to deepen our understanding of how organizational change takes place and how the conceptualization of the program evolved. Section III discusses key lessons learned from CARE's field operations. Section IV presents service delivery outputs. Section V summarizes the financial status of the project and CARE's reproductive health program.

Late 1970's
CARE begins to broaden its focus from predominantly an emergency relief organization to a development organization by creating three new sectors:

- Agriculture and Natural Resources (ANR);
- Small Economic Activity and Development (SEAD); and
- Primary Health Care (PHC).

1978
CARE becomes internationalized. CARE expands into what is now a network of 10 CARE entities.

1985
The century's worst famine grips Africa. CARE delivers food to 6.3 million people in the region.

Section II:

Institutionalizing Family Planning at CARE

This section addresses three main issues:

1) the institutionalization of FP and RH at CARE;
2) the conceptual evolution of the program; and
3) program impact.

As will be seen, careful attention to the processes of organizational change and responsiveness to the evolving external environment were crucial to PFPE's success. The discussion is arranged chronologically

A. Institutionalization

Developing Organizational Commitment

In 1989, CARE undertook an organization-wide strategic planning process, looking at the changes needed to address the challenges of the 1990's. A number of initiatives were launched as a result of this process, including the decision to start a family planning program. The organization's leadership concluded that high fertility and rapid population growth were undermining CARE's other efforts to protect maternal and child health, increase incomes and sustain the natural resource base.

It is important to recognize that CARE decided to undertake FP before discussions with U.S.A.I.D or any other major donor. The later program success reflected, in part, that the organization's commitment was derived internally rather than as a response to potential donor funding.

Program start-up also benefited from strong leadership support. Key CARE officials, including Peter Bell, Chairman of the Board of Directors, Philip Johnston, President and CEO, and William Novelli, Chief Operating Officer, provided continuing encouragement to the nascent program, as well as the needed initial investment.

Both the original CARE decision and PFPE focused specifically on family planning, rather than the broader array of fertility determinants or reproductive health interventions. This narrow focus in the early years (1991-1996) proved to be an effective strategy. It allowed energies and resources to be targeted on a specific gap in CARE's programming and avoided dispersion of effort and resources.

Leadership support, while crucial, did not constitute organizational commitment. Support from a broad array of CARE constituencies was needed for the program to flourish. These included Country Office Directors, health sector coordinators, health project managers, CARE International members, regional managers, CARE's fund raising staff and private donors. A critical part of institutionalization was drawing a "map" of the constituencies that could have an impact on the CARE family planning program. A communication strategy was implemented for each constituency, including personal meetings, presentations, written communication and workshops. This served to elicit the concerns of each constituency and develop appropriate responses.

One way of bringing together all of the stakeholders was to develop and have the board endorse a population policy. (*See Box 1*)

Women's Group Convenes in Niger

1986
President Ronald Reagan honors CARE for its famine relief in Africa.

1989
CARE senior managers participate in a strategic planning exercise. As part of this meeting, CARE examines its organizational capabilities and comparative advantages. They conclude that population and FP programming should be integrated into CARE's existing portfolio.

1990
CARE USA's Board adopts a population policy statement. The CARE Program Manual includes a Population Strategy, which presents the rationale, goals, and strategy for CARE's involvement in the sector.

Box 1: CARE's Original Family Planning Policy

Adopted by the Board of Directors in 1991

CARE believes that poverty and rapid population growth are synergistically related. The combined effect of these two forces impedes the achievement of economic and social well being.

According to the United Nations Fund for Population Activities there are five factors which determine fertility and hence effect population growth. They are: women's status, maternal and child health, information about and access to family planning, family income, and family education. Given that CARE is a development agency, and given that men's and women's decisions about family planning are best made in a context which is favorable to development, CARE seeks to support activities, in all sectors, which will positively affect the five fertility factors mentioned above.

CARE is active in the area of reproductive health education and service, both through its own programs and in cooperation with other entities in the host countries where it operates. CARE upholds the rights of nations and their people to identify their own problems and formulate responses to them, while recognizing the right of every man and woman to unrestricted access to all methods and means of family planning information and services. CARE's support and services are all and will continue to be governed by local laws, customs, religious beliefs, international health standards and, most importantly, by voluntary choice of individuals.

Building Technical Capacity

Building organizational technical competence was also a key part of institutionalization. In part, this meant bringing new headquarters and field staff with expertise in family planning into the organization. This staff became the nucleus of the corps of family planning professionals within CARE. Significant resources were also devoted to staff training – the past eight years have seen a steady stream of workshops, conferences and technical meetings that served to reinforce staff technical skills. (*For a list of headquarters activities including training, see Appendix B*)

Concurrent with the training was the development of the Population Program Guidelines Collection. CARE was in the fortunate position of being able to benefit from over thirty years of research and practical experience in family planning. The challenge was synthesizing this body of knowledge into "CARE-speak." Hence, considerable effort was devoted to developing guidelines, standards, tools and information packets that could help field staff design, implement, monitor and evaluate programs. Over time, the emphasis shifted from synthesizing existing knowledge to developing innovative tools and techniques, such as the Quality of Care Supervision Tool and the Management Capacity Assessment Tool shared extensively with other organizations.

Training and technical guidance were reinforced through intensive technical support to the first generation of CARE family planning projects. Field projects received frequent visits from headquarters and regional technical staff to provide advice and technical inputs.

With the support of the PFPE resources, CARE moved quickly to establish the first generation of field projects in Niger, Rwanda, Uganda and Togo. The designs for the first four projects were completed by the late fall of 1991 and other projects followed quickly thereafter, including Bangladesh, Dominican Republic, Peru and the Philippines. By the end of the first year, eight projects had started. The projects received intensive technical support and careful attention was paid to monitoring and evaluation. Thus, Country Offices began to develop practical experience with FP early in the life of PFPE.

Building a Family Planning Community

Part of the institutionalization process was creating a group within the organization that identified itself as family planning supporters and professionals. The various training events and meetings became fora for creating a sense of community and common purpose in this group. Over time the members of the group developed a sense of their own history and contribution to the organization, as well as exchanging lessons learned. It is clear that there now exists within CARE a substantial group of health professionals who consider family planning and reproductive health as central to their professional identity and purpose, which stands in marked contrast to 1990.

1990
The Technical Assistance Group director authorizes Susan Toole to create a unit separate from the Primary Health CARE Unit that would become the CARE Population Unit.

December 1990
CARE submits an unsolicited proposal for the financing of CARE's projected population activities

May 29, 1991
CARE and USAID's Office of Population sign a five-year cooperative agreement establishing the Population and Family Planning Expansion Project (PFPE).

Community Participation: mapping exercise

Adopting a Learning Process Approach to Program Management

Early in the development of the family planning program, CARE developed a learning process approach to program management. Fundamentally, this meant providing managers at headquarters and in the field with opportunities for critical self-examination of processes and impacts so program operations could be improved.

The elements of the learning process included:

- a collaborative approach to design, implementation, monitoring and evaluation that involved the concerned stakeholders;
- drawing self-portraits of CARE's program on a regular basis in terms of goals, beneficiaries, counterparts, strategies, beneficiaries, processes and products;
- welcoming external knowledge so CARE could profit from the experience of others; and
- using knowledge in a non-threatening way to improve performance, which meant being meticulous about uncovering weaknesses and mistakes, while encouraging risk-taking.

To facilitate the activities mentioned above, the Health and Population Unit in Atlanta has actively supported skills transfer. In addition, technical standards and tools have been published to guide programming.

These guidelines represent major technical works; in all, 18 guidelines or modules in the area of reproductive health have been produced to support CARE's work in the field. The box below lists the guidelines and tools produced through CARE's technical support.

Box 2. CARE Technical Standards and Tools

1. Reproductive Health Project Design
2. Intermediate Goals
3. Health Information Database
4. Budget
5. IEC Guidelines (Print Materials and Strategy Development)
6. Training Guidelines
7. Community Based Distribution
8. Quality of Care Assessment/Monitoring Tool
9. Service Statistics Collection
10. Monitoring and Evaluation Guidelines/Baseline Assessment
11. Mid-term Participatory Evaluation Guidelines
12. Final Evaluation Guidelines
13. Management Capacity Assessment Tool
14. Project Implementation Report Format
15. Portfolio Analysis
16. Best Practices for Maternal and Newborn Health
17. Reproductive Heath for Refugees: Participatory Assessment
18. Health Security Framework & Presentation

May 29, 1991
PFPE anticipates working in 10 countries with a total budget of $25.8 Million from USAID and $7.1 million from CARE. The major strategies of PFPE are:

1. Institutionalization of FP within CARE; and
2. Expansion of FP service delivery through CARE's infrastructure.

Mid 1991
CARE Population Unit is established. Susan Toole becomes director and four additional staff are hired at headquarters, including Therese McGinn, deputy director, Maurice Middleberg, senior population advisor, and two support staff. Three population RTAs are hired for Africa, Latin America and Asia.

Significant and Diverse Funding Base

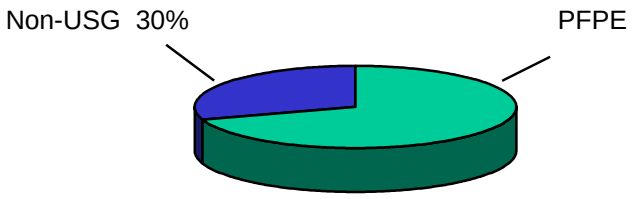
The PFPE grant from U.S.A.I.D was the indispensable core for creating CARE's FP and RH program. It is only thanks to the U.S.A.I.D grant and the accompanying technical support from the Office of Population that CARE was able to build the requisite capacity.

Consistent core financial support from U.S.A.I.D. made it possible for CARE to undertake the necessary organizational learning and establish credibility with USAID Missions, non-USG donors and other constituencies. The later allocations of field support funds demonstrated confidence by the USAID Missions in CARE's ability to implement effective programs.

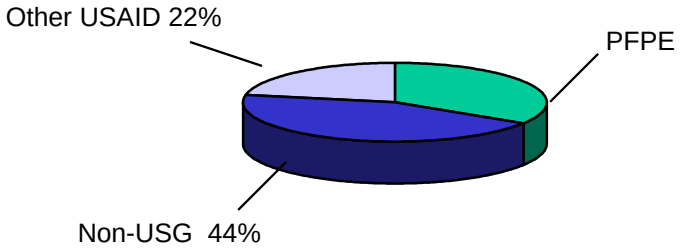
From the outset, however, PFPE required a significant match, creating a strong incentive for CARE to diversify its funding for reproductive health. While this demanded a significant level of effort from CARE staff, the salutary effect

Graphic 1. USAID and Non-USAID Funding

1991-1992
2.4 million



1997-1998
17.1 million



was to rapidly and effectively diversify its funding for family planning and, later, reproductive health. As a result, this served to leverage A.I.D. funds. As graphic 1, illustrates, non-USG resources increased from 30% of a 2.4 million dollar portfolio in 1991 to 44% of a 17 million dollar program in 1998.

The diversification of funding was also important in cementing CARE's organizational ownership of the program. CARE and A.I.D needed to be clear that PFPE was an impetus to CARE's evolving family planning program rather than the "A.I.D. project located at CARE." Early diversification of funding helped establish CARE's ownership of a portfolio funded by multiple donors. *For a list of donors by project, see Appendix C.*

Relationship with U.S.A.I.D

Fundamental to the success of PFPE was the establishment of an appropriate, mutually supportive relationship between A.I.D and CARE in regards to the management of PFPE. Staff from the two organizations quickly evolved effective working relationships that focused on strategic thinking and problem solving. At every level, the program was treated as a partnership between the two organizations. This required creating mutual trust and maintaining absolute transparency with regard to both successes and failures. CARE is appreciative of the fact that A.I.D gave us time and opportunity to learn from experience.

A number of principles evolved from this experience that have applicability to a range of CARE partnerships. These include mutual respect for organizational spheres of decision-making, the role that personal trust plays in organizational relations, the need to develop a shared vision and common expectations, the benefit of sharing credit liberally, the importance of starting small and the willingness to work through failures.

B. Conceptual Evolution

PFPE started off with a particular conceptual model of CARE's approach to FP. This model has evolved over the years to reflect CARE's experience and changes in the reproductive health profession. There were three major phases to this evolution from a primarily family planning program to a broader reproductive health approach. It should be noted that this progression was largely driven by the expressed needs of the communities and CARE field staff.

1992
After a presentations by the Population Unit, the CARE International Board adopts a Population Policy Statement. CARE International commits to raise funds for FP projects.

The first PFPE country projects are launched in Niger, Rwanda, Togo and Uganda.

USAID adopts its "Big Country Strategy," so CARE limits its programs to 10 countries instead of the 16 originally proposed.

Mid 1992
Project design workshop for CARE staff and first set of technical guidelines are published.

Phase I: 1991-96 – Focusing on Family Planning

As stated above, PFPE had two basic objectives:

1. institutionalizing FP at CARE; and
2. expanding access to FP services through CARE's infrastructure.

During the early years of PFPE the focus of the program was strictly on FP. We believe that this narrow focus during the program's nascent period was helpful, centering technical support and money on a clear target. The basic strategy for increasing access to services was to systematically add FP to CARE's existing programs with the additional of new staff that was solely devoted to the incorporation of FP. For purposes of project design, the approach adopted by CARE was to play to the comparative advantage of the Country Offices. Fairly elaborate design guidelines were developed, but they boiled down to two basic questions:

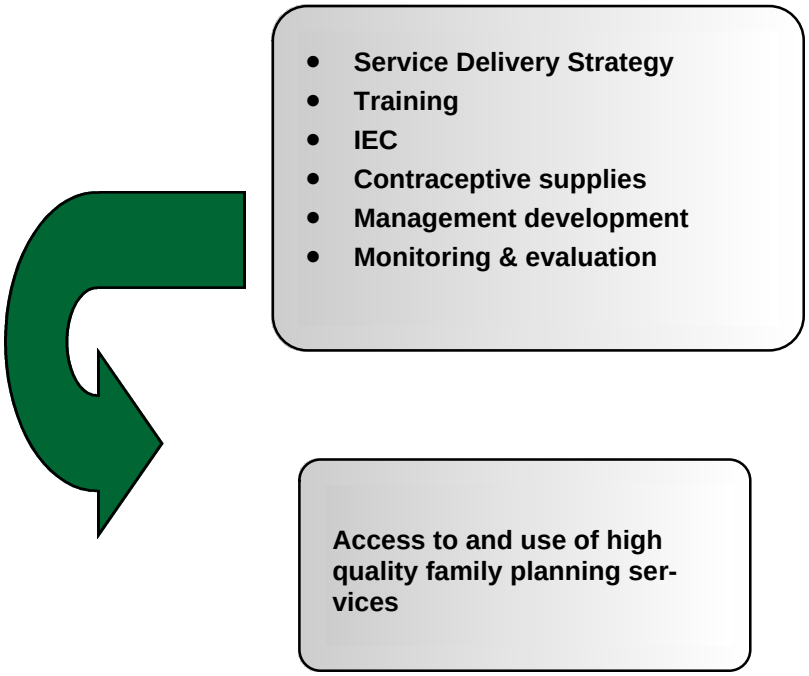
- What are major impediments to the success of the national family planning program; and
- How do these impediments coincided with the CARE Country Office strengths in terms of geographic location of existing programs, access to an under-served population(s) and/or a technical domain (e.g., community mobilization or commodity logistics)?

Kabale Hospital in Uganda

The entire strategy centered on capitalizing on CARE's infrastructure and strengths in order to make FP services more accessible. Of particular importance was building on CARE's long term links with communities. In many countries, CARE has been working in specific regions for years or even decades. As a result, networks of relations with leaders and communities have been established through a wide range of programs which greatly facilitated incorporating FP into existing programs. However, it should be noted that one of the key strategies was that a country office new staff was hired to carry out the FP activities in partnership with existing programs.

The basic analytic model for project development is depicted in the following illustration.

Graphic 2. Analytic Model for Project Development



Family planning was conceptualized as a delivery system composed of multiple elements (e.g., supplies, knowledge, skills, management). The essential design task was to match the weakest elements in the delivery system to the relative strengths of a Country Office. In the Philippines, for example, contraceptive logistics were identified as a critical weakness. This matched with the strengths of CARE-Philippines in commodity management. As a consequence, the PFPE project in the Philippines focused on strengthening contraceptive logistics into the regions and achieved notable successes.

1993
During 1992-93, CARE expands PFPE programs to include Bangladesh, Dominican Republic, Peru, and Philippines.

Non-PFPE projects are also started in Bolivia, Guatemala, Honduras, and Mali.

1992-1993
A series of technical training workshops and meetings are held in 1992-93 to increase technical capacity and create a common vision among PFPE project managers. Several technical guidelines are produced and disseminated to staff to assist with program design, implementation, and evaluation.

