

PDABS-262

104944

U.S. Agency for International Development  
Bureau for Global Programs, Field Support, and Research  
Center for Population, Health and Nutrition

## **STRATEGIC PLAN**

**Center for Population, Health and Nutrition**

December 1995

11

## TABLE OF CONTENTS

<b>I.</b>	<b>CONCEPTUAL FRAMEWORK</b>	<b>1</b>
<b>A.</b>	<b>Critical Functions of the Center for Population, Health and Nutrition.</b>	
1.	Global Leadership	2
2.	Research and Evaluation	3
3.	Technical Support to the Field	4
<b>B.</b>	<b>Operational Approach of the Center</b>	<b>4</b>
<b>C.</b>	<b>Strategies for Priority Setting</b>	<b>5</b>
1.	Country Level Strategy: Joint Programming and Planning Country Strategy	6
2.	Program Level: Priority Activities	6
<b>D.</b>	<b>Opportunities and Constraints</b>	<b>6</b>
<b>E.</b>	<b>Accomplishments and Lessons Learned</b>	<b>7</b>
1.	Accomplishments	7
2.	Lessons Learned	8
<b>F.</b>	<b>Coordination with other Donor Programs</b>	<b>9</b>
<b>G.</b>	<b>Accountability Environment</b>	<b>11</b>
<b>II.</b>	<b>STRATEGIC OBJECTIVES AND RESULTS</b>	<b>12</b>
<b>A.</b>	<b>Overview</b>	<b>12</b>
<b>B.</b>	<b>PHN Center Strategic Objectives and Results</b>	<b>12</b>
	Strategic Objective #1: Increased use by women and men of voluntary practices that contribute to reduced fertility	13
	Strategic Objective #2: Increased use of safe pregnancy, women's nutrition, family planning, and other key reproductive health interventions	13
	Strategic Objective # 3: Increased use of key child health and nutrition interventions	13
	Strategic Objective #4: Increased use of proven interventions to reduce HIV/STD transmission	13
<b>C.</b>	<b>Activities Not Supported</b>	<b>33</b>
<b>D.</b>	<b>Agency-wide Review Process</b>	<b>34</b>
<b>III.</b>	<b>ATTACHMENTS</b>	
<b>A.</b>	<b>Strategic Objective Tree</b>	
<b>B.</b>	<b>Joint Programming, Planning and Special Circumstances Outcome</b>	
<b>C.</b>	<b>Strategic Objective and Program Indicators</b>	

# STRATEGIC PLAN

## Center for Population, Health and Nutrition Bureau for Global Programs, Field Support, and Research

### I. CONCEPTUAL FRAMEWORK

The Population, Health and Nutrition Center ("The Center")<sup>1</sup> strategy is firmly rooted in Agency principles and guidance in the population, health and nutrition (PHN) sector. The Center's strategic approaches directly contribute to the realization of the Agency goal to stabilize world population and protect human health. The Center Strategic Objectives build on thirty years of experience and success, incorporate principles from the Cairo Program of Action (1994) and reflect Agency mandates in the areas of gender and women's empowerment. Shown in Table 1, these objectives directly support and contribute to the achievement of Agency strategic objectives to reduce unintended pregnancies, maternal mortality, infant and child mortality, and STD transmission with a focus on HIV. ( See attachment A, Strategic Objective Tree)

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

The Center's program focuses on improving the availability, quality and use of key interventions in the PHN sector. Sustainability and program integration are important cross-cutting themes. Program sustainability is promoted by building host country capacity to plan and manage programs. A high degree of integration is reflected in the strategic linkages among the Center's objectives: powerful synergies between their subsectors strengthen the impact of all of the objectives. (For further elaboration of the strategic objectives and results, see Part II.)

<sup>1</sup> When we discuss the historical role of PHNC, which was created in 1994, we are referring to the Directorate, the newly created office of Field Support, and previously existing Offices of Population, Health, and Nutrition.

## **A. Critical Functions of the Center for Population, Health and Nutrition**

The Center works to achieve its strategic objectives by providing global leadership, research and evaluation, and field support. These critical functions are unique to the Center and their exercise is essential to providing technical support to Agency strategic objectives in the PHN sector. Integral to this strategy is the pivotal relationship of the Center to key customers and stakeholders within USAID, such as missions and regional bureaus, and outside of the Agency, such as Non Governmental Organizations (NGOs) and host governments.

### **1. Global Leadership**

USAID is a recognized world leader in the population, health and nutrition sector. Over the last thirty years, USAID has been responsible for many major programmatic innovations in the population, health and nutrition field. Many of the program innovations were developed and managed by the Center. Examples include the development and introduction of new and improved contraceptive methods, improved public and private sector service delivery systems, the Child Survival initiative, and the mobilization of the international community in response to the HIV/AIDS pandemic. Perhaps the most powerful force in the Population, Health and Nutrition sector's history has been the strong partnerships between the missions and the Center.

The Center plays a global leadership role that is fundamental to achieving both Center and Agency strategic objectives. The Center's global leadership focuses on two principal activities: policy dialogue and resource mobilization. Moreover, global leadership contributes to the achievement of all results and strategic objectives by enhancing the implementation capacity of USAID-funded field programs and by influencing the wider global community of countries, donors, and non-governmental organizations.

The Center's technical leadership role is expressed through:

**A multi-disciplinary staff.** Working closely with bureaus and with access to the latest technical knowledge, the Center is organized to maintain close contact with country needs and is supported by the Center's research and evaluation portfolio. Task forces and working groups organized around technical themes are an important mechanism to help ensure the Center's responsiveness to new needs.

**Partnerships with Missions.** USAID Missions are the point of direct contact with host countries. The Center attaches critical importance to strengthening country-level capacity for policy dialogue and technical guidance.

**Partnerships with Cooperating Agencies.** The Center's relationships with Cooperating Agencies are a source of technical expertise in policy formulation and the dissemination of technological advances. The Center serves as an important catalyst and source of guidance for CA activities in these areas.

**Intersectoral collaboration.** The Center is in a unique position to examine and foster the intersectoral linkages needed to achieve the Agency's sustainable development goals. Activities include pilot programs assessing the linkages between women's literacy and

fertility reduction, and between reductions in fertility and child mortality and environmental factors. These pilot activities enable policymakers and program managers to better understand the relationships between PHN and other sectors.

**Effective collaboration with other development partners.** The Center promotes USG and Agency interests in its frequent interactions with multilateral agencies, other bilateral donors, and PVOs and NGOs.

**Effective collaboration with the State Department.** The Center helps ensure that chiefs of mission, desk officers, economic counselors, and science attachés are aware of PHN sectoral issues and are able to represent them in relevant international and bilateral discussions.

## **2. Research and Evaluation**

The Center plays a significant leadership role in the arena of research and evaluation, currently managing more than 80 percent of the Agency's research activities in population, health and nutrition. In this capacity, the Center supports the development, testing and dissemination of new technologies and methodologies that address key technical problems and constraints to program implementation in developing countries. For example, results of Center-supported biomedical, operations, demographic, evaluation, applied, and social science research improve services and enhance the impact of population, health and nutrition programs worldwide. The Center plays a key role in developing new, cost-effective technologies such as oral rehydration salts (ORS), new and improved contraceptive methods and the use of vitamin A to enhance child survival. In collaboration with Missions, the Center continues to make a significant contribution to the development of improved operational approaches to PHN tasks. Examples include operations research, community-based distribution systems, and behavior change communications in the area of HIV/AIDS prevention.