The strategy of "systematically adding FP to CARE's infrastructure" concealed a number of complexities and variants. As the program evolved, more than one mode of linking family planning to other programs evolved; this issue was explored in depth at the 1994 Lessons Learned Conference.

One variant of linkage was termed ***parallel programming***, which consists of making family planning available to the same target population as other programs without any deliberate coordination between the sectors. Management structures, staffs, budgets and plans remained largely separate. From the perspective of the target audience the effect was to receive a new service in addition to the existing array of CARE programs. From a management perspective, however, the absence of deliberate coordination neglected opportunities for complementarities and efficiencies.

A second type of linkage came to be called ***coordinated programming***. In this variant, management structures and staffing remained distinct, but deliberate efforts were made to coordinate efforts among programs. This ranged from coordinating training programs to sharing equipment and facilities to scheduling of visits of extension workers.

A third type of linkage may be called ***integrated programming***. It encompasses the type of integration whereby management structures were merged and family planning was treated as one component of a larger program.

Of these variants, field managers tended to prefer coordinated programming. This permitted the gains of increased efficiency and decreased confusion among programs, while avoiding the blurring of purpose and energy that was more likely to accompany complete integration. However, the utility of each style was clearly context specific and depended in no small measure on the skills of the managers.

Phase II: 1996-98: Enriching Lives through CAREful Choices

CARE redesigned its population program to adopt a more comprehensive reproductive health approach, inline with the International Conference on Population and Development and the evolution of CARE's field program. This new design was released in 1996 under the title *Enriching Lives through CAREful Choices.*

The new design focused on three objectives:

- increasing access to essential reproductive health services;
- increasing the capacity of counterpart institutions to offer high quality services; and
- empowering communities to secure reproductive health services.

There are several notable aspects of the shift from the original PFPE approach to the Enriching Lives framework. The new framework definitively shifted the focus from internal capacity building to achieving FP/RH results in the field. No longer was the concern about institutionalizing FP paramount, though staff training and development of technical standards remained a consistent part of the organizational agenda.

In addition, the Enriching Lives framework explicitly adopted a RH approach encompassing family planning, as well as maternal health and sexually transmitted diseases. Recognizing the success of previous efforts, in building technical capacity for FP, several elements were applied to enhance CARE's capacity in designing, implementing and evaluating maternal health and STI programs.

The analytics accompanying project design became increasingly sophisticated, accommodating a wider set of health problems and more detailed renderings of the counterpart institutional capacity and community dynamics. Counterpart capacity building and community empowerment for reproductive health, though always a part of the program, were explicitly identified as organizational objectives.

Almost all of the original FP projects were redesigned to include other elements of RH and the new generation of projects systematically reflected the broader framework articulated by *Enriching Lives.* Correspondingly, such indicators as staff training and technical guidelines also evolved to address this wider array of interventions.

The Enriching Lives through Careful Choices proposal was a two year cost extension of the PFPE project raising the budget ceiling to $39 million dollars and extended the end of the project until June 30, 1998.

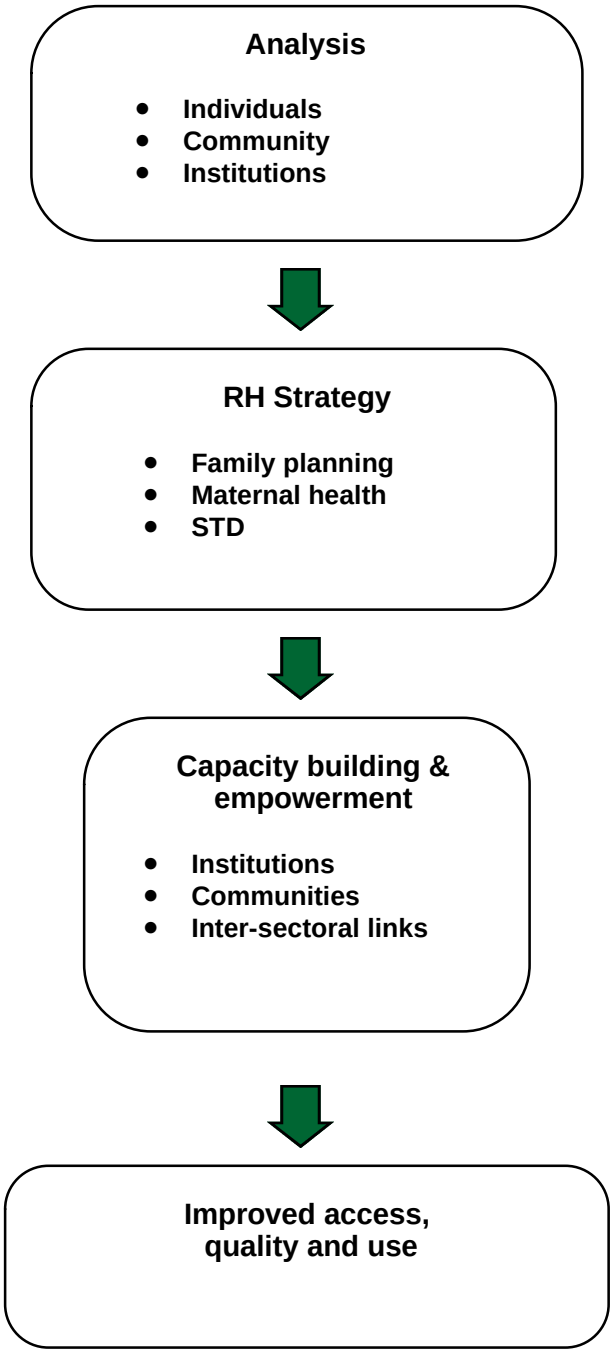
The conceptual framework for the program is depicted in the following graphic.

1994
CARE moves from New York to Atlanta. The senior program advisor, Maurice Middleberg, becomes its director. New staff are hired: Joan Schubert and Carlos Cardenas, bringing different technical and geographical expertise.

Summer 1994
Each of the 8 PFPE projects conduct a participatory mid-term evaluation. Evaluations which reviewed each project's progress to date and spearheaded the identification of needed actions.

November 1994
PFPE sponsors a Lessons Learned Conference, "Embracing Error to Improve Practice," to focus on the results of the mid-term evaluations.

Graphic 3: Enriching Lives Framework



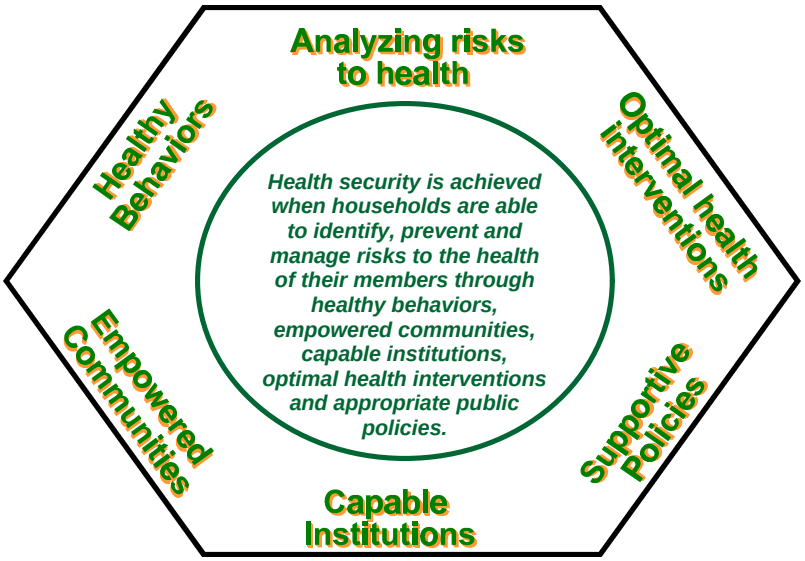
Phase III: 1998-2001: Management of Reproductive Risk (MoRR)

By mid-1998 the conceptual framework for CARE's program had again evolved to reflect broader changes in the organization's approach to development programming, including health programming. CARE had adopted an over-arching approach to programming that is called ***household livelihood security***. CARE's basic mission is to work with families in their own efforts to draw back from the precipice of poverty. The household security approach reflects the organization's view that a broad-based approach to poverty is required and that the household is the appropriate unit for analysis and programming. It is further based on the concept that poverty means high vulnerability to relatively small perturbations in circumstance and environment. That is, poor households are highly vulnerable to risk because they have very few assets that can be used as buffers against negative change. Hence, the role of CARE is to help households acquire the economic, intellectual and social assets needed to manage risk.

> *Illness and trauma are among the major risks to households. Poor health serves to drain productivity, forces the liquidation of economic resources to pay for the cost of treatment and may demand painful trade-offs between essential goods; e.g., food and medicine. Hence, health security is a fundamental component of household security and must be directed at helping households access the assets needed to manage health risks.*

This definition of health security guided the crafting of the new RH conceptual framework, which now focuses on helping families manage risks to reproductive health. The Managing Reproductive Risk framework is depicted graphically below.

Graphic 4. Managing Reproductive Risk Framework



1994
New emphasis is given to strengthening the information system.

April 1995
Reproductive Health (RH) working group is established at CARE HQ, including staff from the Population and Primary Health Care Units.

The purpose of the RH working group is to analyze CARE's role in a more comprehensive program for women's health.

May-June 1995
An external final evaluation of PFPE is conducted by PopTech on behalf of USAID. The Team visited PFPE projects in Peru and Uganda. The Team draws on the mid-term evaluations, conference reports and documented progress on goals.

This framework provides a useful structure to:

- Analyze the local salutation;
- Identify priority health risks; and
- Design comprehensive programs utilizing evidence based interventions that will have the greatest impact on the main health risks for the population. The framework clearly portrays the key elements required for effective health programming.

CARE's Management of Reproductive Risk (MoRR) framework represented an advance over its predecessors in several ways. First, it serves to more clearly link RH to CARE's wider development approaches of household livelihood security and health security. The MoRR framework also explicitly introduced the concept of reproductive risk as a basis for project design, implementation and evaluation. Second, the detailed technical discussion of program elements included in the new framework was clearly more sophisticated that its predecessors, building on CARE's experience and developments in the field. Third, new issues were incorporated into the program including reproductive risk analysis, neonatal health and policy advocacy.

In 1998, CARE submitted a three-year proposal to U.S.A.I.D. to support implementation of the Management of Reproductive Risk framework. Effective July 1999, CARE received a Cooperative Agreement from USAID for the CARE-MoRR project which builds on the work of the PFPE and Enriching Lives through CAREful Choices projects.

C. Program Impact

Ultimately, the processes of institutionalization and conceptual evolution are of interest only insofar as they lead to impact in the field. In this section we look at the impact of CARE's family planning and reproductive health program.

Growth of the Reproductive Health Portfolio

It must be remembered that in 1991 CARE had virtually no family planning program. By June 1999, CARE could boast of a portfolio of 59 RH projects in 32 countries, with some countries having more than one project and often times several donors. The portfolio included 36 projects with a major family planning focus, of which 31 had a clinical component, 27 had a community based distribution component, 23 had a post-partum emphasis and 9 had a commercial component.

CARE also had 33 maternal health projects, and 42 STD/HIV projects. Most projects were integrated, with multiple reproductive health elements, so the project numbers are not mutually exclusive.

Projects covered the range of functional areas. Thirty-eight projects addressed institutional capacity building, 33 had a community empowerment component and 30 had a special focus on quality of care.

Projects also covered a range of target audiences, including 37 country programs with a dedicated male involvement component, 32 featuring an adolescent focus and 2 country programs providing reproductive health for refugees. The latter is an excellent example of the multiplier effect of the PFPE grant. No Office of Population funds have gone into the refugee programs. However, the development of CARE's capacity allowed it to reach audiences served in other ways by the organization. Reproductive health is now an integral part of CARE's refugee programming at no direct cost to the Office of Population. *See Appendix C for a current list of projects by country, title, component and funding source.*

Women's Banking Group in Bangladesh

The team makes several programmatic and administrative recommendations for the proposed extension of PFPE.

November 1995
The RH Working Group in Atlanta designs a comprehensive RH strategic approach for CARE.

December 1995
The new RH approach is included in the design of the Enriching Lives Strategy.

This strategy is the skeleton of a proposal submitted to USAID.

Intellectual Contribution

As CARE's program grew and the staff gained experience, they entered into the intellectual dialogue of the professional community. Before PFPE, CARE staff rarely, if ever, participated in professional meetings on reproductive health, let alone serving as contributors of original intellectual product. That situation has changed dramatically. CARE staff now participate in professional conferences, bringing their unique perspective to bear. In addition, there have been many papers and presentations resulting from CARE's work in family planning and reproductive health. These papers have often been produced in collaboration with other organizations and A.I.D projects, including the Population Council, Georgetown University and the FOCUS Project.

A special emphasis has been placed on developing and disseminating tools using participatory approaches. These include the CARE Mid-Term Evaluation Guidelines, which rely heavily on a process of stakeholder evaluation. CARE, in partnership with FOCUS, has just published a manual entitled *Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents.* Similarly, CARE will soon release *Embracing Participation in Development: Worldwide Experience from CARE's Reproductive Health Programs with a Step-by-Step Field Guide to Participatory Tools and Techniques.*

In addition, CARE staff have produced technical manuals that have gained wide usage and recognition in the reproductive health community, including *Promoting Quality Maternal and Newborn Care* and *Reproductive Health Programming Refugee Settings.*

Impact on the PVO Community

The success of the CARE program has encouraged other private voluntary organizations to adopt an enhanced reproductive health program. The CARE experience also led the Office of Population to support a major program of collaboration with PVOs. Save the

Children, Plan and ADRA have joined in efforts to significantly expand their reproductive health programs.

While the experience of each PVO will be unique, the CARE experience has yielded lessons learned and intellectual products that are of potential utility to other PVOs.

Impact on Family Planning Use

The cumulative growth of family planning use through CARE's programs was significant. During the period June 1993 to June 1998, CARE reached 1.1 million new acceptors and served over 4 million continuing users of family planning, generating nearly 3.5 million couple-years of protection. These figures exceed the original expectations of PFPE. *See section IV for a more detailed description of service delivery outputs.*

1996
CARE is awarded a two-year extension of the PFPE project entitled "Enriching Lives through CAREful Choices." This new strategy incorporates a RH focus that includes maternal health and STI and HIV prevention components as well as FP program activities.

1996
CARE celebrates it's 50th Anniversary.

1996
The CARE Package is inducted into the Smithsonian Institute's American history collection in commemoration of CARE's 50th Anniversary.

Section III

Lessons Learned from CARE's Field Program

CARE's PFPE experience provided valuable programmatic experience for other NGOs in establishing FP and RH activities. Key areas of experience include:

1. NGO models for FP service delivery;
2. Benefits of building on other development activities,
1. Partnerships;
2. PVO advocacy efforts for RH; and
3. Community empowerment and local ownership of RH services.

Puppet Show on RTI/STDs in India

A. Expanding Models of FP/RH Service Delivery

PFPE allowed CARE the flexibility to design and adapt service delivery models uniquely suited to the environments in which CARE works. CARE began its work in FP with a small group of workers supported extensively with technical assistance.

Since many of CARE's existing programs were in remote and under-served areas, there were few agencies capable of service delivery. Thus, many of the initial PFPE projects included a community-based approach linked with a Ministry of Health service delivery structure such as in Togo, Niger, Uganda and Peru. However, as countries gained experience, they developed other partnerships which greatly expanded access to FP services.

As CARE's experience has grown, models of FP/RH service delivery have evolved. Using the three categories presented earlier, these models can be classified as follows:

1. Family Planning Focused

- In **Bangladesh**, CARE provided small grants and technical assistance to 20 Bangladeshi NGOs to help develop and strengthen their family planning activities to reach populations without access to family planning services.

- In the **Philippines,** CARE assisted in reorganizing the national contraceptive distribution system. In a response to a request from the Philippine government, CARE helped to establish the distribution and management information system to forecast and supply needs, and ensure continuous supplies of contraceptives to family planning centers.

- In **Togo**, CARE has also collaborated with the MOH but has worked to assure sustainability for CBD agents through local health management committees. The CBD agents are supervised and supported by the health committees.

- The "Graduation Model" in CARE **Peru** in which community-based distribution activities including training, supervision and re-supply for CBD agents have been taken over by the MOH. CARE works with the MOH to provide training for MOH staff in support for CBD programs. Currently there are 228 health posts in this program and 160 have already graduated and are managing their own CBD programs.

2. Reproductive Health Focused (Enriching Lives)

- Through CARE's Our Bodies Our Health Rural Reproductive Health Project in **Bolivia**, CARE succeeded in breaking down barriers to reproductive health

services for prostitutes and homosexuals by working with the Ministry of Health and local municipal governments to extend service delivery to this segment of the population.

- In **Haiti**, CARE has provided family planning and reproductive health activities in coordination with a Title II project. The RH project has worked with a variety of institutions, both public and private, to establish reproductive health services. It has also linked reproductive health activities with unique aspects of the Title 2 project such as logistics and education.

3. **Reproductive Health in Development (CARE MoRR)**

- Through CARE's Local Organizations Support Project (APOLO) in **Ecuador**, a USAID/Ecuador supported project, CARE is successfully advocating with the Ministry of Health to make quality health care services affordable and accessible to the poorest of the population by sharing model health delivery systems being strengthened by the project. CARE is working with 15 Ecuadorian private for-profit and non-profit health organizations to build these model health service delivery systems that are providing services such as: maternal health, family planning, STI/HIV/AIDS information and services, immunizations, control and prevention of diarrhea, upper respiratory infection treatment, and food and vitamin supplements.

- In **Zambia**, CARE's family planning and reproductive health project includes a component specifically designed for adolescents. Based on findings from participatory learning and action activities, the project worked with the MOH to establish youth-friendly services and at the community level worked with peer support groups to provide education and counseling outreach.

- The workplace model is a relatively new model of service delivery for CARE. An example of this model is in **Honduras** where CARE is implementing an HIV prevention and family planning services program in the workplace. The program is being implemented with the factory owners and the labor union through the support of private funding.

1997
CARE sponsors the Best Practice 2001 Conference which brings together field staff, donors, collaborating agency staff, and counterparts to discuss standards for FP, maternal health, STI/HIV, community participation, IEC, and quality of care.

1998
PFPE is granted a one year no-cost extension. Service delivery statistics exceeded objectives established at the beginning of the project. CARE also exceeded its match target, and leveraged over $19 million (44 percent of total budget) in matching funds.

Thanks to the core support provided by PFPE , CARE's reproductive health portfolio grows to 36 projects in 28 countries.

- In **Guatemala**, CARE is being contracted by the MOH to manage primary health care services (including reproductive health) up to the health center level. The project has placed emphasis on outreach programs to the community.

Integrating FP and RH into other development interventions is not only possible but it enhances the impact of both the development and RH programs. This has most certainly been the case in southwestern Uganda where CARE's Development through Conservation Project worked to educate communities surrounding several national parks about the environmental value of the natural resources within the parks. The communities and local leadership challenged CARE Uganda to promote environment conservation activities through the DTC project without tackling the root causes of environmental degradation from the population pressure from a high population growth rate. The Community Reproductive Health Project was designed to respond to the demand from the communities for FP education and services. Both projects have synergistic strategies that focus on the household, and particularly women, that perform the majority of the agricultural work force in the predominantly subsistence farming and patriarchal society. Together, the two projects and counterparts foster healthier and informed households to enable them to support "manageable" families with scarce resources.

B. Benefits of building on other development activities

CARE's experience has shown that the synergistic nature of development activities has facilitated the application of approaches from other development sectors that can be applied successfully to FP and RH.

CARE has extensively applied participatory learning and action (PLA) activities to reproductive health. In Zambia, PLA was used extensively in the development and monitoring of the reproductive health project. In Bolivia CARE adapted the WARMI methodology for community participation to maternal health risk assessment. PLA approaches have been used with a variety of special populations including refugees and adolescents. This has been a unique contribution of CARE to the reproductive health field. (*See Box 3*)

In Guatemala and Peru, technical assistance provided by CARE's micro-enterprise sector helped to establish women's banks in rural areas. These banks are women-run enterprises and have provided revolving funds for transportation during obstetric emergencies. Similarly in Zambia, CARE was able to draw on technical expertise in income generating activities to pilot youth initiatives linked to reproductive health.

A multitude of community management structures, often established for other development purposes have been mobilized to address reproductive health. Water committees in Peru, Bolivia, Mali and Haiti have facilitated community dialogue about reproductive health issues.

1998
USAID awards CARE a new three-year project called CARE-MoRR. The new project continues to strengthen the cross-sectoral focus. In addition to incorporating the reproductive health areas of family planning, maternal health, STIs and HIV/AIDS, the project will also support child survival activities. It includes a component for networking and partnering through local NGOs.

CARE participates in the PVO/NGO Network project next to Save the Children, ADRA, Plan International and PATH.

1999
The CARE-MoRR project has three goals:

1. To empower five million women and their partners to achieve their

Street theater is a commonly used IEC activity used by CARE programs.

In Nepal, CARE's development program is multi-sectoral including community organization, agriculture and natural resources, forestry, watershed management and income generation. In 1994, when CARE decided to expand programming in health and family planning it built on a well-established project structure in some of the most remote parts of Nepal. The strong community relationships and local government coordination greatly assisted the smooth start-up of activities.

Box 3: Benefits of Building on other Development

In Zambia, the CARE Community Family Planning Project increases people's access to and use of high-quality reproductive health services by improving community and clinic services. At the community level, the project has established a network of 400 trained reproductive health promoters who market contraceptives within their communities. These promoters also provide information and counseling, and refer clients to clinics as necessary. The project further promotes a supportive environment for behavior change through 40 local support groups called "circle of friends", where women, men and adolescents get together once a month to discuss reproductive health issues. The project also works with 172 clinical service providers in 39 marginal-urban areas to ensure access to and the use of high-quality reproductive health services. Through clinic based activity, CARE has strengthened the delivery of family planning services through provider training, institution of quality of care monitoring, and the provision of basic supplies and equipment.

C. Partnership

CARE has established a multitude of partners in its reproductive health programming. Partnerships are crucial for accurate needs assessment, program design and successful implementation and sustainability. CARE's partners have included community-based organizations, NGOs, private and public sectors.

In Ghana, the Wassa West Reproductive Health Project began with a philosophy of partnership building with both the private and the public sector to ensure collaboration and complementary project activities. The project has worked in a unique partnership with the MOH, the Planned Parenthood Association in Ghana, the Ghana Registered Midwives Association, mining companies, the District Assembly, the traditional rulers and the local communities to bring about behavior change among the target groups. Partner meetings ranged from orientation talks at the beginning to a full blown consensus building workshop to ensure that partners knew about the project and were actively involved in setting the pace and fine-tuning of interventions.

In Bolivia CARE partnered with CIES, a local family planning NGO, to provide FP and MH services to rural communities. In Ayacucho, Peru, CARE worked with Vecinos-Peru to provide family planning services in communities previously isolated by guerrilla activity. The CARE Bangladesh NGO-support project worked with 20 local NGOs to develop and assure their capacities to deliver family planning services to under-served areas.

D. RH Advocacy Efforts

PVOs can be strong advocates to change RH policy and to bring essential services within reach of underserved populations. In the majority of cases, CARE focuses policy advocacy efforts at the local levels. In Peru, CARE participated in a successful advocacy effort that allowed CBD agents to provide injectable contraceptives. Similarly in Niger, CARE has been allowed to pilot contraceptive pill distribution through CBD agents.

In several cases, CARE has been successful at bringing attention to the needs of vulnerable populations such as young migrant workers, commercial sex workers, displaced persons and refugees. CARE has effectively changed donor and government strategies to better address the needs of these populations. (*See Box 4*)

reproductive intentions and reproductive health;

2. To empower communities to be organized, effective consumers of and advocates for family planning and reproductive health services;

3. To increase the capacity of a wide range of national institutions (public sector, NGOs, community-based organization and private, for-profit) and small and moderate international PVOs to deliver appropriate, high-quality, family planning and reproductive health services.

The portfolio increases to 59 projects with reproductive health components in 32 countries. These projects include a variety of family planning and reproductive health components and funding sources.

Box 4 : RH Advocacy Narrative

In 1991, through the PFPE Project, CARE began working in the area of MCH/FP in one province of Rwanda. At that time, the political situation was deteriorating and an increasing number of people were fleeing civil unrest. When the genocide started in 1994, hundreds of thousands of Rwandans fled to neighboring countries. HIV sero-prevalence rates in Rwanda prior to genocide had been reported to be more than 30% among the urban population.

For the first time ever, CARE staff started training refugee community health educators to provide RH outreach services. Specific responsibilities for the community health educators included delivering HIV/AIDS prevention education messages, distributing condoms and encouraging camp residents to seek treatment for STDs. By the end of the first year, 80,000 people had sought counseling and treatment for STDs as a direct result of the project. The program gradually expanded to three other camps and more than 2,000 peer educators were trained reaching over 700,000 people by the end of the project.

E. Local ownership of RH services

PVOs can play an important role in empowering communities in the ownership and influence over local RH services.

In Togo, CARE worked with local health service management committees to assure the continued support and supervision of CBD agents. In Bolivia, the “La Sala” model, which provides RH services for vulnerable populations, is now under the leadership of participants.

CARE has consistently found in its reproductive health programming that communities are the best advocates for integrated reproductive health services. In areas where single RH strategies were used, community members quickly pointed out the necessity of multiple components, involving men, involving youth, women’s

status and other needs. CARE often had to make choices how to respond. FP programs can provide the impetus and opportunity for women to become leaders in their communities. (*See Box 5)*

Box 5 : Local Ownership of Service Narrative

TUMUHIRWE KELLEN FLORENCE

Kellen was born in 1963 in Kyabuhangwa parish, Kamwezi sub-county, Rukiga county, Kabale District. She is a single parent with 5 children. She completed 'A' level after which she started living on her own. Kellen started to work with Community Reproductive Health Project (CREHP) Phase I in 1994 when she was a Community-Based Distribution Agent (CBDA) for family planning methods mainly, condom and pills and referring clients for other long term and permanent FP methods. Then during CREHP II she was elevated to a Community Reproductive Health Worker (CRHW) status i.e. in addition to FP she also provides appropriate messages on maternal health and sexually transmitted infections (STIs) and where to get appropriate services. Kellen is now a CRHW for Kyogo Parish in Kamwezi sub-county. Since she started working for CREHP she says, a lot has been achieved which has greatly changed her personal life. Specifically, she has:

- *Gained confidence to speak in public,*
- *Gained status in the community, and*
- *Gained skills in interpersonal communication.*

Besides these, she has been identified by the community as an opinion leader. She was even elected unopposed as the women's representative to LCIII Local Council (at sub-county level). She represents her parish at LCIII. Furthermore, CRHW work has also exposed her to other NGOs and leadership positions. For instance, she works with World Vision as Correspondent Analyst, she is a member of the Community Based Health Care Association (CBHC) and heads various women groups in her parish and sub-county. She has also formed CRHW music and drama groups who spread messages on MH, FP and STIs to sensitize the communities through songs and drama.

1999
The basic cluster of RH components is FP, maternal health (MH), STI/HIV, and newborn health (NH).

CARE is successful at leveraging USAID resources through a wide variety of funding sources including multilaterals, bilaterals, and private sources. CARE-MoRR resources directly support only eight of the 53 projects.

CARE's reproductive health program expects to reach over a million people this year with information related to critical reproductive health topics.

Excerpts of this timeline were taken from:

[1] Wilcox, Sandra *The Story of CARE's Successful Integration of Family Planning and Reproductive Health Services: A Case Study* Washington: NGO Networks for Health, February, 1999

Section IV

Service Delivery Outputs

A. Overall

As the PFPE Project evolved from a vertical family planning program into a more comprehensive reproductive health approach, the monitoring indicators changed accordingly. From 1993 to 1998, project reports tracked FP results. In 1998 the indicators monitored were expanded to include MH and STI. In addition, as new programmatic approaches were introduced, such as the Health Security framework, field reports showed results of community empowerment and institutional strengthening activities.

The following section reports the cumulative quantitative indicators for family planning for the period 1993–1998. Outcomes for 1999 are not included in these graphs to avoid double counting with the CARE-MoRR project. It is important to note that during PFPE's last two years our partner's (MOH/ NGO) capacity to provide RH services greatly increased. Consequently, CARE's role shifted to one of an assistance organization. Thus, to avoid double counting, service statistics for the last two years do not reflect those reported by partners.

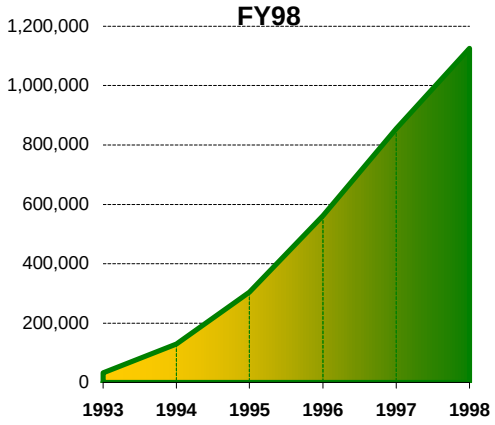
B. New Users

From June 1993 to June 1998, CARE's population projects recruited 1.1 million new users. In most of the areas CARE works, access to FP and RH services have not been readily available prior to CARE's intervention, thus new users are also first time users to a family planning method. As emphasis is placed on community approaches, new users have higher numbers for non-clinical methods such as pills, condoms and vaginal tablets.

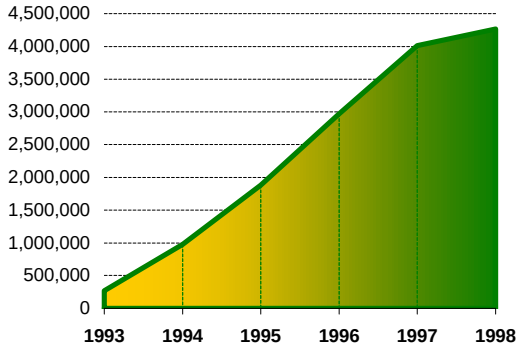
C. Continuing Users

Between 1993 and 1998 there were over 4 million continuing users. Reporting of continuing users was much better among the Asian projects than the African and Latin American projects. As occurs in most FP programs, projects cannot assure that new users to FP will consistently come back to a project provider or clinic. As more re-supplying options are made available, users choose to re-supply from different and more convenient sources. Therefore, CARE's accomplishments for continuing users come mostly from Asian countries that still depend largely in CBD service delivery models.

Graphic 5: Cummulative Number of New Users form FY93 through FY98



Graphic 6: Cummulative Number of Continuing Users from FY93 through FY98

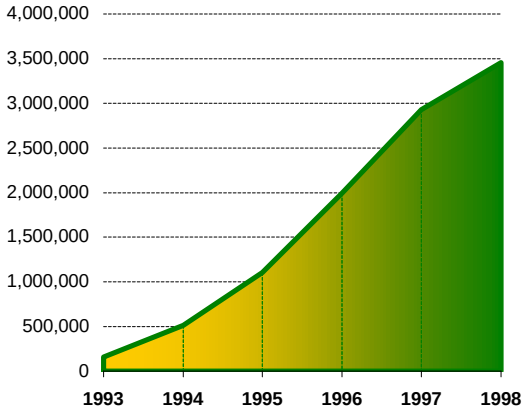


D. Couple Years of Protection (CYPs)

During the reporting period, the cumulative number of CYPs reached nearly 3.5 million. In rural settings, where CARE generally works, methods most likely utilized by first time users are non-clinical methods and therefore, provide a small amount of CYPs. Thus, the level of effort for CARE's program is not necessarily reflected in the CYP indicator. However, injectables have become increasingly popular over the last couple of years.

Additionally, there was an increased number of referrals for clinical methods, primarily for IUDs, Norplant and sterilization. PFPE supported all behavior change, educational recruitment and community mobilization activities leading to a successful referral and recruitment process, as well as creating the referral links with clinical providers.

Graphic 7: Cummulative Number of CYPs from FY93 through FY98

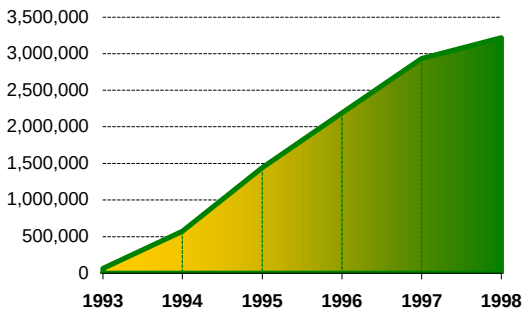


CARE takes credit for 50% of the CYPs from referrals, even though in the majority of cases, referrals are accompanied by a community promoter.

E. Persons Informed

RH education for behavior change has been a cornerstone of the PFPE project. This effort is reflected in the output of over 3 million persons informed on RH topics. In many cases, as mentioned above, CARE faced target populations with no previous exposure to family planning. Hence, IEC for education and awareness was required. The goal of PFPE's IEC/ BCC activities to recruit new users and avoid drop-outs of continuing users. Activities included group talks, home visits, and counseling sessions, and constitute the total number of persons informed. Although other IEC activities were supported (such as radio spots, street theater, poster, flyers, billboards, etc) none of these are counted in the 'persons informed' indicator.