Research and evaluation outcomes may be classified into two categories: technologies and program approaches. In the technology field, the Center plays a major role in biomedical research on human reproduction, contraceptive development, the introduction of new contraceptives, and the development, testing, and introduction of new health and nutrition interventions, such as vaccines in child health programs and techniques for the prevention and treatment of diarrhea. With respect to program approaches, research focuses on improving the delivery of family planning and reproductive health services, and behavior changes for reducing risks of disease incidence and improving health practices.

A pioneer in results monitoring, the Center collects and analyzes data to improve program performance and to assess program progress toward achieving global impact. The Center has taken the lead in the development of indicators and methodologies for evaluating programs and trends in the sector. The Demographic and Health Surveys (DHS), a concept originating with predecessor elements of the Center over twenty years ago, is continuously refined and is recognized as providing the best worldwide data for the PHN sector. The Center also reports performance and impact data to the Agency, Congress and other stakeholders, including the general public. Other donors and international agencies rely heavily on these data and analyses for program planning and evaluation.

### 3. Technical Support to the Field

The Center is customer-driven with field missions as its primary clients. The rationale for all of the Center's critical functions is to support the field by providing information, commodities, and services. The Center's field technical support is the critical link through which advances in research are reflected in program improvements at the country level. The Center also works with missions to ensure an appropriate fit between Global Bureau initiatives and country-specific situations, and provides a ready mechanism by which missions can benefit from the experience and knowledge that USAID has gained worldwide.

This technical support functions through core resources which the Center provides to all PHN results packages that carry out field support activities, conduct research and evaluation activities, and which provide support to international organizations. These resources are used to "push the technical envelope" of programs, ensure cross-country fertilization of new ideas and approaches, and support innovative ways of implementing activities.

#### **B. Operational Approach of the Center**

Over the years, the Center, in collaboration with field missions, has evolved a *modus operandi* that has served the field well. The model has its counterparts in the private sector but is rare in the development field. In this model, the Center plays a special role initiating and leading a process that is tested and refined through pilot trials in the field and ultimately used to enhance and contribute to mission programs. In general, this approach follows the sequence of:

- need and/or problem identification
- product/program development
- field testing and validation
- diffusion and marketing
- post-diffusion market testing and refinements
- institutionalization

The Center has a long history of success with this operational approach largely because it is empirically based, considers both efficiency and impact, and is consumer-driven from the start. This process also has multiple applications worldwide and is a mechanism for diffusing technology and innovation from north-to-south and also from south-to-south. This operational approach is exemplified by the contraceptive social marketing program, described below.

The Center shapes programs by drawing on its special capabilities to develop and test new approaches, and then widely disseminating the most effective approaches through mission programs. This strategic approach assures that all missions benefit efficiently from proven worldwide experience. The alternative of Missions attempting to gain similar experience and expertise on their own would be costly, administratively burdensome, and less likely to produce replicable results.

The Center has used the iterative process described above to achieve dramatic increases in contraceptive prevalence and reductions in infant and child mortality worldwide. Program approaches and technologies that have reached millions of women and children include

community-based delivery systems, the development of oral rehydration therapy (ORT), and new contraceptive methods such as Norplant® and low-dose oral contraceptives.

---

### Contraceptive Social Marketing A Case Example

In the early 1970s, a need was identified to make contraceptives more accessible while simultaneously generating revenues that could offset program expenditures and increase operational sustainability. The idea was developed to use commercial distribution channels and marketing techniques to distribute, promote and sell contraceptives at subsidized prices. This concept—contraceptive social marketing (CSM)—had been piloted in India in 1967. The success of the approach, providing consumers with a product they desire at an affordable price, with positive benefits to both the public health and commercial sectors, was further studied and refined.

Over the last 20 years, CSM programs have evolved tremendously. The early programs supplied private sector sales outlets with donated commodities; the products were then resold at low prices. As the program evolved and the market for the commodities expanded, the commercial pharmaceutical sector became involved in the program. Pharmaceutical manufacturers began to supply the products, relying on USAID for technical assistance and support for marketing at the start-up phase of a program.

These recent innovations in sustainability reduced the sales outlets' dependence on the donor community, eliminated all distribution costs, expanded outlets through the use of wholesalers and sub-distributors, and promoted in-country competition by ensuring low price levels and distribution efficiencies. This refined CSM model was first introduced in the Dominican Republic in 1986, and is now implemented in a number of countries including Morocco, the Philippines, Indonesia, Turkey, Bolivia, Peru, Colombia, Ghana, Ethiopia, Zambia, Tanzania, Uganda, etc.

The success of CSM demonstrated the significant role the commercial sector can play in achieving public health benefits. A wide range of other products, including oral rehydration salts, is now available through these channels, including oral rehydration salts. Commercial marketing tools have also contributed substantially to programs in, for example, HIV/AIDS prevention and breastfeeding promotion. To date, more than 50 countries have introduced social marketing—largely with USAID support. By emphasizing the role of the user as an independent consumer who makes his or her own choice of products, social marketing has created new, sustainable ways to reach and serve the public.

---

Management and logistics systems developed through the operational approach have contributed to program sustainability and program institutionalization. At the present time the Center, in keeping with a strategic focus on reproductive health, is using this process to develop rapid STD diagnostics, new contraceptive methods, Vitamin A supplementation, service delivery strategies for safe motherhood interventions, and quality of care initiatives.

#### C. Strategies for Priority Setting

The Agency is confronted with severe resource limitations. Consequently, when considering functional and operational approaches to achieving strategic objectives, the Center must establish priorities in terms of both the countries the Center focuses on and the activities it supports. These priorities must be empirically based, considering both efficiency and impact.

##### 1. Country Level Strategy: Joint Programming and Planning

The Center has taken the lead in developing and implementing the Joint Programming and Planning Country Strategy (JPPC). JPPC is a framework that identifies, in collaboration with Agency partners, priority countries for the PHN sector and establishes mechanisms to maximize access to resources for the highest priority countries. Within the JPPC strategy, joint programming countries are those with the highest potential for worldwide, as well as local or regional impact across the PHN sector and, consequently, are central to the Center strategy. To reach its strategic objectives, a significant level of Center resources will be committed to achieving results in selected countries. (The list of Joint Programming Countries appears in Attachment B)

Joint planning countries are other sustainable development countries that are lower priority in terms of their global impact but are sites for PHN sector activities implemented under bilateral assistance programs. Although less critical to the Center strategy, joint planning countries also receive services funded through Field Support. The Center is committed to develop and maintain strong responsive relationships with these countries and to support their initiatives in the PHN sector.

## **2. Program Level Strategy: Establish Priorities**

The Center has also established priorities at the program and activity level. To determine programmatic direction and focus, the Center considers whether the activity:

- is customer-driven in that there is a clearly stated need/demand;
- is technically feasible;
- has an impact on the problem or condition;
- is critical to achieving the Center's strategic objectives;
- reflects and builds on the Center's comparative advantage;
- promotes cost-effective and sustainable interventions;
- is managerially efficient;
- has the potential to leverage resources;
- is mandated by Congress or of special interest to the Congress and the Administration.