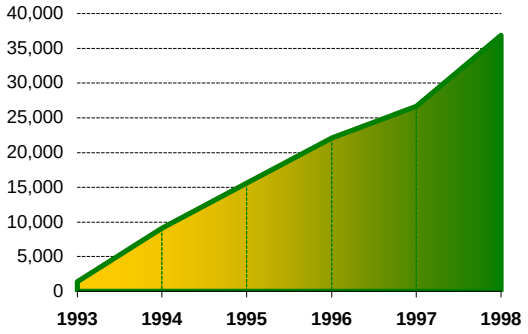
Graphic8: Cummulative Number of Persons Informed from FY93 through FY98



F. Providers Trained

PFPE implemented training activities aiming to improve the skills of both service providers and program managers. A total of 36,000 people participated in training activities. Most health providers, especially community health workers, had a chance to participate in initial training sessions as well as refresher courses. Management training focused on enhancing supervisory and monitoring systems, projects design, logistics, and evaluations. Conversely, community health worker training emphasized contraceptive technology and counseling skills.

Graphic 9: Cummulative Number of RH Providers Trained from FY93 through FY98



Section V

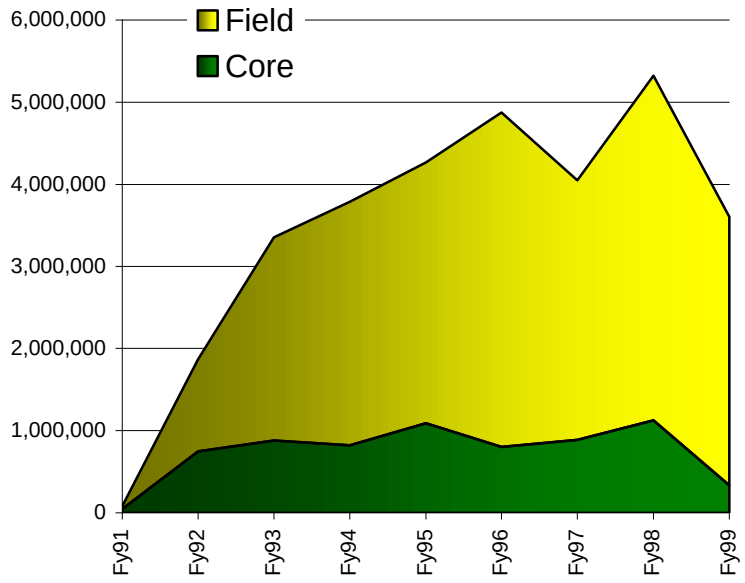
Financial Information

A. Core and Field Expenditures

PFPE was originally budgeted at $25.8 million in USAID funds, with AID/ Washington expected to provide $17.1 million and the USAID Mission an additional $8 million in buy-ins. CARE was expected to provide a 25% match, equivalent to $7.1 million. The PFPE ceiling was later raised to $39 million, while the CARE match was raised to $10.1 million.

Like all USAID projects, the funding mechanism supporting the PFPE changed in 1995 with the introduction of the field support system. This resulted in two USAID Missions deciding to end funding for PFPE activities, while others were added. In addition, CARE began to track separately its use of core and field support funds.

Graphic 10: Core and Field Expenditures PFPE Project FY91-FY99



USAID financial support was obligated to CARE to institutionalize FP within the organization, to build technical capacity within CARE and to expand family planning services within a number of pre-selected PFPE countries. Core funds were used to strengthen internal technical capacity and expand access of CARE's target populations to family planning. It was anticipated that by strengthening CARE's reproductive health capacity, the PFPE project would also increase CARE's capacity to leverage USAID funds.

Activities supported by PFPE contributed to the expansion and/or improvement of all of CARE's family planning and reproductive health projects, including non-PFPE and non-USAID supported projects. In fact, support provided to non–USAID projects permitted significant leveraging of USAID funds, allowing CARE to fully accomplish our match obligations.

Core funded activities cut across the entire range of CARE Country Offices and resulted in products and outcomes that have had significant application in the PVO and population communities.

Core funded activities are generally of three kinds:

(1) **New Initiatives,** which include:

- Developing and diffusing technical standards and tools: One of the hallmarks of PFPE has been developing technical standards and tools that serve as guidance to field staff in PFPE countries and extended to other countries in which CARE is providing reproductive health services. The technical standards serve as a synthesis of extant knowledge and provide a quick reference for field staff on critical issues. They are a critical mechanism for diffusing state-of-the-art information in a large, decentralized PVO and are updated as warranted by research and field experience.

  The technical tools are innovations, such as the Quality of Care Supervision Tool or the Management Capacity Assessment Tool, that translate concepts and issues in the population field into practical techniques that can be applied by field staff. Furthermore, tools designed by the PFPE project have relevance to other PVOs that are introducing family planning interventions within their broader development activities.

- New project designs: One of the keys to maintaining a successful program is ensuring that field projects are properly conceptualized and designed at the outset. Understanding that while a good design is no guarantee of success, it is very hard for projects to recover from poor designs. For this reason PFPE core funds were used to support the needs assessments and projects designs at the country level. Technical assistance to Country Offices was a principal task of the Health and Population Unit staff. This support was later

Table 2: Summary of PFPE Expenditures

Item	Phase I 1991-1995	Phase II 1995-1999	Total Budget
Core	17,100,000	3,411,326	20,511,326
Buy-ins	8,699,832	N/A	8,699,832
Field Support	N/A	12,277,208	12,277,208
Total USAID Budget	25,799,832	15,808,385	39,047,021
Match Required	7,100,000	3,000,000	10,100,000
Obligated Budget	23,238,636	10,498,100	33,736,736
Match Raised	7,113,612	10,096,618	17,210,230

extended to the project launch and consolidation phases, as well as to the mid-term and impact evaluations.

- Bridge funds for project start-up: Core funds were also used to support the initiation of projects that might otherwise be substantially delayed due to the field support funding cycle; such start-ups occurred with the concurrence of the local USAID Mission. CARE country offices receiving start-up funds were required to make a reasonable commitment to secure follow up funds. Examples include Nicaragua and Guatemala, where start-up funds were successfully followed up with no-core funds.

(2) **Research:**

Core funds were also used to support operations research at the country office level, such as the case of Zambia and baseline and impact evaluations in a variety of countries. In addition, core funds were also used to support cross-national analyses of CARE population projects. The purpose of the analyses was to identify strengths and weaknesses in CARE's population and reproductive health programming as the basis for continuous improvement.

(3) **Technical leadership:**

Building CARE's internal capacity has been a key component of the institutionalization of family planning at CARE. Consequently, financial resources were used to improve the technical management skills of CARE staff at the field level. Activities in this area included workshops, cross visits, dissemination of lessons learned, management systems developed, etc.

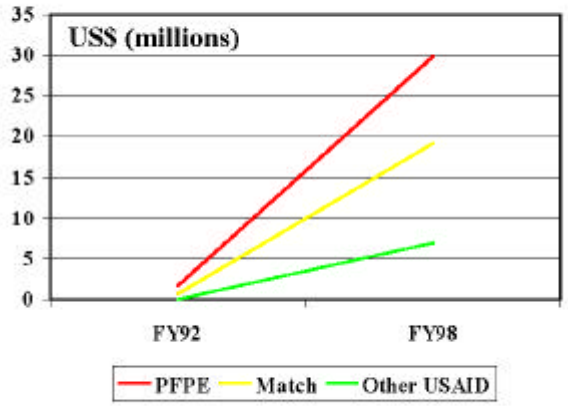
As a result, the quality, validity and effectiveness of the CARE's Population and Reproductive Health Program greatly improved over the last 8 years. In fact, building up CARE's capacity has been crucial to attract other donors and leverage USAID funds for family planning and reproductive health.

B. Leveraging USAID funds

Core funds provided by the PFPE have made it possible for CARE to increase its total population and reproductive health portfolio with support from other donor sources. The rapid growth of CARE's family planning and reproductive health portfolio has demonstrated its ability to effectively leverage core resources to support reproductive health programming worldwide. In the period 1991-92, the PFPE project supported 70% of a portfolio valued at $2.4 million. In 1998, over 40% of CARE's $17 million population and reproductive health portfolio came from donors other than A.I.D.

PFPE's contractual obligation was to raise and spend $10.1 million by June 1999. As of June 1999, CARE had spent $17.2 million in matching funds, exceeding the contractual obligation by 51%.

Graphic 11:
Cumulative Expenditures for Reproductive Health



Appendix A

Planned PFPE Outputs and Realized Activities

Institutionalization Objectives	
Expected Output	**Current status**
One (1) Reproductive Health Team created, with overseas Regional Technical Team	The Reproductive Health Team at CARE includes 3 senior technical advisors, 1 program associate, and 2 support staff in Atlanta plus 3 Regional Technical Advisors (RTAs) based in London, Nairobi and Guatemala City. The team is fully operational, has an articulated strategy and operates within the parameters of annual operating plans. Also reflective of the reproductive health capabilities is the Reproductive Health for Refugees staff, which includes 2 technical officers. Many of the original PFPE field staff have been promoted to senior management positions within the organization.
Staff from 15-20 overseas offices trained	Overseas staff from 32 CARE Country Offices have participated in workshops and conferences sponsored by the Reproductive Health Team. In addition, field staff regularly attend and make presentations at professional conferences, including APHA and Global Health Council.
Increase in number of staff with population and family planning experience	Thirty-six RH projects with FP components now operate in 26 countries, each with appropriate full-time staff. One of the most significant changes brought about by PFPE has been the development of a professional RH community within the organization that ensures an enduring commitment to programming at the field level.

Institutionalization Objectives	
Expected Output	**Current status**
All CARE country (38) offices address population in their Multi-Year Plans	Issues of population, family planning and reproductive health are now routinely considered in the development of Country Office long range and annual plans. Furthermore, reproductive health and population dynamics are integral components of the household livelihood security framework for programming.
$7.1 million raised from major non-A.I.D. donors	CARE has now received grant obligations in excess of $30 million to support its work in population/reproductive health. Match expenditures through June 1999 exceeded $17 million.
Minimum of 1 ANR; 1 SEAD and 4 PHC projects integrated with family planning activities	This objective has been significantly exceeded as the majority of RH projects are clustered with other CARE programs.
Collaborative relations established with a minimum of 10 population/family planning agencies	**Cooperation/coordination with other international CAs:** • **AIDSCAP:** Nepal, Ethiopia, Lesotho, Togo • **AVSC:** Bangladesh, Nepal, Peru, Philippines, Uganda • **CDC:** Uganda, Tanzania, Kenya, Peru, Ecuador, Ethiopia • **CEDPA:** India • **Evaluation project:** India • **FHI:** Mali, Nepal • **INTRAH:** Mali, Togo • **IPPF Affiliates :** Guatemala, Nepal, Mali, Togo, Palestine and Tanzania • **JHU/PCS**: In Zambia, Bangladesh, Nepal • **JSI** : Zambia, Nepal, and Togo • **Linkages:** Uganda • **Pathfinder**: Uganda, Bangladesh, Ethiopia, Peru, Mozambique • **PSI**: In Zambia, Ethiopia • **Pop Council**: Zambia, Uganda ,Guatemala, Honduras • **SOMARC:** Uganda, Bangladesh, Nepal and Mali • **Headquarters:** MSH, Pop Council, CEDPA, FPLM/JSI, PCS/JHU, AVSC, NGO networks for Health, and Focus on Young Adults. Other CAs routinely participate in CARE's RH training activities.

Institutionalization Objectives	
Expected Output	**Current status**
One Population Strategy Statement developed and institutionalized	The original Population Strategy was shaped by a conceptual framework consisting of five interrelated elements that relate and feedback into each other: 1) Policy, 2) Strategy, 3) Guidelines & tools, 4) Projects and Services and 5) Learning In 1996, a more comprehensive RH strategy called *Enriching Lives through CAREful Choices was established.* Then, in 1998, the Managing Reproductive Risk framework was developed.
One Evaluation Protocol designed and institutionalized	Four separate evaluation protocols have been developed and used extensively in CARE RH projects 1. A **baseline** survey instrument that is used in project design and against which progress can later be measured. 2. A **mid-term evaluation** methodology that uses intensive, participatory approach to asses project implementation. 3. An **impact evaluation** protocol that focuses on accomplishments, comparing them to expected outputs as stated in the original project design. Final evaluations also provide extremely important qualitative information, lessons learned, errors and mistakes. 4. Changes in institutional capacity can be measured via the **Management Capacity Assessment Tool**.

Field Project Outputs	
Expected Output	**Current status**
16 family planning service delivery sub-projects designed	PFPE projects were designed, implemented, evalu- ated in : 1. Bangladesh (currently a non-PFPE project) 2. Bolivia 3. Dominican Republic (currently closed) 4. Ghana 5. Haiti 6. India 7. Nepal 8. Niger (currently a non-PFPE project) 9. Peru 10. Philippines (currently closed) 11. Rwanda (currently closed) 12. Togo (currently a non-PFPE project) 13. Uganda PFPE-supported technical assistance has also helped in the design, implementation and project evaluation of lo- cal USAID-supported and non-USAID supported pro- jects: 1. Bolivia 2. Cambodia 3. Cameroon 4. Ethiopia 5. Ghana 6. Guatemala 7. Haiti 8. Honduras 9. India 10. Kenya 11. Laos 12. Lesotho 13. Mali 14. Madagascar 15. Mozambique 16. Nicaragua 17. Peru (2 non-PFPE projects) 18. Rwanda 19. Somalia 20. Sudan 21. Tanzania 22. Thailand 23. Uganda (2 non-PFPE projects) 24. Vietnam 25. West Bank Gaza 26. Zambia

Field Project Outputs	
Expected Output	**Current status**
Minimum of 4 integrated development/family planning component sub-projects designed	The majority of PFPE projects were implemented in close coordination with other CARE subprojects.
Commodities distributed in a minimum of 8 subprojects	Contraceptive distribution has occurred in all PFPE projects and in most of the projects financed from other sources. Between 1991 and 1995 the initial PFPE projects were involved in contraceptive logistics, but as our partnerships have strengthened and CARE's role has evolved, the MOH and other partners have largely taken over this role.
Minimum of 8 family planning service delivery models tested	Lessons learned conference (1994) and BP2001 conference (1997) reviewed CARE population programming experience and provided guidance for future programming. Because of CARE's decentralized structure, unique models have been implemented in a variety of setting, including: • **NGO Support model**: Bangladesh • **Logistics model**: Philippines • **Community/CBD support model**: Togo • **Graduation model**: Peru • **Adolescents**: Zambia, Cambodia • **Title 2 model, Public and Private Partnership**: Haiti • **Private partnership model**: Honduras, Ghana • **MOH model**: Guatemala
Estimated 2,697,000 CYP provided over LOP (if Bangladesh included; 809,400 CYP without Bangladesh)	3,454,947 CYP provided.
100 percent of sub-projects evaluated	All PFPE projects were evaluated: (MTE, Final) 1. Bangladesh (currently a non-PFPE project): 1994, 1996 2. Bolivia: 1998 3. Dominican Republic (currently closed): 1996 4. Ghana: 1999 5. Haiti: 1999 6. Nepal: 1997 7. Niger (currently a non-PFPE project): 1994, 1995 8. Peru: 1994, 1996 9. Philippines (currently closed): 1994, 1996 10. Rwanda (currently closed): 1994 11. Togo (currently a non-PFPE project): 1994, 1998 12. Uganda: 1994, 1996

Appendix B

Headquarters Activities

Year	Projects Designed, Launched, and Supported	Technical Capacity	Tools and Guidelines	Fundraising and Strategic Development
91-92	• **Designed:** Niger, Rwanda, Uganda, Togo • **Launched:** Niger, Rwanda, Uganda, Togo	• Recruiting the Population program team, the RTAs, and project managers • Project design workshop for CARE staff • Quality of Care workshop for CARE staff	• Project design guidelines • Evaluation guidelines for CARE's family planning projects • Cost analysis guidelines • Budget preparation guidelines	• Strategic Planning meeting held in Nairobi, Kenya • Development of the BIG Country Strategy • Secured obligations in the amount of $358,000 through unrestricted allocations and foundations grants
92-93	• **Designed and Launched: Bangladesh, Dominican Republic, Peru, Philippines,** Bolivia, Guatemala, Honduras, Mali • **Supported:** Niger, Togo, Rwanda, Uganda	• Family planning technical skills workshop held in East Africa for CARE staff	• Model reporting format • Quality of CARE supervision tool • Management Capacity Assessment Tool	• Strategic Planning Meeting • Ratification of the Population Policy by CARE International • Raised over 1 million dollars