## **D. Opportunities and Constraints**

The coming decade is a particularly important one for the PHN sector. Millions of young people are entering their reproductive ages and, even under the medium fertility assumption of the United Nations, world population is projected to reach 10 billion by the year 2050. More than 12 million children under five still die each year in the developing world. WHO estimates that close to 500,000 women die annually from preventable pregnancy-related

causes. The total global number of HIV infected persons is expected to double from 20 million to 40 million by the year 2000.

While the tasks are daunting, there are clear opportunities to produce significant impact and to attain Center and Agency objectives in the reduction of fertility, infant, child and maternal mortality, and HIV/AIDS transmission. Key positive elements that will contribute to significant achievement in the PHN sector include the existence of a clear demand on the part of consumers for services, and proven technologies and operational approaches to respond to that demand.

The constraints to achieving the strategic objectives are not unique to the PHN sector. At the host country level, success depends on political will to achieve impact, political stability, the availability of an effective and efficient infrastructure, and strong financial support for population, health and nutrition programs.

Other potential constraints to success in the sector may be internal to USAID and relate to the uncertainty of the Agency's budget situation and inadequate staffing in the PHN sector. Indeed, this strategy is based on the assumption of continued support to international development assistance as a whole, and to the sector in particular.

#### **E. Accomplishments and Lessons Learned**

As previously noted, USAID is an acknowledged leader in the PHN sector. This leadership is largely due to USAID's unique combination of a strong field presence and its ability to access technical innovations and benefit from research that closely supports program implementation. One of the important lessons learned over the 30 years of USAID's efforts in the PHN sector is that maintaining a close connection between field implementation and technical innovations is critical to achieving an impact. The accomplishments highlighted below reflect the Center operational approach discussed earlier and highlight the symbiotic relationship between the Center and field missions.

##### **1. Accomplishments**

**Decreases in average family size in the developing world (excluding China) from 6.1 children per woman in the 1960s to 4.2 in 1994.** These decreases can be directly linked to USAID's efforts to expand the use of family planning services. Today, more than 50 million couples use family planning, largely as a result of USAID's efforts. USAID's technical leadership and research activities have been crucial to this outcome. These activities include:

- the development and subsequent widespread use of innovative service delivery models, including community-based distribution and contraceptive social marketing;
- biomedical research on new and improved contraceptive methods, such as improved IUDs, better surgical contraceptive techniques, and the development of Norplant®;
- improved distribution channels,

- innovative interventions, including state-of-the-art communication strategies; the effective use of evaluation data to improve programs and demonstrate needs; and improved management capacity.

**Declines in infant mortality in USAID-assisted countries from an average of 97 deaths per thousand live births in 1985 to 87 per 100 births in 1991.** Launched in 1985, USAID's child survival initiative has had a major impact on infant mortality, and is a direct result of applying technological innovations to targeted field programs. Key achievements include:

- the proportion of the world's children vaccinated against the major vaccine-preventable childhood diseases has increased from 37 percent in 1984 to an estimated 80 percent in the early 1990s;
- Oral Rehydration Therapy has been developed and institutionalized, and is now widely used and accepted as an intervention for diarrheal diseases, preventing millions of infant and child deaths from dehydration;
- interventions have been developed to address micronutrient deficiencies, long known to be linked to blindness and mortality in children

**Eradication of polio from the Western Hemisphere.** USAID's efforts and global leadership in combination with the Pan American Health Organization, the U.S. Centers for Disease Control and Prevention, and Rotary International have been successful in totally eradicating polio from the Western Hemisphere.

**Mobilizing resources to fight the spread of HIV/AIDS.** In less than ten years, USAID's support for HIV/AIDS prevention has leveraged an unprecedented global response to a single infectious disease. Every WHO member country now has a plan for HIV/AIDS control; new interventions to establish sustained behavior change have been developed and introduced; knowledge about HIV/AIDS, means of transmission and prevention practices have increased significantly in the developing world.

## **2. Lessons Learned**

These accomplishments are the result of effective, efficient program activities. Some of the most important lessons to emerge from these programs are summarized below.

**Access to high quality family planning and health programs is important to ensure continued impact and appropriate care.** Components of high quality programs include appropriate training, cultural sensitivity, availability of a range of contraceptive methods, STD screening, comprehensive child survival interventions, and appropriate maternal care. Operations research has shown that where clients are treated with dignity, obtain the method of their choice and are properly counseled, couples are more likely to continue using a modern, effective method of contraception.

**Program sustainability should be addressed at the early stages of program planning.** Planning for sustainability should include steps to improve management, remove legal or

regulatory barriers to service delivery, strengthen local institutions, train managers and service providers, and engage the active participation of the private sector. Two essential lessons for program sustainability are:

- **Programs must make use of a wide variety of implementation channels, including the public sector, nongovernmental organizations, and the for-profit private sector.** Nongovernmental organizations and private voluntary organizations, noted for their innovative approaches, flexibility and responsiveness to client needs, play a critical role. Reliance on a single delivery channel can make a program vulnerable to disruption (or collapse) of that one channel.
- **Local participation is essential in the design and implementation of programs.** It can also contribute to a sense of "ownership" and continued commitment on the part of community members.

**Programs must be constantly improved through technical innovations, managerial improvements, and the application of lessons learned.** For example, after research demonstrated the benefits of vitamin A and micronutrient supplementation in combatting blindness and child mortality, child survival programs began to incorporate supplementation, food fortification and dietary diversification to reduce these deficiencies. Sophisticated communication technologies have been successfully incorporated into information and education campaigns for family planning, HIV/AIDS prevention and child survival programs. These campaigns have reached millions at relatively low cost and have been shown to affect behavior change. Managerial improvements, such as decentralized administration and better handling of vaccines and other critical supplies have greatly improved the reach and quality of public health programs at local levels.

**Continuity at the international, country and community level is essential.** Successful programs require continuous and strong commitment from policymakers, continuous financial and technical support, and a reliable supply of contraceptive or health commodities.

**Demonstrating program impact and unmet need requirements have contributed to policy development and has supported the introduction and/or expansion of key program interventions.** The use of Demographic and Health Survey data in simulation models has helped convince policymakers in many developing countries of the need to launch family planning, child survival and maternal health programs. Techniques to measure the impact of family planning and child survival interventions on decreasing fertility and mortality have been strengthened remarkably, and have been used successfully to refine programs to better meet client needs.

#### **F. Coordination with other Donor Programs**

As a leader among donors in the PHN sector, USAID places great importance on donor coordination as a means to avoid duplication and to ensure that the most urgent program needs are met. Although USAID has a comparative advantage in service delivery programs, other donors often play important complementary roles in other areas such as policy dialogue and training. Donor coordination occurs through formal and informal communication, and

through USAID's leadership in multilateral meetings on population, health and nutrition.

In the population sector, USAID, through the Center, maintains a close working relationship with the United Nations Population Fund (UNFPA), the largest multilateral donor in the sector. USAID continues to cooperate with UNFPA through participation on the U.S. delegation to the UNDP/UNFPA Executive Board, participation on the UNFPA working group on contraceptive requirements and logistics, and through technical consultations with UNFPA staff on operational aspects of integrating reproductive health services into family planning programs. Through its Missions, USAID also coordinates with UNFPA on population program activities at the country level.

The Center also maintains regular contact with the International Planned Parenthood Federation (IPPF) and the World Bank, participates actively on World Health Organization (WHO) task forces and working groups to coordinate biomedical and reproductive health research programs, and has been the largest donor to the WHO Global Program on AIDS (GPA).

USAID carries out a wide range of donor coordination activities in the population, health and nutrition sector at the policy and technical level. A particularly important initiative in the last year has been the formalization of cooperation with counterparts in Japan to undertake joint programming in population, child survival and HIV/AIDS under the U.S.-Japan Common Agenda. Also, the Agency:

- is a leading member of a UNDP working group on health sector reform;
- collaborates with WHO and UNICEF on technical issues related to child health and nutrition, malaria, sanitation, child survival, and women's health;
- collaborates with the UN Joint and Co-sponsored Program in global strategic and country-specific planning for HIV/AIDS;
- is active on UNICEF's Executive Board;
- participates in technical consultations and shares program experiences and lessons learned with major bilateral donors such as Canada, Japan, Germany and the United Kingdom; and
- cooperates actively with private foundations and NGOs such as the Rockefeller Foundation and the Carter Center.

Donor coordination will become even more important in the future as efforts increase to achieve the goals of the 1990 World Summit for Children, the 1994 International Conference on Population and Development, and the 1994 Paris Summit on AIDS. The Center will provide important leadership in this international effort by identifying urgent program needs, mobilizing global resources, and making key technical contributions to program planning and execution.

## **G. Accountability Environment**

USAID must ensure that its programs are responsive and accountable to the end-user. Program managers should strive to meet the individual needs of clients and patients rather than specified targets. Programs should be responsive to needs and problems as they are locally defined, emerging from a bottom-up process rather than being imposed from the top-down. The active involvement of women clients, providers, and community leaders is essential. Center programs seek to involve women at all stages of program design, planning and management to ensure that programs are meeting the real needs of clients. In addition, Center programs encourage the development and involvement of indigenous PVOs and NGOs.

Centrally-managed PHN activities seek input from USAID Missions, regional bureaus, and other donors and—at the country level—local counterparts. This participatory process helps to ensure that the Center portfolio benefits from multiple perspectives and fresh ideas. Moreover, the existence of this large and diverse constituency places the Center under a healthy scrutiny.

In addition to the end-user, the Center has a number of other stakeholders. These include the American taxpayer and the U.S. Congress, host country governments, women's health advocates, people living with HIV infection, NGOs, and other U.S. domestic constituencies. These groups have been routinely involved in examinations of USAID's progress in the PHN sector and in the strategic planning process.

# STRATEGIC PLAN

---

## II. STRATEGIC OBJECTIVES AND RESULTS

### A. Overview

This section presents the content of the Center's Strategic Plan.<sup>2</sup> Section B summarizes the Center's strategic objectives and results. Section C describes the Center's four strategic objectives in more detail, the rationale for selecting each objective, the problem areas to be addressed, the principal results, and key assumptions. The performance indicators selected to measure progress in achieving strategic objectives and results are found in Attachment C.

As the resources available to achieve results and strategic objectives are limited, the Center will not continue to support a number of programmatic interventions that do not address these objectives. These activities are discussed in section D. The process by which the strategic plan was developed and reviewed by clients and stakeholders, as well as by colleagues within and outside the Agency, appears in section E.

### B. PHN Center Strategic Objectives and Results

As noted in Section I, the Center's strategic objectives contribute to attainment of the Agency's strategic objectives and goal. The four strategic objectives for the PHN sector are linked. Although each strategic objective could be pursued independently, there are obvious relationships and synergies. For example, improvements in child survival affect fertility behavior; healthy women are more likely to bear healthy children and to be able to care for them. Improved birth spacing contributes to maternal and child health, while use of barrier methods of family planning helps prevent sexually transmitted diseases, including AIDS. Prevention of HIV/AIDS is important to the health of women and their children. Breastfeeding contributes to birth spacing as well as child survival.

It should also be noted that the Center's strategic objectives are consistent with the strategic objectives of many USAID Missions and regional bureaus. This is to be expected because the Center shares responsibility with missions and regional bureaus for planning, implementing and monitoring PHN programs in USAID-assisted countries. By accessing the Center's technical capability through pre-positioned contractors, missions can benefit from a wide range of proven expertise and experience. If secured independently, this expertise would be costly, would present an enormous management burden on missions and, perhaps, would produce less technically sound results.

The results are intermediate-level outcomes that guide programs and activities and allow the Center to monitor progress.

Each of the Center's strategic objectives has four program results. These 16 results are intermediate-level outcomes that allow the Center to closely monitor progress toward the

---

<sup>2</sup> See Attachment A, Strategic Objective Tree.

strategic objectives. Importantly, these results reflect the role that the Center plays in its three critical functions: technical leadership, research and evaluation, and technical support to the field.

<b>Table 3. Strategic Objectives and Results Center for Population, Health and Nutrition</b>	
<b>Strategic Objectives</b>	<b>Results</b>
<b>S.O. 1. Increased use by women and men of voluntary practices that contribute to reduced fertility</b>	<b>P.O. 1.1 New and improved technologies and approaches for contraceptive methods and family planning developed, tested, evaluated and disseminated</b>
	<b>P.O. 1.2 Improved policy environment and increased global resources for family planning programs</b>
	<b>P.O. 1.3 Enhanced capacity for public, private, NGO and community-based organizations to design, implement, and evaluate sustainable family planning programs</b>
	<b>P.O. 1.4 Demand for, access to, quality of family planning and other selected reproductive health information and services increased</b>
<b>S.O. 2. Increased use of safe pregnancy, women's nutrition, family planning, and other key reproductive health interventions</b>	<b>P.O. 2.1 Approaches and technologies to enhance key reproductive health interventions identified, developed, evaluated and disseminated</b>
	<b>P.O. 2.2 Improved policies and increased public and private sector resources and capacity to deliver key reproductive health services</b>
	<b>P.O. 2.3 Access to essential obstetric services increased in selected countries</b>
	<b>P.O. 2.4 Quality of essential obstetric services increased in selected countries</b>
<b>S.O. 3. Increased use of key child health and nutrition interventions</b>	<b>P.O. 3.1 New and improved cost-effective interventions developed and disseminated</b>
	<b>P.O. 3.2 Improved policies and increased global, national and local resources for appropriate child health interventions</b>
	<b>P.O. 3.3 Enhanced knowledge of key child health and nutrition behaviors/practices in selected countries</b>
	<b>P.O. 3.4 Improved quality and availability of key child health/nutrition services</b>
<b>S.O. 4. Increased use of proven interventions to reduce HIV/STD transmission</b>	<b>P.O. 4.1 Effective interventions to reduce sexual transmission of HIV/STD identified, strengthened, implemented and evaluated in emphasis countries</b>
	<b>P.O. 4.2 Improved methods and tools for reducing perinatal and parenteral HIV transmission available for program use in emphasis countries</b>
	<b>P.O. 4.3 Enhanced capacity for public, private, NGO and community-based organizations to design, implement and evaluate HIV/STD prevention and care programs</b>
	<b>P.O. 4.4 Knowledge, availability and quality of HIV/STD interventions increased in emphasis countries</b>

The Center will achieve its results and strategic objectives if:

- **USAID continues to be a global leader in population, health and nutrition. The availability of significant levels of USAID human and financial resources for the PHN sector will ensure that the Center has the capacity to influence policies and to design, develop and implement programs.**

- **Other donors and international agencies continue to be active partners.** Sustained commitment from other donors is crucial to achieving PHN strategic objectives. USAID cannot do it alone.
- **Host country and other stakeholders continue to play key roles.** Host country governments, communities, foundations, NGOs and PVOs must maintain if not increase support for activities in the sector.