Year	Projects Designed, Launched, and Supported	Technical Capacity	Tools and Guidelines	Fundraising and Strategic Development
93-94	• **Designed and Launched:** Ethiopia, Cambodia • **Supported: Bangladesh, Dominican Republic, Peru, Philippines,** Bolivia, Guatemala, Honduras, Mali, Niger, Rwanda, Uganda, Togo	• Family planning technical skills workshop held in West Africa for CARE staff	• Training guidelines • IEC guidelines • Counseling Guidelines • MTE guidelines • Guidelines for integrating population into long range plans • Procedure for setting Behavioral Intermediate goals	• CI population Task force met • RH Team developed 4 year work plan • CARE population video • Obligations for 3 million secured
94-95	• **Designed and Launched:** Zambia, eastern Uganda, Kenya, Guatemala, Bolivia, Nepal • **Supported: Bangladesh, Dominican Republic, Peru, Philippines,** Bolivia, Guatemala, Honduras, Mali, Niger, Rwanda, Uganda, Togo	• Lessons Learned Conference: Embracing Error to Improve Practice • External evaluation of RH projects by PopTech		
95-96	• **Designed and Launched:** Sudan, refugee initiative (Tanzania), Haiti, Honduras, West Bank/Gaza, Cambodia, India, and Vietnam. • **Supported:** Zambia, eastern Uganda, Kenya, Ethiopia, Guatemala, Bolivia, Nepal	• IEC workshop held in Asia for CARE staff • Management development workshop for CARE staff	• Enriching Lives strategy disseminated • CBD guidelines • Revised project guidelines	• Enriching Lives Programming framework developed • Match expenditures at $5.2 million

Year	Projects Designed, Launched, and Supported	Technical Capacity	Tools and Guidelines	Fundraising and Strategic Development
96-97	• **Designed:** Kenya, Mozambique, Haiti, Honduras, Indonesia • **Launched:** Niger, Togo, Ethiopia, Kenya, Uganda, Peru, Philippines, India, Bangladesh • **Supported:** Sudan, Tanzania, Kenya, Uganda, Zambia, Bolivia, Honduras, Peru, Haiti, Bangladesh, Cambodia, India, Nepal, Philippines, and West Bank/Gaza.	• IEC workshop held in East Africa for CARE staff • Reproductive Health workshop held in Latin America for CARE staff • Reproductive Health workshop held in Africa for CARE staff • Maternal health Workshop held in Asia for CARE staff • BP 2001 Conference	• Asia Reproductive health profile • Revised IEC guidelines • End of project evaluation guidelines	• Health Security framework developed • Reproductive health regional team structure clarified
97-98	• **Designed:** Egypt, Ghana, Rwanda, Nicaragua, Guatemala, Tajikistan • **Launched:** Mali, Ghana, Niger, Nicaragua, Guatemala • **Supported:** Ethiopia, Kenya, Ghana, Lesotho, Uganda, Sudan, Madagascar, Zambia, Haiti, Bolivia, Peru, Guatemala, Philippines, Cambodia, Bangladesh:	• IEC workshop held in Latin America for CARE staff • Maternal health Workshop held in Africa for CARE staff • IEC workshop held for CARE staff in Francophone countries	• Best Practices 2001 report/ guidelines • Maternal health program guidelines	• CARE-MoRR technical guidelines • Over 17 million in match funds secured

Appendix C

CARE's Reproductive Health Projects by Country, Title, Components and Funding Source

Country	Project	Components	Donors
• *Bangladesh*	Safe Motherhood	MH/NH	UNICEF, AUSAID
• *Bangladesh*	SHAKTI	STI/HIV	DFID, Netherlands Embassy
• *Bolivia*	Market Networks	FP/STI/HIV	USAID/BHR-PVC
• *Bolivia*	Our Bodies Our Health	FP/MH/STI/HIV	CARE-MoRR, PROCOSI
• *Cambodia*	Adolescent Health	FP/STI/HIV	UNFPA/EU
• *Cambodia*	BAHAP	STI/HIV	USAID-ANE Bureau
• *Cambodia*	CARAM	STI/HIV	University Of Amsterdam
• *Cambodia*	Jivit Thmey	FP/MH	USAID/Cambodia
• *Cameroon*	Truck Drivers and HIV/AIDS	STI/HIV	DFID
• *Ethiopia*	Population and HIV/AIDS	FP/STI/HIV	Government of Netherlands
• *Ghana (new)*	Ashanti Region Community Health	FP/STI/HIV	Gates Foundation
• *Ghana*	Wassa West Reproductive Health	FP/STI/HIV	CARE-MoRR
• *Guatemala*	Mayan Reproductive Health	FP/MH/STI/HIV	DFID
• *Haiti*	Reproductive Health 2001	FP/MH/STI/HIV	CARE-MoRR, Anon2, Zehnder Fond, UNFPA
• *Haiti*	RICHES	FP/MH/STI/HIV	USAID-BHR-PVC, UNFPA
• *Honduras*	Community Agro-forestry Project	FP/MH/STI/HIV	Government of Netherlands
• *Honduras*	Reproductive Health in the Workplace	FP/MH/STI/HIV	Gates Foundation
• *Honduras*	Title II Hogasa Project	FP/MH/STI/HIV	USAID/Title II/Gov. of Honduras
• *India*	Allahabad Women's Project	FP/STI/MH	DFID
• *India (new)*	ASRHA	FP/STI/MH	DFID

Country	Project	Components	Donors
• *India*	Improving Women's Reproductive Health	FP/MH/STI	CARE-MoRR
• *India*	INHP	MH/FP/CS	USAID/Title II/ Gov of India/WFP
• *India*	Jabalpur Adolescent Reproductive Health	FP/MH/STI	UNFPA, Frances Velay
• *India*	MISP	MH	CIDA
• *India (new)*	OK TATA	STI/HIV	DFID
• *India (new)*	Shram Shakti	FP/STI/HIV	DFID
• *Indonesia*	Population and the Environment	FP	UNFPA
• *Kenya*	Nyanza Family Planning Project	FP/STI/HIV	DFID
• *Kenya*	SASSH	STI/HIV	DFID
• *Laos*	Border Areas HIV/AIDS Prevention	STI/HIV	USAID-ANE Bureau
• *Laos*	STEM	STI/HIV	AUSAID
• *Lesotho*	SAFE II	STI/HIV	DFID
• *Madagascar*	TOUCH 2000	FP/MH/CS	USAID/Madagascar
• *Mali*	Koro Community Health	FP/MH/STI/HIV	USAID/Mali
• *Mali*	Macina Community Health	FP/MH/STI/HIV	USAID/Mali
• *Mozambique*	Child Spacing Project in Nampula	FP	USAID/ Mozambique, Frances Velay, Jersey, DFID
• *Nepal*	Remote Areas: FP and Health	FP/MH/STI/HIV	CARE-MoRR, Nils Fletre, USAID-Nepal
• *Nicaragua*	Matagalpa RH	FP/MH	USAID/Nicaragua
• *Nicaragua*	MESA	FP/MH	PFPE/CARE-MoRR
• *Niger*	Zinder Reproductive Health	FP/MH	DFID
• *Peru*	Multi-Sectoral Population/ DFID	FP/MH	DFID, CARE-MoRR, FONCODES
• *Peru*	Peru 2000	FP/MH	USAID/Peru

Country	Project	Components	Donors
• *Philippines (new)*	SMILE	FP/MH	Western Mining Co.
• *Rwanda*	Gitarama Reproductive Health	FP/STI/HIV	USAID/ Rwanda
• *Somalia*	Reproductive Health Awareness and Action	MH/STI/HIV	Mellon Foundation
• *Somalia (new)*	Safe Motherhood	FP/MH	UNFPA
• *Sudan (new)*	Basic Health for War Displaced Greater Khartoum	MH	USAID- BHR
• *Sudan*	North Kordofan Maternal Health	FP/MH/STI/HIV	UNFPA, DFID
• *Tanzania*	Community Reproductive Health	FP/MH/STI/HIV	USAID/BHR-PVC, Woodruff
• *Thailand*	Border Areas HIV/AIDS Prevention	STI/HIV	USAID-ANE Bureau
• *Togo*	PPFT	FP/MH/STI/HIV	DFID, UNFPA
• *Uganda*	Community Reproductive Health Education	FP/MH/STI/HIV	CARE-MoRR
• *Uganda*	East Uganda Reproductive Health	FP/MH/STI/HIV	DFID
• *Uganda*	Kumi Reproductive Health	FP/MH/STI-/IV	DFID
• *Vietnam*	Adolescent Health	FP/STI/HIV	UNFPA
• *Vietnam*	Border Areas HIV/AIDS Prevention	STI/HIV	USAID-ANE Bureau
• *Vietnam*	CARAM	STI/HIV	University of Amsterdam
• *West Bank*	Pilot Health Project	FP/MH	CARE-MoRR-ANE Bureau
• *Zambia*	Community Family Planning	FP/MH/STI/HIV	USAID/Zambia

Appendix D

Project Summaries

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"Our Bodies, Our Health" A Reproductive Health Project

Background: Women in rural areas in Bolivia are three times as likely to die due to reproductive health problems than those in urban areas. They have little access to clinics and pharmacies. Most rural health services are poorly equipped and staffed. Few auxiliary nurses or recently graduated doctors have been trained in reproductive health services and they often lack basic equipment and medicines.

In 1995, CARE initiated a project, "Our Bodies, Our Health" aimed at improving rural reproductive health services in Tarija, Potosí and Santa Cruz. The objective is to improve the reproductive health of 400,000 women of reproductive age and their partners living in rural areas and border towns with a special emphasis on marginalized groups in selected areas of the three departments.

Today CARE, in association with the Bolivian Ministry of Health, trains health personnel (doctors, nurses and auxiliaries) so that they can educate and counsel men and women, and offer high-quality reproductive health services.

Unique Aspects of the Project

"Our Bodies, Our Health" works on improving the way reproductive health care is provided. These improvements include the distribution system of family planning methods, providing Papanicolau exams, and the management of reproductive health risks. CARE trains local health personnel who offer reproductive health services and activities in communities where they are assigned. CARE provides follow-up assistance once the initial training has been completed. CARE, through this project, provides reproductive health equipment, basic medicines and reproductive health knowledge.

Another important aspect of the project has been its focus on vulnerable groups. Yacuiba is a border town the Department of Tarija located next to Argentina. Major highways meet in Yacuiba that unite Paraguay, Brazil and Argentina, making Yacuiba a commercial and transportation hub. The highly transient population is at greater risk of contagious diseases. Prostitution is common in commercial border towns and Yacuiba is no different.

In order to address this situation, CARE decided to implement activities in Yacuiba to slow the spread of STDs and HIV/AIDS. CARE first conducted a series of studies to better understand sexual behaviors that allowed for the transmission for STDs. With this knowledge, CARE began working with commercial sex workers, men who have sex with men, policemen, truck drivers and students, to provide them with information to protect themselves from infection.

Major Accomplishments:

In all of 1996, only 11 cases of STDs had been reported in the Yacuiba hospital. But during four months of intense surveillance, through CARE's activities, more than 400 STD cases were found and treated. This dramatic increase has been used to educate the local health and government personnel. It has been a wake up call to the realities of Yacuiba and served to support CARE's work. Local networks have been established in Yacuiba to work with marginalized groups who are at risk of contracting STDs and HIV/AIDS.

In a protected environment, called "La Sala" groups of commercial sex workers and men who have sex with men gather to discuss among themselves issues of self-esteem, gender, STDs and HIV/AIDS. They also learn how to use condoms and techniques for negotiating safer sex practices with sex partners, in order to protect themselves from STD and HIV/AIDS.

Members of the police force, municipal government representatives, health providers and social workers have been sensitized to situations of violence and exploitation that commercial sex workers and men who have sex with men face. Through the work of CARE, these people, who are often the victims of prejudice and scorn, are being assisted in living a safer, more productive life.

Baseline and follow-up surveys in Entre Rios, Tarija and in Yacuiba, Tarija have demonstrated increases in contraceptive prevalence from 12.3% and 13.6% in 1996 to 26.3% and 23.3% in 1998.

CARE supports the improvement of reproductive health, which is vital to the future of Bolivia. CARE actively advocates for the recognition and respect of human rights, including sexual and reproductive rights.

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A Community Mobilization Initiative for Safe Motherhood in Bangladesh

BACKGROUND: In July 1996, CARE undertook a Safe Motherhood Initiative as part of its reproductive health program: NGO Family Planning Services Project in 5 selected sub-districts (Thanas) under Moulvibazar and Dinajpur districts. During the implementation of NGO Family Planning Services Project (NGO-SP), the project identified a great unmet need for the maternal health services among the project participants. The findings of a participatory vision exercise, conducted by the project in 1995, again reiterated the importance of high quality maternal health services to the local communities. It was determined that the quality of such services had to be improved and demand for services needed to be generated. The use of maternal health services, particularly emergency Obstetric Care (EmOC) remains low. To date efforts to improve utilization of EmOC services have largely focused on training of key clinical staff, and making provision of relevant equipment and supplies. It is recognized that the current government maternal health-related projects do not have the full capacity to accomplish this. CARE Bangladesh has particular strengths in working with the MoHFW in building capacity of their staff, in mobilizing communities to support and use services, and in addressing issues related to women's status and empowerment. CARE proposed to expand upon its past experience, and work jointly with the government, NGO and CBO counterparts to complement and strengthen their Safe Motherhood activities through this project.

In Bangladesh, women face problems in reproductive health decision making and child bearing. Maternal mortality continues to remain high (4,5/1000 live births) with an estimated 28,000 women dying annually, and 1.4 million suffering from pregnancy related painful and term complications. Many front-line health and FP workers are unable to recognize danger signs of obstetric complications for referral. Unsafe home deliveries and traditional practices prevail. At present about 5% of all pregnant women with complications reach medical facilities in Bangladesh. Studies estimate that 60% of the maternal and neonatal deaths occur within 48 hours post partum. The Government of Bangladesh , so far, through various projects has attempted to build the capacity of referral centers, mainly district hospitals and thana health complexes by training their staff on basic techniques of obstetric care, including anesthesia, surgery and blood transfusion, and providing necessary equipment, medicines and supplies. Despite the above efforts, a situational analysis carried out by CARE revealed that the majority of maternal deaths occurred at household level, particularly where the distance from service facility was over 5 kilometers. Women were prevented from utilizing EOC services, and often subjected to harmful practices (e.g. in obstructed labor dilatation of cervix of uterus was achieved by applying lubricants or ex-

ternal pressure). The study showed that, due to their low status, women required approval for their evacuation by elderly family members, village doctor, mother, mother-in-law, local educated men, father, teacher, husband, TBA, or neighbor. The study indicated that the transport problem was compounded by lack of cooperation from the rickshaw-van pullers, lack of ready cash, bad law and order situation, and poor road condition worsening during rainy season. The study suggested the specific roles that family, communities and NGOs could develop regarding organizing cash and transportation systems, and liaisons with the EmOC services.

PROJECT GOAL: The SafeMotherhood Project aims to ensure the provision of adequate and quality maternal health services through GOB facilities at district and than a level, to promote behavioral change and develop support system at the community level towards increasing utilization of maternal health services.

KEY STRATEGIES

The SafeMotherhood Project will achieve the above goals by:

- Improving capacity of GOB health service providers at the institution and outreach level to provide a comprehensive, high quality package of maternal health services.
- Promoting women's ability to make informed choices for their own reproductive health.
- Developing appropriate Behavior Change Communication strategies to raise awareness about, and create demand for maternal health services, particularly EmOC, while addressing harmful traditional practices in the community.
- Establishing support systems that increase utilization of appropriate services when needed, including transportation, communication and funds to meet medical expenses.
- Disseminating and advocating to policy makers the adoption of successful strategies for improving health seeking behavior of women.

LESSONS LEARNED/PROGRESS: Progress has been made in the areas of:

- Identification of key constraints such as lack of adequate transportation, traditional practices and decision making process during the time of delivery.
- Identification and segmentation of population groups to be reached through appropriate BCC methodologies with specific messages and approaches for each target.
- Training project staff, specifically in participatory methods for qualitative assessment and community mobilization, basic concepts and knowledge on maternal mortality and obstetric complications, and in-house training in referral facilities.
- Mobilization of key players at community level to assess current needs, problems and constraints, and jointly identifies and implements feasible solutions, particularly for resource mobilizations and establishment of transport system.
- Development of BCC materials, such as Birth Planning Card (BPC), Flush Card on danger signs etc. Some of the BCC materials find recognized by the GoB and development partners for wider use.
- Development, test and documentation of different community facilitation methodologies, tools and guidelines.
- Development of a monitoring system capturing process and key indicators.
- Designed as an operational research project to examine the effectiveness of different approaches in addressing the three delays
- Demonstrating changes in utilization of the Emergency Obstetric Care (EOC) services (5% to 25% in two years of implementation time) in the intervention sub-districts, which is significantly higher than the non-intervention areas.
- Demands have been created among the Government officials to continue and replicate the CARE's SafeMother initiatives.

FUTURE DIRECTIONS: Adjust the above programs according to the changed policies and service support of the GOB, particularly in connection to Health and Population Sector Planning (HPSP).

- Influence the curriculum development for GOB field staff to reflect project learning on Safe Motherhood activities.
- Explore possibilities of future replication of SAFEMOTHERHOOD model in other districts.
- Explore the possibilities of addressing Adolescents Reproductive Health as a priority issue.
- Design and test small scale project in addressing Violence Against Women (VAW), which is the important cause of maternal mortality and morbidity; Community Midwives to replace the Traditional Birth Attendants (TBAs).
- Design and test different approaches to involve men and elected Union Parishad (lowest administrative unit of local Government) Women members in improving Reproductive Health in Bangladesh.

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HIV/AIDS Prevention in Ghana: Peers, Partners and Action Research

Background: With an overall prevalence rate of 4% (1998), HIV infection in Ghana is still localized within clustered pockets of infection. In comparison, its neighbor, Cote d'Ivoire, is experiencing a generalized epidemic. The infection in Ghana centers in regions and areas with a high concentration of industries and high migration patterns. Hence, the mining centers have higher levels of infection. Mineworkers, mostly migrants, have been recognized as one of the most vulnerable groups both for acquiring HIV and spreading it to other parts of the country. Another vulnerable group in miming communities is commercial sex workers (CSWs), who often migrate between the mining centers and neighboring countries.

Work related to prevention of sexual transmission of STDs and HIV in mining areas is notoriously difficult. CARE's SAPIMA (STD and AIDS Prevention in Mining Areas) project in the Wassa West District of Ghana has gradually been achieving acceptance as well as results. The final goal of the SAPIMA project is to contribute to the reduction of acquisition of STDs and HIV through the promotion of safer sex practices among those engaged in mining and those associated with them. The target population is estimated to be 80,000 people who are both formal and non-formal miners, their sexual partners and the satellite population with dependent economic activities in the Wassa West District.

Unique Aspects of the Project: The project had as its initial focus the dissemination of awareness and knowledge, increasing the availability of condoms, and improvement of the diagnosis and treatment of STDs - all using a variety of strategies based in the realities of the areas concerned. The second phase introduced a wider focus on reproductive health needs of the communities, as that was seen not only to be intrinsically linked to the work (the link being sexual health), but was a strongly stated need of the local communities. The current phase is aimed at addressing the factors that influence risky behavior by using a range of societal, community, group and individual techniques through the active involvement, analysis and participation of a range of societal groups. Of particular interest is a focus on the factors that make some miners adopt safe sexual interaction, while others do not.

Successes on the part of the project implementation can be linked to three building blocks that constitute a firm foundation for the project strategy. These are: 1) ***partnership building,*** 2) ***action research & adaptive management processes and*** 3) ***the peer education system.***

Partnership building started at the beginning of the project with both the private and the public sector to ensure collaboration and complementary project activities. The SAPIMA project has worked in a unique partnership with the MOH, the Planned Parenthood Association in Ghana, the Ghana Registered Midwives Association, Mining companies, the District Assembly, the traditional rulers and the local communities to bring about behavior change

among the target groups. Partner meetings ranged from orientation talks at the beginning to a full blown consensus building workshop to ensure that partners knew about the project and were actively involved in setting the pace and fine-tuning of interventions.

Action research has been undertaken at the various stages in terms of baseline surveys, periodic KAP surveys and focus group discussions. SAPIMA employed a strategy that is based on an adaptive management process which relies on action research to adjust implementation where necessary. It started with the baseline survey, to establish the knowledge, attitudes and practices on STD/HIV prevention and to determine the messages and desired media-mix to reach out to the target groups. Besides the development of an IEC strategy that befits the target groups, SAPIMA made efforts to facilitate effective STD case management in the district, in collaboration with specific partners such as the District Health Management Team, the clinics at the mining companies and other private service providers in the formal as well as non-formal sector.

The immediate effects of the SAPIMA project are a result of an IEC strategy that is evolving around a Peer Educator (PE) system. The PEs are volunteers from the local mining communities (including miners and commercial sex-workers). They are therefore the critical link between the project and the communities. To reach the high-risk group populations, CARE trains the PEs to educate their friends and neighbors in HIV/ AIDS and STD awareness and prevention. CARE provides them with communication tools, including audio cassettes, short videos and printed materials to use in their presentations and group discussions. The 1998 KAP survey showed that about two-thirds have seen a PE in action and 38% named the PE as one of his/her information sources on HIV/AIDS.

Major Accomplishments

- The project's IEC component has achieved tremendous results in terms of raising people's awareness and increasing their knowledge of STDs and HIV/AIDS through peer educator system, billboard development, radio broadcasting, puppet show, etc.
- The sale of condoms in the district is over 23,000 condoms every six months by lotto agents, hairdressers, chemical sellers, peer educators, etc.
- Referrals of STD cases made to the district hospitals have increased due mainly to the activities of SAPIMA peer educators, condom distributors, chemical sellers and non formal health sector providers.
- SAPIMA opened new channels of communication for providing accurate information and counseling services to clients and customers, through the training of spiritualists, herbalists and chemical sellers intervening in the non-formal health sector.
- An institutional assessment of organizations providing family planning activities in the district and a baseline survey has been undertaken. Additional staff including an IEC Coordinator, Quality of Care Advisor, CBD Coordinator and two field Supervisors have been recruited. Training programs for 100 CBD agents have been completed (50 old Peer Educators, 20 Village Health Team (VHT) members as well as 30 people selected from various inaccessible areas). A manual for training middle level service providers has been developed.

Future Challenges

- Developing and implementing an effective approach to behavior change is one of the most important challenges the project can address.
- Developing community capacity to analyze and plan for change in relation to the societal factors that influence communication and behavior.
- Keeping the peer education program vibrant when the primary target group (mainly the non-formal miners) are changing all the time.
- Strengthening partnerships with institutions and communities through better and clearer equality of involvement.
- Ensuring the sustainability of the project's impact and activities through localized improvement of management systems, and involvement of communities in the management, supervision and support of activities aimed at societal and service change.
- Collaboration with the MOH staff to achieve the FP objectives has been proved difficult in many cases because public services are either of poor quality, hindered by high turnover or lack of basic resources. For the FP program success, CARE has planned to organize joint supervision with the MOH staff.

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Linking Reproductive Health and Other Programs in Haiti

Background: Haiti is the poorest nation in the Western Hemisphere. Political turmoil and social inequities have contributed to the poor health status. Life expectancy is 55 years. In 1994, the infant mortality rate stood at an estimated 87 deaths per thousand births, while under-five mortality reached 141 deaths per thousand children and total fertility rate is an estimated 4.8 births per woman nationally, rising to 5.8 per woman in rural areas. Poor access to reproductive health information and services is reflected in the maternal mortality ratio of 460 to 600 deaths for every 1.00,000 live births.

The northwest region of Haiti is one of the country's poorest regions with a total average of household income ranging from less than US$100 to a high of US$460 in 1996. A combination of inadequate food supply and lack of access to resources has resulted in a situation where significant percentages of the population find themselves in vulnerable households. Given the political and economic crises since 1991, the 1991-94 embargo, and extensive drought over recent years, the food security situation of many households in this region is more intensively threatened. Over recent years, subsistence primary livelihood means is being replaced by a strategy where households are pursuing several primary activities, the most common being livestock production, commerce and agriculture wage labor. Put into a national context, economic status of northwest Haiti was already the lowest in Haiti in 1994. Only 9% of households were above the poverty line, against an average of 19%.

CARE's Reproductive Health 2001 Project (RH2001) for the Northwest and northern Artibonite regions is a five-year project: 1996 to 2001. The final goal is to promote reproductive health, contributing to a decrease In the TFR, in maternal mortality, and in the transmission of STDs, by increasing access to and use of appropriate, high-quality RH services served by participating institutions. The project strategy focuses on strengthening the RH service delivery capacity of local health institutions through working partnerships with local NGOs and the Haitian government. The project supports 26 RH institutions. Support includes training service providers; support for mobile clinics; In-field technical assistance; financial support for institutions' through individually designed micro-projects; a set of Integrated activities with the CARE DAP strategies for food security promotion.

Title II Program: Development Assisted Project (DAP): CARE is one of the three major distributors of food aid in Haiti. The Northwest and northern Artibonite regions historically have represented areas with extensive food distribution, another indication of the difficulties faced by the population. In 1995 following the resolution of the most recent political crisis in Haiti, CARE Haiti developed a revised strategic approach toward food-aid, an evolution from the delivery and distribution of commodities to food-

assisted development programs. Food commodities are used to help reestablish the base for sustained development. The final goal of DAP is to enhance the food and nutritional security of the most vulnerable population in Haiti's northwest region. Intermediate goals are: 1) To increase the availability of food to vulnerable households, 2) To increase the access of vulnerable households to adequate quantities and types of food, and 3) To increase the appropriate utilization of food by vulnerable households.

CARE's 1995 DAP addresses household livelihood protection through five components, including:
1. Primary School/Community Outreach Health, Hygiene;
2. Nutrition Program; and a Maternal/Child Health Nutrition (MCHN) program;
3. Food Security Support Unit (FSSU);
4. Rehabilitation and Maintenance of Productive Infrastructure.
5. Monitoring Targeting and Impact Evaluation (MTIE);

Currently the RH2001 project is coordinating its activities with the first three components and is working on coordinating more with the forth component, MTIE.

I. Coordination of RH2001 with the Primary School/Community Outreach Health and Hygiene Program: Major activities in this project include feeding school children in primary schools and forming school committees called Parent/Teacher/Director/Students Associations (ADPEP).

1. Reproductive Health Student Education Program
2. The RH 2001 project personnel (nurses and IEC staff use the existing ADPEP structure to discuss with parents the Reproductive Health School Education Program. The ADPEP participates in prioritizing the different subjects and decides on the appropriate age group of the students.
3. The Project staff provide a TOT course for school teachers.
4. Teachers then conduct reproductive health awareness sessions for the students.
5. Students are referred to health centers participating in the RH2001 program with trained service providers.

II. Coordination of RH2001 with the Rehabilitation and Maintenance of Productive Infrastructure Program: This project has a "food for development" component. Through this project, the communities surrounding the health facility organize to build a shelter on the grounds to be used for all health education sessions Including both the MCHN and the RH2001 project.

III. Coordination of RH2001 with the Maternal Child Health and Nutrition Program: Major activities in the MCHN project include nutrition education, growth monitoring and food distribution both in health institutions and at community health posts.

1. Joint partner health facilities: the MCHN project and the RH 2001 project work in the same health facilities. 100% of all MCHN project sites also have reproductive health project support.
2. Joint programming with partner service providers for training sessions, regular meetings. Informational campaigns.
3. Set up reference systems between the two projects' nutrition clients referred to family planning clinic and maternal health services and visa versa.
4. Project staffing: one cohesive health team- staff for both MCHN and RH2001 project trained to give technical assistance both in reproductive health and nutrition.

IV. Coordination of RH2001 with the Food Security System Unit: **This component is responsible for assuring the logistics of the food distribution for all projects and has a fleet of 20 trucks.**

After several focus group discussions in the communities, the project developed colorful billboards with various health messages to be placed on the trucks. As food distribution diminishes the billboards will be removed from trucks and placed in different communities. Trucks stop for several hours in front of schools and health facilities. The billboards serve as media educating the communities on different reproductive health messages including STDs, maternal health and family planning. The billboards are scheduled to be placed on the trucks on June 21st.

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From Farm Management to Family Management: Involving Men in Reproductive Health Care

In 1992, CARE/Honduras began implementing a collaborative project with the Ministry of Natural Resources (MRN) and communities in Yoro, Santa Barbara, Copan and Lempira (PACO: Community Agroforestry Project). The objective of this project was to "increase the capacity of families to ensure their food security and generate an increased household income." The communities were chosen because of "serious problems of sustainable land-use in areas of low soil fertility and in communities with weak organizational infrastructure." Studies in the project areas indicated that the population was not reaching its goals either in the number of children desired or in birth spacing. Approximately 50% of women who said that they did not want another child for at least two years were not using any family planning method. Only 42% of women believed their partners would support them in the decision to plan their families. Instead of focusing on women, as do most interventions in reproductive health, CARE decided to explore three different strategies for improving men's participation in the process of reproductive health decision-making.

With support from the Population Council INOPAL/III project, CARE developed a proposal to test strategies in order to increase male participation in reproductive health activities "and integrate these activities into the PACO project" (now DIPPAC). The operations research took place between June 1995 and November 1996.

The hypothesis tested was that exposure to materials and organized discussions about reproductive health would result in: 1) greater reproductive health knowledge among men; 2) that couples would practice more family planning use; and 3) more communication about reproductive health for men/ couples than those not exposed to the interventions.

Villages participating in the Community Agroforestry Project (PACO) had been divided into four sectors to facilitate extension activities. Accordingly the operations research project was designed to test different strategies in each sector. The O.R. project was conducted in three of the four areas with similar socio-demographic characteristics.

In Sector A, a reference manual entitled, "La Cartilla", was used to disseminate information on reproductive health. PACO extensionists trained community volunteers to provide reproductive health education during ongoing meetings with farmers and cooperative members. The manual includes participatory activities and questions to stimulate reflection and discussion. The manual focuses on (1) responsible fatherhood; (2) reproductive health; (3) family planning; (4) sexually transmitted diseases: and (5) safe motherhood and lactation.

In Sector B, the "Family Management Plan" was based on the "Farm Management Plan" used as a strategic tool by PACO to manage natural resources. The objective of the interactive "Family Management Plan" booklet is to help rural couples meditate on the size of their families, and the timing and spacing of their children in relation to their available resources, goals and desires. The booklet was designed to be used by semiliterate individuals. No writing is required and responses are indicated by marking an X in the appropriate boxes. The booklet addressed the following themes: (1) household resources; (2) childcare; (3) maternal/paternal health; (4) prenatal care; (5) postnatal care; (6) nutrition; and (7) couple communication. No intervention took place in sector C, which was the comparison area.

The **dependent variables included:** a) Contraceptive use; b) Use of reproductive health services; c) Male support in the use of reproductive health services; d) Couple communication; and e) Knowledge about reproductive health.

RESULTS: Promoters feel motivated about their work when they see tangible results in their own communities. To be valued as people and to receive public recognition for the work that they do for their communities is highly motivating for the promoters. In many of their replies, the promoters showed that they had tried different methods of conveying messages. They realize they cannot use the same techniques with everyone or in every situation. The promoters considered the reproductive health intervention important and necessary for the community.

There were significant differences between time periods in the knowledge and practice of preventive reproductive health behaviors. Significantly more males and females knew what a woman should do to prevent cervical cancer during the post-intervention period (82.5% vs. 62.7%). In addition, the proportion of both males and females that responded that they did not know declined significantly by more than 14 percentage points (21.2% to 6.9%). There were also significant increases in the proportion of men and women with knowledge of common warning signs during pregnancy. Higher proportions responded that hemorrhaging and stomach pains were warning signs (44.0% vs. 27.5% and 44.0% vs. 27.5%, respectively). The percentage that did not know declined significantly by more than 20 percentage points (29.6% to 10.9%).

Men were significantly more likely to be able to name modern female methods after the intervention. Women were also significantly more likely to be able to name modern contraceptives after the intervention.

Family Planning Behavior: The project's field interventions lasted approximately 16 months from May, 1996 to August, 1997. During that period, contraceptive use increased from 37% to 55% of women interviewed, with most of the increase attributable to an increase in female sterilization.

In regards to STD prevention, there were also significant differences in knowledge. As the communications indicator, there were no large improvements in couples communication overall. However, according to the men interviewed, there was a change ($p < .05$) in the proportion who reported having spoken with their partner about family planning in the last 15 days (41.12% to 54.0%) There was no significant difference according to the women interviewed, (37.7% vs. 46.5%). The percentage of women who reported having spoken with their partner about STDs/HIV in the last 15 days increased significantly from 36.6% to 60.7%.

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A Woman-Centered Approach to Improving Reproductive Health in Uttar Pradesh, India

Background: Uttar Pradesh is the most populous state in India with a population of approximately 150 million. In addition, it has poor health and socioeconomic indicators, problems compounded by the large population. In Uttar Pradesh female literacy is estimated at 26%, life expectancy for women is shorter than for men. The total fertility rate is 4.75, population growth rate is currently 2.24%, the infant mortality rate is 98, and lastly, the contraceptive use rate is 20%, all far below the national averages. Rates of immunization coverage (BCG-49%, DPT/Polio-34-37%, and Measles-26%) are critically low, as are the number of deliveries attended by trained personnel (18%). There is a high rate of unmet need (17%) for temporary family planning methods.

In view of the above demographic and socio-economic setting and to take advantage of CARE-INDIA working with the Integrated Child Development Services program of Government of India, this project was developed in consultation with district and state officials in Uttar Pradesh. The project's goal is to empower 300,000 rural women of reproductive age in Uttar Pradesh to make informed decisions about their reproductive health, including the number and timing of children, and avail high quality and accessible health services with support from their partners and other members of the community.