The Center recognizes the reinforcing role of activities in related sectors. These include interventions that improve the role and status of women, facilitate equitable economic growth, reduce environmental degradation, and promote political stability and good governance. These activities are supported by other units in the Agency and/or by other donors and are not a primary focus for the Center.

### C. Strategic Objectives and Results of the Center

#### Strategic Objective #1: Increased Use by Women and Men of Voluntary Practices that Contribute to Reduced Fertility

Center Strategic Objective #1 and Program Results	
Strategic Objective	Program Results
1. Increased use by women and men of voluntary practices that contribute to reduced fertility.	1.1 New and improved technologies and approaches for contraceptive methods and family planning identified, developed, tested, evaluated, and disseminated
	P.O. 1.2 Improved policy environment and increased global resources for family planning programs
	P.O. 1.3 Enhanced capacity for public, private, NGO and community-based organizations to design, implement, and evaluate sustainable family planning programs.
	P.O. 1.4 Demand for, access to, and quality of family planning and other selected reproductive health information and services increased.

#### 1. Rationale

This strategic objective contributes to the Agency's strategic objective of reducing unintended pregnancies, which in turn, contributes to the sector goal of stabilizing world population and protecting human health. When and at what level the world's population stabilizes depends in large part on the speed of the fertility transition. Therefore, the strategic objective is directed toward reduced fertility.

Some developing countries have completed or are near completing this fertility transition. However, many more are at the mid-stage of this transition and a large number are still at early stages. Fertility has declined dramatically in the developing world since the mid-1960s,

with average completed family size declining from more than 6 to 4.2 children per woman by 1994 (excluding China). To stabilize world population at between 8 and 9 billion by the year 2025, fertility levels in developing countries will need to decline further to 2.6 children per woman. As fertility in developing countries was very high a decade or two ago, large numbers of women are either in or entering their reproductive ages. Though individual women are having fewer children on average than their mothers, there are simply more women having children today. This phenomenon, called population momentum, means that programs must meet the needs of a growing number of people.

Data on fertility and reproductive intentions in developing countries indicate that actual fertility exceeds desired fertility by nearly one child per woman. Fertility can decrease through a variety of means, including delayed age at first birth, prolonged postpartum amenorrhea achieved through breastfeeding, use of family planning, and abortion.<sup>3</sup> The voluntary practices referred to in this strategic objective include all of these behaviors except abortion.

There is ample evidence to demonstrate that family planning programs are the most effective means to close the gap between actual and desired fertility. An estimated 56 percent of the decline in fertility in the developing world can be attributed to family planning programs. Family planning programs not only increase contraceptive use, but promote breastfeeding, reduce reliance on abortion, help prevent sexually transmitted diseases, and contribute to lower desired family size. Other interventions, such as female education, also indirectly affect fertility by delaying age at first birth and reducing desired family size.

Family planning programs are most effective when they respond to individual needs. The most successful programs provide ready access to high quality, affordable, and voluntary services. The emphasis on voluntarism in this strategic objective underlines USAID's commitment to and respect for individual reproductive rights and needs and informed choice in matters relating to family planning.

Finally, Strategic Objective #1 explicitly refers to both women and men because the voluntary practices that relate to fertility reduction differ for women and men. Male responsibility in sexual and reproductive behavior is critical. Increased use by men of available methods and support by men for women's use of contraception, breastfeeding and decisions concerning sexual activity, marriage and childbearing are also essential.

## 2. Problem Areas to be Addressed

Despite important family planning successes, a great deal of work remains to be done. While modern contraceptive prevalence in the developing world (excluding China) has increased dramatically from roughly 10 percent in 1965 to 42 percent in 1994, approximately 120 million women have an unmet need for family planning services today. These women have expressed a desire to space or limit childbearing, but are not currently using any method of contraception. Actual unmet need is much higher if young adults, unmarried

---

<sup>3</sup> These factors are referred to in the scientific literature as "proximate determinants" of fertility.

women, and women and men who use inappropriate methods are included. During the next decade, more than 200 million additional women will enter their reproductive years, owing to population momentum, presenting new challenges for delivering needed services.

Given this large existing and projected unmet need for services and the proven success of family planning programs in reducing fertility, the Program of Action adopted at the 1994 International Conference on Population and Development (ICPD) recommended that all countries work toward achieving universal access to quality family planning and reproductive health services by the year 2015. Consistent with this goal, USAID's population assistance will focus on improving the accessibility, quality and responsiveness of family planning and related reproductive health services in recipient countries.

USAID has concentrated its effort on maximizing access to information and services and improving the quality of care in family planning. Center programs support all the components of family planning programs, including service provision, training, information and communication, sound program management, research, commodity procurement and logistics, policy development, and program evaluation.

Family planning services are the most cost-effective reproductive health intervention and will continue to be the predominant focus of USAID's population assistance program. New emphasis, however, is being given to broadening the range of services to include, where feasible and appropriate, other selected components of reproductive health, such as HIV/STD prevention, post-abortion care, and prevention of harmful practices.

Young adults present an important new program challenge, particularly given the large numbers of young women and men entering their reproductive years. At present, these groups are often neglected by family planning and reproductive health programs, and are exposed to the risk of unintended pregnancy and/or sexually transmitted disease. To address this problem, the Center has developed a new initiative to provide basic education on reproductive health and contraception before the onset of sexual activity. The initiative will encourage abstinence and delayed marriage and onset of sexual activity; address the issue of school drop-out due to unintended pregnancy; provide sensitive and confidential family planning information and services; and lay the basis for life-long reproductive health.

In addition, programs must involve men more fully in family planning. More communication and shared decision-making on family size and family planning matters between partners need to be encouraged, and male responsibility for sexual health, fertility, and child-rearing should be fostered.

### **3. Program Results**

Four program results contribute to the achievement of the first strategic objective.

**P.O. 1.1: New and improved technologies for contraceptive methods and family planning identified, developed, tested, evaluated and disseminated.** The Center will continue to focus on increasing the number, quality and acceptability of available contraceptive methods, and on identifying and developing improved contraceptive methods and interventions to enhance the availability and acceptability of family planning and

reproductive health programs. The activities carried out by the Center will, for example, build on past successes in introducing new IUDs, condoms, and hormonal contraceptives into national programs. The vast majority of USAID funding for this work comes from the Center.

**P.O. 1.2: Improved policy environment and increased global resources for family planning programs.** The Center will continue to work with USAID Missions to encourage host country governments to define, promulgate and implement policies related to the provision of quality family planning and reproductive health services. At the same time, the Center will urge national governments and international donors and lenders to provide increasing support for family planning and reproductive health programs.

**P.O. 1.3: Enhanced capacity for public, private, NGO, and community-based organizations to design, implement, and evaluate sustainable family planning programs.** The Center will focus efforts on improving the management capacity of family planning provider organizations, including the development of strategic plans and management information systems. The Center also will provide assistance to host country organizations to strengthen business and marketing skills and to develop strategies for increasing cost recovery and financial sustainability.

**P.O. 1.4: Demand for, access to, and quality of family planning and other selected reproductive health information and services increased.** The Center's activities will increase demand for the adoption of voluntary practices that contribute to improved reproductive health and reduced fertility. Center initiatives are designed to increase awareness of and demand for family planning and reproductive health interventions by improving the policy environment, public information and communication, and spousal communication on family planning and reproductive health issues.

The Center recognizes that demand for reproductive health services is influenced significantly by women's educational levels and child mortality patterns. Demand for family planning tends to be higher among better-educated women, and to increase as infant and child mortality levels decline and couples have greater certainty that their children will survive.

The Center will optimize the supply of modern, effective, affordable, and high-quality family planning and reproductive health services. It will also emphasize efforts to involve women in the design and management of family planning and reproductive health programs and to ensure the accessibility and sustainability of high-quality service delivery systems.

The Center will achieve this program outcome by supporting programs to:

- maximize access and quality of care;
- improve service delivery strategies and systems;
- ensure a regular and adequate supply of a broad range of contraceptives;
- improve access to accurate and comprehensive family planning information;

- institutionalize training systems and improve human resource capability in service delivery institutions;
- improve the management capacity and capability of service delivery organizations;
- increase the participation of women in the design, planning and management of family planning and reproductive health programs;
- enhance public and private sector participation in service provision; and
- test, implement, and evaluate integrated family planning and reproductive health delivery approaches.

The Center, in cooperation with USAID Missions and with assistance of the Cooperating Agencies (CAs), is well-placed to address each of these program priorities. USAID is the preeminent donor engaged in the provision of family planning and related reproductive health services. Technical leadership, developed over the past 30 years, and an experienced cadre of trained population specialists enable the Center to exercise strong leadership in international efforts to address individual family planning and related reproductive health needs.

#### 4. Key Assumptions

Strategic Objective #1 and associated results can be achieved if:

**Meeting individual reproductive needs continues to lead to fertility reduction.** One of the core operating principles of USAID's population assistance program is that individuals and couples have the right to determine freely and responsibly the number and spacing of their children; USAID's role is to help provide the necessary information and means to do so. The U.S. has always opposed and continues to oppose any use of coercive practices in family planning programs.

Experience has proven that when safe, modern, affordable family planning services are made widely available, there is ample demand for such services and, hence, fertility declines.<sup>4</sup> It is assumed that desired family size will continue to decline in USAID-assisted countries, and that meeting individual reproductive needs will continue to result in significant reductions in fertility.

#### 5. Monitoring and Evaluation

Service statistics systems developed in the early days of family planning program implementation served as the primary source of data for the acceptor-based evaluation methods used at the time. Concerns about data quality and the fact that service data covered only a subset of the population (i.e., those being served by the program) called attention to the need for population-based data. Despite early skepticism about feasibility and expense,

---

<sup>4</sup> It is acknowledged that the timing and pace of the decline have varied from country to country.

household surveys were seen as the best way to collect the data needed to validate program estimates of contraceptive acceptance, use, and continuation and to then describe contraceptive use and fertility in the population at large. Support from USAID and other donors led to the launching a series of multinational survey efforts such as the World Fertility Surveys (WFS), then Contraceptive Prevalence Surveys (CPS) and now the Demographic and Health Surveys (DHS).

Over the years, WFS, CPS and DHS have provided excellent sources of data on contraceptive knowledge and use, fertility trends, and perceptions of program image and thus have provided measures of many of the family planning indicators, including sustainability, that have been developed. These surveys have been the primary source of information on reproductive health behavior in the developing world. The DHS Project has conducted over 80 surveys covering nearly fifty countries since 1984. DHS will provide one of the primary sources of data for evaluating Strategic Objective 1.

An unfortunate legacy of the move to supplement data from program-based systems with that from surveys is that program information systems in most countries were neglected. As a result, data resources available today that measure family planning program effectiveness are almost totally dependent on household surveys. While these surveys are an excellent source of data on individuals' behaviors and perceptions, they do not provide information on internal program features such as training, logistics, supervision, and management. Gaps in availability of program data seriously constrain evaluation capabilities in many locations, especially with respect to data on program inputs.

The Service Availability Module of the DHS, carried out in some countries, and Situation Analyses, conducted by the Office of Population's Operations Research project, provide at least some of the data needed to evaluate program inputs. These two sources are likely to take on increasing importance as more emphasis is placed on tracking program inputs. In addition, a revitalization of program data systems and better coordination of new and existing program and population-based data collections strategies will be priorities.

**Strategic Objective #2: Increased Use of Safe Pregnancy, Women's Nutrition, Family Planning, and other Key Reproductive Health Interventions**

<b>Center Strategic Objective #2 and Program Results</b>	
<b>Strategic Objective</b>	<b>Program Results</b>
<b>S.O. 2. Increased use of safe pregnancy, women's nutrition, family planning, and other key reproductive health interventions</b>	<b>P.O. 2.1 Approaches and technologies to enhance key reproductive health interventions identified, developed, evaluated and disseminated</b>
	<b>P.O. 2.2 Improved policies and increased public and private sector resources and capacity to deliver key reproductive health services</b>
	<b>P.O. 2.3 Access to essential obstetric services increased in selected countries</b>
	<b>P.O. 2.4 Quality of essential obstetric services increased in selected countries</b>

1. Rationale

Despite overall improvements in health status in developing countries, maternal mortality remains at very high levels. Estimated average maternal mortality rates in developing countries are 450-500 per 100,000 live births—nearly 15-20 times as high as in developed countries. In sub-Saharan Africa, the risk of death associated with pregnancy is as much as 200 times the risk in developed countries. Worldwide, over 500,000 women die during pregnancy and childbirth each year; 98 percent of these deaths occur in developing countries. A large percentage of these deaths are due to abortion-related morbidity and mortality. For every maternal death, there are 14 stillbirths and neonatal deaths; most are due to the poor health status of the mother and lack of proper care during pregnancy and delivery.

Poor maternal nutrition is an underlying cause of much of this morbidity and mortality. Conservative estimates are that:

- 500 million women suffer from anemia;
- 500 million women are stunted as a result of childhood protein-energy malnutrition;
- 250 million women suffer the consequences of severe iodine deficiency (i.e., goiter, cretinism, deaf-mutism); and
- 2 million women are blind due to vitamin A deficiency.

Most maternal deaths are preventable. The most common direct obstetric causes of maternal death in developing countries are hemorrhage, infection, hypertensive disease, obstructed labor and consequences of unsafe abortion. These major complications of pregnancy can be prevented or treated with known technologies, namely family planning, micronutrient supplementation, immunization, life-saving skills training, and recognition and case management of the most common problems. The potential mortality reductions and cost-savings associated with emergency treatment of septic and incomplete abortion have been well-documented. The challenge facing the Center is to identify and apply low-cost, technically appropriate interventions in settings characterized by limited infrastructure and inadequate human and financial resources.

There are also important synergies between the Center's efforts to reduce fertility and maternal mortality. High-risk pregnancies, specifically those in women less than age 18, over age 34, less than two years apart, or to women with four or more children continue to be one of the most important factors influencing maternal mortality. Births spaced too closely and poor maternal nutrition affect infant mortality. Many women, however, are unaware of these increased risks or lack ready access to needed information and services. USAID assistance in family planning will focus increased attention on these high-risk groups, both to reduce the unmet demand for family planning and to reduce the morbidity and mortality associated with these high-risk pregnancies.

Interventions to improve reproductive nutrition have been tested and shown to be cost-effective in multiple country settings. Iron supplementation and malaria chemoprophylaxis have boosted birth weights while improving mothers' nutritional status. Targeted behavior-change communications can alter harmful nutritional practices at the individual and

community level. Improved reproductive health reduces maternal and infant and child mortality, and contributes to the acceptability of, and demand for, family planning services.