Unique Aspects of the Project:

1. The project takes a holistic view of women's reproductive health and not family planning in isolation.
2. It addresses demand generation through:
   - Formation and development of Women Health Group (WHG) in each of 1600 project villages by Animator, a women from the same village.
   - Orientation of members of WHG by Auxiliary Nurse Mid-Wife and Anganwadi Worker of ICDS program on reproductive health and family planning
   - Use of local folk media (Puppet shows, magician) for mass IEC campaign on Safe Motherhood, RTIs/ STDs, and Family Planning.
   - Pictorial IEC material developed on Safe motherhood (flash cards), Flip charts on RTIs/STDs based on script written by women for the puppet show.
3. Its nucleus is the Anganwadi Centre, a ccommunity based centre for the delivery of ICDS services, managed by Anganwadi Worker.

4. The Centre makes services accessible by:
   - Strengthening the existing infrastructure for service delivery - public sector and private medical practitioners.
   - Promoting village level services.
   - Convergence of services at Anganwadi Centre, being the focal point for distribution of supplementary nutrition to under 2 and pregnant and lactating mothers as well as delivery of basic reproductive and child health services. The ANM and AWW provide the services on fixed day once a month schedule.
   - Training of grassroots level workers using participatory training methodology, pictorial IEC material and Zoë model.
5. The Centre further promotes sustainability through:
   - Community based monitoring system.
   - Involvement of men in the program.
   - Linkage of WHGs with development/income generation activities.

Project Development

The state of Uttar Pradesh was selected from four needy states using National Family Health Survey data. Among these four states, Uttar Pradesh had the highest TFR, birth rate and population growth rate. The districts of Sitapur and Shahjahanpur were selected based on the socio-economic, demographic and health indicators available from district level surveys conducted by USAID in 15 priority districts for the large IFPS project funded by them. Secondary data was collected from district level surveys, NFHS, Census 1991 and research studies. Primary data about reproductive health morbidity (RTIs/STDs) and practices, status and quality of reproductive health services provided by various institutions such as Sub-Health Centres, Primary Health Centres, Community Health Centres in the blocks and district hospitals was collected using focus group discussions with women, field observations and discussions with district and field staff of health and ICDS departments.

Major Accomplishments

Out of 1600 villages proposed to be covered by the project in 13 blocks (11 in Sitapur district and 2 in Shahjahanpur district), 320 have been covered in phase-I up to October 1998 (about 60.000 women) and another 424 will be covered in phase-II by August 1999. In the 320 villages where project activities have been implemented for about 9-12 months, 1,442 community-based workers promoting reproductive health have been trained, 1,374 service providers and managers have been trained and 19,900 persons have been reached by the project sponsored IEC RH campaign. Other indicators include:

Indicator	Baseline Status	Current status
Antenatal registration	40.9%	83.6%*
Home deliveries by trained Traditional Birth Attendants	13.5%	75.2%*
Users of spacing methods (Condom and OCP)	4.5%	11.9%*

*Based on monthly monitoring reports received from the villages- to be verified during MTE.

Future Challenges

- Monitoring of project activities spread over 1600 villages and covering approximately 300,000 women of reproductive age group
- Sustainability of program impact
- Management of RTIs/STDs in the absence of availability of medicines from public sector service delivery facilities. Due to high prevalence of RTIs, the number of CuT insertions among women who wish to get it is very small whereas, this is the only long-term spacing method available in the program.

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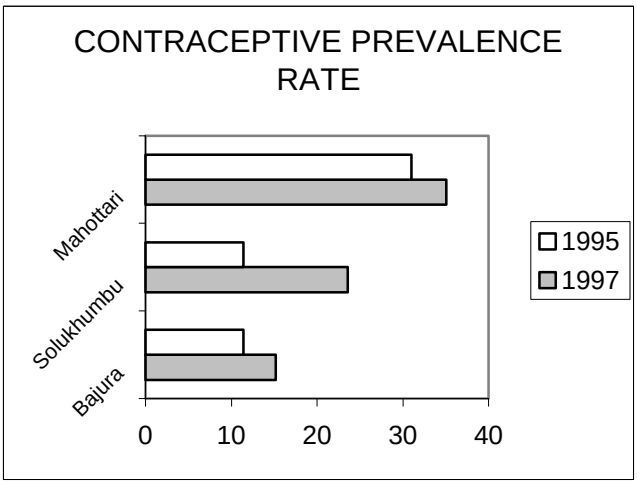
Integrating Reproductive Health in Development Programs in Nepal

CARE-Nepal has been working in Nepal since 1978. In the first decade, CARE focused mainly on drinking water, irrigation, and suspension bridges. The program evolved toward area-based projects specializing in rural, remote multi-sector programs including community organization, agriculture and natural resources, forestry, watershed management, and income generation. In the early part of this decade CARE decided to greatly expand its programming in health and family planning, building on a well established project structure in the field, including some of the most remote parts of the country, and the strong relationships with local communities and His Majesty's Government.

CARE-Nepal's Family Health Project was implemented from 1994 -1997 within three districts in Nepal, including two of the most remote in the country. Health indicators are among the poorest in the world, and services are few, inadequately staffed, and badly equipped. TFR in Nepal is 4.6 (1996 DHS), but in one district of the project it was estimated to be 8.7 at baseline. Life expectancy is 55, and Nepal is one of the few countries where life expectancy for women is lower than for men. Growth rate is 2.37%.



GOAL of the Project

Improved health status of community members, through 1) increased functional knowledge and use of family planning by men and women of reproductive age, and 2) increased awareness and application by mothers of sound health practices relating to maternal and child health, nutrition and sanitation.

The project catchment population started at just under 90,000 people but grew to cover around 150,000 through planned expansion.

The project used a three pronged strategy.

First it increased knowledge and awareness of mother and child health and family planning services so that families could make informed choices about health. Second, CARE worked to strengthen the Government health services at the community level through training and support. Third, CARE instituted community-based distribution systems to make contraceptives available at clients' doorsteps, while facilitating mobile camps and outreach clinics for clinical services.

Basic Health and Family Planning Indicators in Nepal

Mortality (Nepal Family Health Survey 1996 (DHS)) for the five years preceding the survey:	
Infant	78.5
Under five	118.3
Maternal (/100,000 births)	539
Life expectancy at birth (HDR98)	
Male	56 years
Female	54 years
Access to “piped” water (DHS96)	
Urban	57%
Rural	29%
Access to means of excreta disposal (DHS96)	
Urban	74%
Rural	18%
Overall	23%
Pop/doctor (88-91)	16,667 (UNDP)
Pop/nurse (88-91)	33,333 (UNDP)
Contraceptive prevalence rate (CPR) % of married women using any modern method	
1996	28.5%
1991	24.1%
1981	7.6%
1976	2.9%

(JNMA)

The biggest challenge to the project was the remoteness and inaccessibility of two of the project areas. In Bajura District, CARE provided the first ever VSC services for women. This involved flying the medical team and equipment into the district and then walking up to two days to the actual clinic sites. Other challenges included developing skills of Community Based Distributors in districts where female literacy was as low as 7.3 percent. CARE developed and adapted monitoring tools to accommodate this. The scarcity of services caused CARE to dedicate much effort to improving the capacity of locally based Government health service providers.

The overall use of any modern method of contraception jumped nearly 40 percent to 23.6 percent from 16.9 percent for the three districts of the Family Health Project, in two years. The use of Depo-Provera almost tripled, oral pills doubled and condom use nearly doubled. In the baseline survey, no respondents reported community-based distributors as a source of contraceptives. In the evaluation, 27 percent reported this source. Only two percent of respondents said they did not know of any source for contraceptives, compared with 25 percent in the baseline survey.

In Bajura, where less than one percent of births had been attended by any kind of health worker, attended births increased impressively. In the final evaluation, CARE-trained and supported Traditional Birth Attendants (TBAs) attended 44 percent of births. In Mahottari, attended births more than tripled, with births attended by a TBA rising to 29 percent from 8 percent. While the project was being implemented, Safer Home Delivery Kits (SHDK) were introduced. The evaluation survey showed that just over one third of births used a SHDK.

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The Multi-Sector Population Project in Peru

Background: Peru suffers from serious deficiencies in access to, and the quality of, family planning services. Access to family planning services is poor because of budgetary constraints (limited health infrastructure and poor transportation) and geography (the coastal desert, the Andean Cordillera and the Amazon jungle each pose unique physical barriers). The quality of the services available is poor because few medical staff have received formal training in reproductive health, or in provider-patient relations, and lack necessary equipment and supplies. Attitudes are a barrier because of myths and rumors surrounding contraceptives (especially in rural areas), and because the public regards health care as curative rather than preventive; clinical facilities, even when close by, are frequently only sought in cases of serious illness.

In response to these needs, CARE is implementing the Multi-Sector Population Project (MSPP). The MSPP is a joint venture for USAID, CARE Peru and the Ministry of Health. MSPP service areas are distributed among Peru's three principal geographic regions, the Pacific coast, the Andean highlands and the Amazon jungle. The MSPP increases access to family planning services by assisting communities to establish networks of volunteer family planning "promoters". The promoters, usually a man and woman in each community, are trained to provide information on family planning, contraceptives (pills, barrier methods, and, in some areas, injectables), and to refer women and men to MOH clinical facilities for alternate long-term methods, or complementary services.

The project also works to enhance the quality of care at MOH clinical facilities. MOH staff receives training in different aspects of family planning counseling and service delivery, and clinical sites are provided with essential equipment, furnishings and supplies on the basis of an on-site diagnosis of needs. Staff is trained to train and supervise the promoters, so that CBD activities can be sustainable.

The MSPP, which began in 1992, includes key reproductive health components, as well as a community organization and empowerment approach that focuses on empowering communities to facilitate, determine and demand responsive reproductive health care. The project is called "multi-sectoral" because it works in conjunction with other CARE Peru projects in the service areas. This coordination strengthens the project in a variety of ways. Familiarity with other CARE projects enhances community acceptance of the MSPP. Community members, organized under existing pro-

jects participate in the selection of the MSPP promoters, and in the use of the services. Support to the MSPP is provided through 8 of CARE's regional offices in Peru.

While changing Peru's geography or improving its transportation system may be out of reach, the MSPP does succeed in bringing family planning information and services closer to its target populations. A network of volunteer family planning "promoters" makes hormonal and barrier contraceptives readily available in peri-urban and rural communities, and provides referrals to MOH clinical facilities for alternate or complementary reproductive health services. The promoters are carefully trained by the project and are able to provide information in terms (including the use of an indigenous language) that are most readily understandable to the people in their communities. Because the promoters are elected by community organizations, they enjoy wide acceptance. This is enhanced by the MSPP's association with other CARE-Peru projects (in health and water, agriculture, food support and small economic activity development).

The MSPP boosts the quality of clinic-based reproductive health services by training staff (topics include contraception, counseling and training techniques), donating equipment (IUD kits, gynecological tables, etc.), and providing regionally-appropriate educational materials (posters, pamphlets, radio advertisements). Quality of care is monitored by project and MOH staff on an ongoing basis.

All of the project's training and IEC activities are directed at changing attitudes. The work of the promoters is extremely important in that it introduces (often for the first time) the concept that fertility can be a matter of choice, and demystifies contraceptives. When the promoters encourage women to go to the local health post for a Pap test, they establish a basis for preventive health care practices. And when the clinical health rare provider has been trained in counseling and provider-patient relations, the patient is that much more likely to return.

Achievements

To date, CARE has trained over 3,650 community promoters and over 1,800 MOH field staff who have provided more than 55,000 CYPs, by supplying acceptors with short-term contraceptives and making referrals to MOH clinical facilities for clinical methods. Project training has covered a variety of areas including human sexuality, family planning options, counseling, and quality of care. CARE has also developed a wide variety of IEC materials that are regionally adapted, colorful and easy to read; these materials are broadly used by community promoters, as well as in the 960 health posts, 43 health centers and 10 hospitals that have improved their family planning services through the project. According to survey data, the contraceptive prevalence rate for the area has increased from 12% in 1992 to 29% in 1997.

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CARE's Reproductive Health for Refugees Initiative

Background: "Crisis and Condoms"
In 1991, through the PFPE Project, CARE began working in the area of MCH/FP in one province of Rwanda. At that time, the political situation was deteriorating and an increasing number of people were fleeing civil unrest. As the displaced population grew, CARE staff repositioned themselves along with the refugees, following or accompanying the population as it moved south away from the fighting. When the displaced settled into other areas, CARE added to its existing relief and MCH activities, by expanding services to include outreach efforts with a team of family planning community volunteers.

When the genocide started in 1994, hundreds of thousands of Rwandans fled to neighboring countries. HIV sero-prevalence rates in Rwanda prior to genocide had been reported to be more than 30% among the urban population. CARE and other organizations including PSI and JSI, with funding from AIDSCAP launched the first HIV/AIDS prevention program for refugees. Many CARE field staff, fleeing for their lives, brought their community-based education and contraceptive distribution experience with them as they moved into the camps.

For the first time ever, CARE staff started training refugee community health educators to provide RH outreach services. Specific responsibilities for the community health educators included delivering HIV/AIDS prevention education messages, distributing condoms and encouraging camp residents to seek treatment for STDs. By the end of the first year, 80,000 people had sought counseling and treatment for STDs as a direct result of the project. The program gradually expanded to three other camps and more than 2,000 peer educators were trained reaching over 700,000 people by the end of the project.

RHR Consortium: Soon afterward, CARE's innovative work caught the attention of the Mellon Foundation, which acknowledged the importance of reproductive health in refugee settings. As a result, the Reproductive Health for Refugees (RHR) Consortium was formed in 1995 to promote the institutionalization of reproductive health information and services in refugee situations worldwide. In addition to CARE, charter Consortium members include the International Rescue Committee, Marie Stopes International and John Snow Research and Training Institute and the Women's Commission for Refugee Women and Children. The RHR Consortium focuses on five essential and complementary technical areas of reproductive health. These are family planning, HIV/AIDS/STDs, emergency obstetrics, ma-

ternal care and sexual and gender violence. Activities involve delivery of educational and clinical services; needs assessment, design and subsequent project development; technical assistance; training; administration of a small grants program; advocacy and public education; creation of a central information databank; and documentation/ dissemination of findings from refugee situations. Since its inception, the RHR Consortium has had considerable influence on refugee reproductive health policy, as well as institutionalization and provision of reproductive health services in refugee settings.

Unique Aspects of the Initiative - **"Do Refugees Have Sex?:"** In 1994, donors and relief workers placed very little effort on reproductive health services in refugee and displaced camps. While some camps offered basic MCH services, they often overlooked comprehensive reproductive health services. When the refugee camps formed in Tanzania, CARE found itself in a unique position, due to its knowledge, understanding and prior RH work in Rwanda. Given CARE's technical expertise that was established through the USAID-supported PFPE Project, CARE was able to respond quickly and competently by developing RH programs designed to meet the special needs of refugee populations and leveraging additional funding to meet these needs.

Major Accomplishments

Participatory Approaches - The Community as Expert*: Over* the past five years, CARE has brought a unique perspective to refugee reproductive health. Through the use of Participatory Learning and Action (PLA) methodologies, CARE has assisted refugees in defining their own problems and generating their own solutions. Participatory methodologies have facilitated communication and have also allowed sensitive areas such as sexual and gender violence to be addressed in conservative communities, albeit in the broader context of women's health. The participatory nature of refugee reproductive health exercises undertaken in Somalia, Rwanda and Kenya maintains a more balanced relationship between relief workers and refugees/displaced communities by allowing refugees to have an important voice in determining the services they need. Several examples from CARE Somalia's Reproductive Health Awareness and Action Project in Yirowe will be highlighted during the presentation.

Materials Development: In order to assist other agencies and organizations interested addressing refugee reproductive health, CARE was charged with producing two training curricula. The first training module was a one- day "awareness building" curriculum which focused on refugee reproductive health programming for relief generalists. The second manual, a five-day training curriculum, is designed to provide comprehensive RH refresher training for clinicians. Both manuals have been widely distributed to the international relief community. Recently, due to strong demand by field practitioners and organizations, CARE reprinted an additional 200 copies of the five-day training manual.

Organizational Commitment: Over the past five years, institutional awareness of the importance of RHR has increased markedly. As part of CARE's disaster preparedness training for field staff, CARE's Emergency Group conducted two training sessions that highlighted RH as a core element in East Africa and Asia. A recent technical assistance request from CARE Australia in Macedonia enabled the deployment of two technical officers to conduct RH needs assessment exercises with Kosovar refugees. Staff also helped the overburdened host populations and health care providers determine the types of RH program interventions most critical for the region. Highlights of key findings from this recent study will be discussed in the presentation**.**

Challenges - "Sustaining the Momentum:" Although the global community no longer ignores the reproductive health needs of women and men in refugee and displaced settings, women's reproductive health issues still need greater international interest, more dedicated personnel, and additional funding to continue building on the accomplishments of the past five years. Through it's own experience, CARE has learned that providing modest seed funding through pilot projects can serve as a substantial motivating factor to allow field office to focus program efforts on RH and to attract donor interest in the field. CARE will continue to ensure that momentum for these crucial issues is not lost.