## **2. Problem Areas to be Addressed**

Despite the efforts to date, most women in developing countries are not seen during pregnancy or delivery by a health worker who is able to educate mothers regarding care and nutrition during pregnancy or to identify and manage high-risk pregnancies. More importantly, few women have access to life-saving obstetric services critical to the reduction of maternal mortality.

Maternal nutrition has also received little attention. Although the importance of anemia in influencing pregnancy outcomes has been documented and efforts have been made to increase the availability of iron supplements, only a small fraction of women receive and consume the recommended amounts. It is also known that few women in developing countries are aware of the special nutritional requirements during pregnancy and lactation, and few well-designed communications efforts to address this issue have been undertaken to date.

Finally, sexually transmitted diseases and other reproductive tract infections often go undetected or untreated in women, leading to ectopic pregnancy and infertility and, in pregnant women, to prematurity, stillbirth, and spontaneous abortion. Left untreated, these infections can also facilitate the transmission of HIV. Technically sound reproductive health care is seldom offered within the context of routine health services and, if offered, is often of poor quality.

## **3. Program Results**

The burden of morbidity and mortality associated with reproductive health is enormous and complex. Moreover, while much is known about the causes and consequences of poor maternal health and nutrition, much less is known about how to intervene, especially in severely resource-constrained situations. For the foreseeable future, high technology models of care are simply not affordable. Consequently, the Center will develop and test low-cost, technically feasible interventions and replicate those interventions having proven efficacy.

The core of the Center's reproductive health strategy will continue to be the reduction of high-risk pregnancies through the provision of safe and effective family planning services. Under its expanded initiative, however, USAID will seek to provide women and their families with the knowledge needed to reduce harmful practices and facilitate access to quality reproductive health services. Through this initiative, women will:

- seek and receive improved care during pregnancy, delivery, and the post-partum period, including family planning counselling and services;
- have access to and use emergency (life-saving) obstetric care in targeted countries;
- receive and consume recommended iron supplements during pregnancy and following delivery; and

- increase their intake of nutrient-dense foods during pregnancy and lactation.

The Center's unique role in this global effort is the development and testing of new or improved technologies or approaches to altering reproductive health behaviors and delivering key services. It is expected that models successfully tested under this initiative will be scaled-up and implemented with financing from host countries and other donors.

**P.O. 2.1: Approaches and technologies to enhance key reproductive health interventions identified, developed, evaluated and disseminated.** New models for delivering antenatal and life-saving obstetric care will be designed and evaluated in the field. These models will assess the use of new technologies (e.g., slow release iron supplements), the effects of increased use of non-physician health personnel, the incorporation of improved methods of detecting/referring women with pregnancy-related complications, and the promotion of safe pregnancy with family planning and other reproductive or maternal health services. Using behavior change communications, new techniques for improving food consumption patterns during pregnancy will be evaluated. In addition, methods to enhance the availability of and compliance with iron supplement regimens will be assessed, as well as methods for preventing STD/HIV.

**P.O. 2.2: Improved policies and increased public and private sector resources and capacity to deliver key reproductive health services.** In conjunction with USAID missions, other donors and host country counterparts, USAID will contribute to efforts to heighten awareness of the importance of reproductive health services and to develop policies and programs that enhance the quality and availability of such services. This assistance will document, for example, the burden of poor reproductive health services on young adults and the barriers to improving access and quality of reproductive health care. The Center will also play a leading role in developing and testing the methods and curricula needed to train health professionals in reproductive health practices. A target group for such capacity building efforts will be private sector providers who have often been neglected but who are a primary source of care in many countries.

**P.O. 2.3: Access to essential obstetric services increased in selected priority countries.** Using behavior change communications techniques, alternative approaches to enhancing knowledge and altering care-seeking behavior will be designed and tested in selected countries. These interventions will be designed to ensure that women, their husbands, mothers-in-law, and others influential to decision-making have correct knowledge of the complications of pregnancy and know where to go to receive life-saving obstetrical care. The Center will also work with missions and host country counterparts to design and implement programs to enhance the availability of essential obstetric care. This will include, for example, helping to design bilateral programs and leveraging other donor resources to finance equipment, supplies, and the construction or renovation of facilities.

**P.O. 2.4: Quality of essential obstetric services increased in selected countries.** To reduce the morbidity and mortality associated with pregnancy and delivery, the quality of care in referral facilities must be dramatically upgraded. Service providers will be trained in basic life-saving skills and counseling skills in all phases of reproductive health care, namely: pregnancy, delivery, postpartum, post-abortion, family planning, and STD/HIV prevention.

The Center is uniquely positioned to assist developing country counterparts design and test improved approaches for delivering essential obstetrical care, design curricula and train service providers, and develop and implement behavior change strategies. Center assistance also complements financing available from other donors for construction, equipment, and medical supplies.

#### **4. Key Assumptions**

Strategic Objective #2 and associated Results can be achieved if:

**USAID is able to develop and test appropriate interventions to deal with the most significant causes of maternal morbidity and mortality. Additional work is needed to pinpoint the interventions and approaches that will have the greatest impact on maternal mortality and morbidity.**

**Host country and donors scale-up successful pilot activities. To have a large-scale impact, host countries and other donors must be willing and able to finance the costs of scaling-up models with proven efficacy. The Center has sufficient resources to develop and test the models and approaches but looks to host country governments and other international donors to support the construction or renovation of facilities and provide equipment, supplies, and recurrent costs needed to achieve national coverage.**

#### **5. Data Sources**

**USAID, through Center-supported projects, plays a leading role among donor agencies and host countries in the development of indicators for use in monitoring programs aimed at reducing pregnancy-related morbidities and maternal death. These indicators reflect necessary components in the causal pathway to maternal survival and will provide programmatic guidance and evidence of improved outcomes. In 1995, Center-funded activities in countries including Bolivia, Guatemala and Indonesia will begin to field test these key program indicators, which will then be evaluated and modified as needed for national program use in these and other countries. Indicators included in the Center performance measurement plan have been closely guided by these efforts.**

**As program approaches for reducing maternal deaths have been refined, significant gaps in available data have become apparent. Thus, performance monitoring in this strategic objective area is in formative stages and requires continued support to advance the state-of-the-art. Household surveys such as the DHS can provide important data on availability of services, knowledge and maternal recall of practices surrounding pregnancy and delivery. Additionally, a key set of interventions will need to be monitored within facilities designated to appropriately treat complications of labor and delivery. Systems to record and report on data of this type are only now being developed and tested.**

**The Agency goal to contribute to a one-half reduction in maternal mortality also poses measurement difficulties. Measurement of maternal mortality levels and trends is widely-recognized as very difficult. While an estimated 500,000 maternal deaths occur annually, most occur in remote villages and are not identified through routine data collection. In**

addition, compared to the number of pregnancies and births that occur annually, maternal deaths are statistically rare, thus requiring very large samples of the population to provide valid measures. Information on maternal deaths from causes such as unsafe abortion are extremely hard to obtain, making such data virtually unavailable. The Demographic and Health Survey project has recently added the capacity to measure maternal mortality and is currently the only source of nationally-representative data for multiple countries.