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Reproductive Health Program Expansion in Uganda

Background: CARE Uganda began its work in the three districts of Kabale, Kisoro and Rukungiri in southwestern Uganda in 1988 through the implementation of the Development through Conservation (DTC) project. This project was designed to educate the communities surrounding the Mbwindi impenetrable and Mgahinga gorilla National Parks about the environmental value of the natural resources within the parks. The Community Reproductive Health Project (CREHP) was designed in 1991 collaboratively by the Ministry of Health (MOH) Uganda and CARE to respond to the demand from the communities, in the same three districts of DTC project operation for Family Planning education and services. The communities and local leadership challenged CARE Uganda for promoting environment conservation activities through the DTC project without tackling the root causes of environmental degradation from the population pressure from a high population growth rate. Both projects have synergistic strategies that focus on the household and particularly women that perform the majority of the agricultural work force in the predominantly subsistence farming and patriarchy society. Together, the two projects and counterparts foster healthier and informed households to enable them support "manageable" families with scarce resources.

Project Design: CREHP which is in its second phase of implementation serves a combined population of 1,205,000 and 769,300 direct beneficiaries, in the three out of 45 districts in Uganda. The first phase of CREHP (CREHP 1) was implemented from 1992 to June 30th 1996. CREHP 1's principal focus was on improving the reproductive health of men and women in Kabale, Kisoro and Rukungiri districts through strengthening family planning services at community level. CREHP 2 consolidates and refines the FP component and introduced only those additional components of Reproductive that are critical in the area as was expressed by the CARE partners.

Project Goal: The goal of CREHP 2 is improved reproductive health of men and women in Kabale, Kisoro and Rukungiri districts by the year 2001. The project has five intermediate goals: 1) Increased use of modern Family Planning (FP) methods in the project area, 2) Increased number of women seeking maternal health services at health facilities, 3) Increased knowledge of FP, MH care and prevention of STI, 4) Increased number of women, men and adolescents seeking STI services, and 5) Improved quality of FP, MH and STI services at delivery points and at community level within the project area. The five year second phase of CREHP has a focus on:

- Consolidating FP activities in order to expand access, increases use and improve quality of services

- Strengthening the Government of Uganda (GoU), Non-Governmental Organizations (NGOs) and private sector health capabilities in the target areas for adequate reproductive health services, and
- Introducing concepts and interventions to improve MH and reduce the prevalence of STI at both community and service delivery points in the three districts
- Providing services to and estimated total number of 769,300 direct beneficiaries.

New Innovations: The project developed and reviewed the following tools to incorporated MH and STI components. These include: 1) FP community based strategy and training curriculum, 2) IEC strategy, 3) Clinical RH curriculums, and 5) Supervision tools. All these adopted guidelines and incorporated lesson learned from MOH, WHO/ Safe Motherhood, CARE International and other RH projects in Uganda.

Achievements: Since 1992, family planning and reproductive health services have been extended from five health facilities to 75 facilities in the project area. The project has contributed to almost 60,000 CYP and the modern contraceptive prevalence rate for the area increased from 2.9% in 1992 to 10.6% in 1996. There have 209 health workers trained in reproductive health and 185 CRHWs have been trained and equipped.

Lessons Learned:

1. Capacity building is cited as CREHP 1's strongest contribution towards providing skills for FP service provision in the three districts of the project operation
2. The overall strategy of working with the existing infrastructure of the District Health Teams, collaborating NGOs and other partners to strengthen clinic-based services has been quite successful. However, there is need for memoranda of understanding with partners/stakeholders to ensure the sustainability of the Community level and clinic based activities as the project increases its activities in RH. The project now has a Project Management Advisory Committee which fosters more involvement of stakeholders in project management to ensure both accountability and sustainability.
3. The projects CRHWs are extremely successful in providing FP information and contraceptive services. However as the project takes on more activities in other components of RH, there is recognized greater need to pay more attention to their knowledge of and ability to provide MH and STI services. Additionally, greater attention needs to be given to improving their selection given the varying needs of communities, the population/ geographical coverage, logistics, contraceptive supply, supervision, incentives and eventual sustainability by the communities.
4. The project developed a good management information system which is now being strengthened and refined by support in training in Data for Decision Making for both project and counterpart staff, with funds from CARE CDC Health Initiative. The training focuses on data collection, recording, analysis, reporting and feedback for effective decision making at all levels.
5. The project experienced serious constraints from the original assumptions on contraceptive supplies, IEC and clinic equipment, in addition to the initial over optimistic estimate of FP acceptors and CYP. The project is now working closely with the private sector for contraceptive social marketing to complement the public sector supplies.
6. Although the project showed an improvement in knowledge of FP methods, finding from the end of CREHP 1 evaluation showed a need for further strengthening of the IEC component which was lacking in quality output and impact despite a high demand from all project stake holders for IEC materials. The IEC strategy has been reviewed to also incorporate MH and STI components.
7. The project client profile compounded by strongly defined gender roles implied a need to focus on men and to reach out to more women at greater risk including adolescents. Nevertheless, this does not mean under estimating the equally strong resistance from women themselves to accepting FP as indicated from the responses of male respondents in the end of CREHP 1 evaluation survey.

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Partnership for Adolescent Sexual and Reproductive Health:
Listening to and Investing in Youth

Background: As with most developing countries, Zambia's population is youthful with 26% of it's nearly 10 million inhabitants aged between 10 and 19 years (Zambia DHS, 1996). Almost 70% of these young people live in poverty and most have limited access to jobs, secondary education and health care.

Most Zambian adolescents are sexually active by their mid-teens and many face social and peer pressure to engage in sexual intercourse at an even earlier age. In a national sample of adolescents from the 1996 ZDHS, more than two thirds of adolescents reported being sexually active by age 18. The 1996 ZDHS stated that by age 19 almost one quarter of girls are pregnant or mothers. In 1994, at the University Teaching Hospital in Lusaka, it was estimated that self induced abortion accounted for up to 30% of maternal mortality and a quarter of these deaths occurred in women under 18.

In addition, STIs including HIV are a major health problem for adolescents. A 1997 study by UNICEF and the National AIDS Program found that adolescents make up about 40% of the STI clients who present to out patient departments in Lusaka (Webb, 1997). According to a 1994 sentinel site survey of childbearing women carried out in nine provinces, 20% of the sample of urban females were found to be HIV positive. Girls in the 15 to 19 year-old age group are five times as likely to be infected with HIV than boys.

Yet, despite high risk of unplanned pregnancy, unsafe abortion and STIs, only a small proportion of adolescents take action to prevent unwanted pregnancy and STIs. According to the 1996 ZDHS, only 4.7% of 15 to 19 year-old girls in Zambia were using a modern method of contraception; condom use was as low as 3.5%.

Project Development: The Health Sector Program at CARE Zambia felt the need to understand the reproductive health needs and concerns of adolescents in peri-urban areas. CARE Zambia was implementing projects, the Community Family Planning project and the Whole Child Health project. Although the CFP project successfully addressed the reproductive health needs of adults, it was felt that little was known about the sexual behavior and reproductive health needs of the adolescents. Based on CARE's experience in the use of PLA for exploration and programming purposes, it was decided that a participatory appraisal on sexual and reproductive health needs of adolescents should be done prior to designing an intervention for the youths.

In March 1996, the first participatory appraisal was conducted in Chawama compound. Using a variety and mix of verbal and visual tools, this methodology helps participants appraise their situations. The results of the Chawama PLA were used to prepare the project proposal for PALS, which was submitted to donors for funding. Participatory appraisals were conducted in 13 other compounds in Lusaka, Ndola and Livingstone where PALS activities were implemented. The PLA results confirmed the DHS findings that adolescents who initiate sex at an early age have multiple sexual partners and lack awareness that they are at risk. The results were disseminated at various levels in order to share the methodology that was developed as well as raise awareness on the gravity of adolescent reproductive health concerns peri urban areas. During these dissemination meetings inputs were sought from major stakeholders such as Neighborhood Health Committee members, parents and clinic staff for designing project activities. This input assisted in tailoring interventions to ideas that reflected community interests and generated a lot of support for the program.

The goal of the project was to reduce adolescent sexual and reproductive morbidity and mortality so that young Zambians can lead healthy productive lives. The project adopted two lines of action:

At the clinic level, the project worked with the Ministry of Health to strengthen the delivery of adolescent sexual and reproductive health services through:

- The creation of adolescent-friendly services, facilitated by the formation of youth friendly corners
- Improving technical competence of health providers with special emphasis on improving interpersonal relationships with adolescents and provision of high quality care
- Supervision and support
- Creation of awareness in the community, the clinic and among adolescents through health education and community outreach activities

At the community level, the project worked with adolescents, Neighborhood Health Committee members, Community Health Workers and Social Welfare Department through:

- Formation of peer support groups whose overall responsibility is to provide peer education (e.g. through drama) and also peer counseling
- Support of adolescent activities such as counseling and health education and provision of social amenities

Unique Aspects of the Project

- Reaching a traditionally hard to find group- i.e. adolescents.
- Developing an adolescent driven intervention by giving adolescents a chance to analyze their sexual behavior, reasons for the same and how they feel their behavior impacts upon their lives in order to address issues that concern them.
- Using PLA to explore sensitive topics i.e. sexual behavior and reproductive health and design a culturally acceptable intervention supported by various stakeholders

Major Accomplishments

- Significant change in provider attitude and proficiency in the delivery of adolescent reproductive health services
- A significant impact on adolescents adoption of healthful behaviors and practices e.g. use of condoms and having one sexual partner
- An increase in the number of adolescents accessing family planning, antenatal, treatment and information on the prevention of STIs including HIV.

FUTURE CHALLENGES- Program **sustainability** is the greatest challenge because:

1) Most youth come from poor families
2) Youth are mobile and their needs keep changing
3) Drug availability for STI treatment is erratic in public sector clinics
4) Although the District Health Management Team and the Central Board of Health support the program they lack the capacity to manage it

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Testing Models of Health Care Delivery and Financing in Ecuador

BACKGROUND: At present, 30% of Ecuador's population, or 4 million people, lack health care coverage; furthermore, there are high morbidity and mortality rates among the maternal and child population. The deterioration and inequity of health care services exacerbate these statistics. In addition, Ecuadorian communities lack local participation, health education, and tend to seek medical treatment rather than preventative health services. At the public sector level, services remain centralized and, therefore, outside local jurisdiction. Communities perceive these services as low quality due to factors such as a shortage of human resources, lack of medical equipment and materials, frequent strikes, etc. Moreover, within both the public and private sector there exists innumerable examples of duplication of activities, nearly all bereft of an integrated, holistic approach to health services.

Until 1992, to address the issues above and to ensure sustainability of its projects, CARE Ecuador worked with the Ministry of Health (MOH). However, an evaluation indicated that sustainability of the projects was quite uncertain, particularly due to MOH's lack of dedication and interest in future funding of the activities. Consequently, with funding from USAID, CARE-Ecuador has administered the Support for Local Organizations Project (APOLO) since 1995 with the mission to improve primary health care by developing models which deliver high quality services and which are equitable, sustainable, and replicable and to focus on promoting health sector reform in Ecuador. APOLO aims to accomplish this goal through the development, expansion, and replication of alternative and sustainable models of health financing and health service delivery and the dissemination of our "lessons learned" with national and international policy makers and the public health community.

- Aspirations for Health Care Reform in five areas: Equity, Solidarity, Quality, Efficiency, and Effectiveness.
- The models use a comprehensive approach in defining personal and community "health" which goes beyond primary health care. As a result, the models encourage integrated solutions including recreational activities, environmental projects, participatory education, & inter-generational opportunities,
- CARE aims to reach sustainability in five areas: social, political, organizational, technical and financial.

- To achieve financial sustainability, APOLO provides TA and training to partners in cost recovery strategies, basic accounting, budget planning, sliding scale fees, targeting of subsidies, and identifying the break-even point.
- **UNIQUE ASPECTS OF THE APOLO PROJECT**APOLO succeeds in improving the effectiveness, quality, and coverage of health care services through fostering collaboration and partnership through increased and alternative approaches to policy makers.
- APOLO is responsive and sensitive to partners' needs in training topics, specific project development, and sustained participation of non-profit private organizations, other private sector entities, and municipalities.
- APOLO promotes policy advocacy in sharing its lessons learned along the way and offering alternative approaches to policy makers.

INNOVATIVE MODELS

- Post-graduate Reform of the Human Resources training program within the Catholic University Medical School to include training regarding the health problems of the lower socio-economic communities. The training encourages development away from a University setting and does not require that the students leave their health practice in order to study. APOLO is advocating that this training model be accepted on a national level.
- The Plan Carnet (sliding scale fee system) assists to categorize people by their socio- economic status. With this system we are able to target subsidies and, thereby, extend the supply of high quality services to low income people.
- Decentralization - Structural change in the Government of Ecuador that encourages joint participation between municipalities and social organizations with the purpose of transferring authority and competencies to the local level and optimizing the management of health services.
- Expanded Health Package - Collaboration with CEMOPLAF an IPPF organization to increase its Health Package in a sustainable manner without jeopardizing the delivery of family planning services while increasing its cost recovery and offering itself as a replicable model.
- Social Franchise Model - Establishes an alternative management model for health services without affecting the financial sustainability of the health organization. The model involves building a primary health care network in which the parent organization offers its services (training, marketing, monitoring and evaluation, supervision, and name) and the franchises, in return, deliver a percentage of their profits.

PROJECT DEVELOPMENT: In 1995, CARE invited 25 organizations to submit their concept papers for evaluation. The 18 organizations that responded did not meet the criteria; nevertheless, APOLO chose to visit these organizations and require them to present their projects based on a standardized formula previously received. From these, APOLO chose 9 organizations with which to conduct a Rapid Feasibility Study (RFS) designed by APOLO. The RFS methodology includes the collection and analysis of data and primary sources of information through focus groups, interviews with key informants, surveys and direct observation. Secondary information is collected through the study of documents from the organization and other sources. This latter information then clarifies the demand for and supply of health services in the area. The specific areas of focus of the RFS include social, technical, political, organizational and financial sustainability of the project.

> *Based on the information gathered through the RFS, APOLO, together with its partners, developed an appropriate model for each organization and its respective location and began implementation. Thereafter, APOLO conducted a more detailed assessment of the capacities of the organizations to identify their strengths and weaknesses. From these results, a Long Range Strategic Plan (LRSP) was developed as well as a work plan, including the TA and training in order to address the respective needs of each organization.*

As a part of the RFS, APOLO also developed a monitoring and evaluation system to measure the results, advances, and impact of each project as a whole and to specifically monitor the social, technical, political, organizational, and financial sustainability of each project. APOLO remains dedicated to systematizing its findings from this process and recording the progress of the models in each of the key areas aforementioned.

MAJOR ACCOMPLISHMENTS TO DATE

- Ten models are successfully in operations and our partners are utilizing the LRSP and other introduced systems [Health Information System (HIS), Human Resources Management, Integrated Management of Childhood Illnesses (IMCI), Monitoring and Evaluation (M&E), etc.]. Two of these models are fully completed and in the phase of being systematized. Additionally, CEMOPLAF (related IPPF organization) hopes to replicate these models within four of its clinics.
- In 1998 the national government approved its National Health Plan in which APOLO assisted them to formulate its policy of decentralization as demonstrated by one of the models (Chordeleg).
- APOLO also participated in a national dialogue by presenting a model of a municipal health committee, which was embraced by the national government to be implemented as a national policy. This strategy is a form of decentralization and advocacy to empower the municipality, community, and health providers to work together using their resources in an efficient manner .
- Nine managerial tools have been published: Institutional Analysis, Rapid Feasibility Study, Qualitative Investigation and Social Marketing, Focus Subsidy Model, Plan Carnet, Operationalizing Equity, Decentralization of Health Services, Costs Handbook for PHC, and IMCI – Fostering Partnerships through the Implementation of Governmental Practices.

Associate organizations have been trained in Benchmarking so that they may identify related products, services, and processes within the scope of the work of partner organizations to exchange ideas and experiences. Additionally, Benchmarking involves encouraging an interchange of technical and operational information in order to assimilate appropriate lessons..

Indicators	Baseline Statistics	Planned	Achieved
Number of models developed	0		10
Number of organizations strengthened		25	41
Innovative models designed		5	8
Innovative mechanisms for health fi-		4	4
Cost Recovery			
Fund. Pablo Jaramillo	N/A		64%
CEMOPLAF Otavalo	36%		71%
CEMOPLAF Lago Agrio	28%		62%
ASME-CX	N/A		69%
Santa Elena	N/A		64%
Chordeleg	N/A		38%
Bolivar	N/A		34%
FUNEDESIN	N/A		15%
Riobamba	N/A		30%
Coverage			225,000
Training and Workshops	0		1048

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