### Strategic Objective #3: Increased Use of Key Child Health and Nutrition Interventions

Center Strategic Objective #3 and Program Results	
Strategic Objective	Program Results
S.O. 3. Increased use of key child health and nutrition interventions	P.O. 3.1 New and improved cost-effective interventions developed and disseminated
	P.O. 3.2 Improved policies and increased global, national and local resources for appropriate child health interventions
	P.O. 3.3 Enhanced knowledge of key child health and nutrition behaviors/practices in selected countries
	P.O. 3.4 Improved quality and availability of key child health/nutrition services

#### 1. Rationale

USAID's approach to improving child health and nutrition has focused on developing and applying effective low-cost interventions that address the principal causes of morbidity and mortality.

This effort has achieved impressive results:

- worldwide immunization rates of children against the six major vaccine-preventable diseases rose from 37 percent in 1984 to an estimated 80 percent in the early 1990s;
- the use of ORT increased from 12 percent (1983) to over 40 percent of diarrhea episodes (1991);
- polio was eradicated from the Americas (1994), and
- Indonesia has successfully eliminated child blindness resulting from severe vitamin A deficiency.

These unprecedented improvements in child health save an estimated 4.2 million children's lives worldwide each year and have reduced infant mortality in USAID-assisted countries by more than 10 percent since 1985.

USAID is a global leader in child health and nutrition. Substantial investments in child survival-related research (\$650 million) and implementation activities (\$4 billion) between 1985 and 1994 have produced the enviable record noted above. The Center played a leading role in applied research (e.g., oral rehydration therapy) which has had impact worldwide, far beyond the countries in which the research was conducted.

In many cases, the Center plays a leading role in implementing key child health and nutrition activities. For example, the Center has made pioneering contributions to the development of modern communication and social marketing methods, quality assurance techniques, and health care financing approaches as applied to child health and nutrition programs in the developing world.

But the job is not done. While child survival programs have achieved dramatic decreases in mortality among children, an estimated 13 million children under five years of age still die each year in the developing world. Most of these deaths are due to acute respiratory infections, diarrhea, and perinatal causes. In Africa, malaria accounts for up to 20 percent of child deaths. In addition, many millions more children suffer acute morbidity and disability.

Recent analyses also report that over one-half of infant and child deaths in the developing world are due to the interaction between undernutrition and disease; most of this interaction appears to be the result of potentially reducible mild and moderate degrees of undernutrition rather than severe starvation.

## **2. Problem Areas to be Addressed**

Child survival includes a variety of interventions. Some, like ORT and immunization, have been supported by donors and host country governments for over a decade and have met the early challenges of creating awareness and facilitating access. For the present and future, the key challenge is to ensure the appropriate use of these interventions through sustainable service delivery systems.

Other programmatic areas of child survival (e.g., ARI<sup>5</sup> diagnosis and treatment and the prevention and/or treatment of malaria in selected African countries) have received less attention and assistance. Programs in breastfeeding and appropriate child feeding also need to be expanded, especially at the community level. Finally, the problems of quality of services, excessive reliance on public sector services, and dependence on donor assistance remain to be addressed. Thus, the major problem areas to be addressed by the Center are:

- the low level of actual and appropriate use of ORT, especially in hard-to-reach areas;
- the dependence of developing countries on donor funding for vaccine supplies and the decline of immunization levels in selected countries;
- the lack of early and appropriate detection and treatment of pneumonia;

---

<sup>5</sup> acute respiratory infections.

- the absence of early diagnosis and prompt treatment of malaria;
- the low level of early initiation of breastfeeding and appropriate child feeding practices in selected countries;
- inadequate performance of health systems to deliver child health program to those in need;
- insufficient private sector involvement in the delivery of child health programs; and
- special concerns such as persistent diarrhea, treatment of very young infants, dietary management of illness, and emerging health issues.

### 3. Program Results

The strategic objective will be accomplished through four specific program results.

**P.O. 3.1: New and improved cost-effective interventions developed and disseminated.** A range of technologies and interventions will be developed, evaluated and available for adoption by national programs. These will focus on improving prevention and case management interventions against vaccine-preventable diseases, diarrhea, pneumonia, malaria and micronutrient deficiencies.

**P.O. 3.2: Improved policies and increased global, national and local resources for appropriate child health interventions.** The Center will focus on fostering a favorable policy environment and increasing public and private sector human and financial resources to support child health activities. Emphasis will be placed on ensuring that national and local resources are invested to address priorities in child health, such as increasing host country financing of essential child vaccines and using private sector channels to increase the availability of essential child health commodities such as ORS.

**P.O. 3.3: Enhanced knowledge of key child health and nutrition behaviors/practices in selected countries.** The Center will introduce and/or expand effective information, education, communication and behavior change activities, and identify and implement strategies to facilitate the adoption of effective preventive and care-giving behaviors by households and communities.

**P.O. 3.4: Improved quality and availability of key child health/nutrition services.** The Center will promote improvements in the availability and quality of child health services. The Center will foster the development and implementation of policies, plans and programs promoting standards for quality of care and the routine availability of essential child vaccines and pharmaceuticals. The Center will also encourage the adoption and implementation of new and improved care, in cost-effective interventions focusing on correct case management for CDD,<sup>6</sup> ARI, and in selected African countries, malaria.

---

<sup>6</sup> CDD refers to control of diarrheal diseases.

#### **4. Key Assumptions**

Strategic Objective #3 and associated program results can be achieved if:

**Strategies tested on a small scale can be scaled up to have a larger impact. New technologies and methods need to be tested and validated in a limited area. However to have an impact on infant and child mortality, activities will need to be expanded. Based on past successes, the Center is confident that successful pilot activities can be replicated on a larger scale by communities, host country governments and other donors.**

**Improved health services, better caretaker practices and greater household and community demand will increase the sustainability of child survival services. If services are improved and the consumers of those services express greater demand and support for care, child health services will be more sustainable and require less outside support. Evidence to date supports this assumption but close program monitoring will be required to ensure that the desired long-term sustainable impact is achieved.**

#### **5. Monitoring and Evaluation**

**The Center's commitment to child survival includes a strong foundation in monitoring and evaluation of program performance and impact. A standard set of core process and intermediate-outcome indicators has been used to monitor the global program, to manage regional and country programs, and to report annually to Congress. Working in partnership with UNICEF, WHO, and host countries, USAID makes considerable investments in the data needed to track progress in child survival. These efforts contributed to a set of globally agreed-upon goals at the 1990 World Summit for Children, which are scheduled for mid-decade evaluation through surveys to be carried out in over 100 countries.**

**Performance indicators for the strategic area of child health and survival focus primarily on knowledge and practices within households and communities and among health providers/facilities. At an impact level, DHS data provide the best available direct measures to assess the Agency's goal of reducing infant and under-five mortality. DHS data also cover many of the Center's performance indicators at the strategic objective level.**

**Center-supported projects are developing indicators for new challenges and program emphases, such as measuring the sustainability of child survival programs, quality of services delivered by health workers and individual and community-level behavior change. Additional new child survival approaches, such as integrated management of childhood illnesses, will require corresponding measures for performance monitoring. Building on past efforts, innovative methods such as the preceding birth interval technique that measures under-two year old mortality, are being developed for local use and to provide measures of childhood mortality at the national, provincial and district levels.**

## Strategic Objective #4: Increased Use of Proven Interventions to Reduce HIV/STD Transmission

Center Strategic Objective #4 and Program Results	
Strategic Objective	Program Results
S.O. 4 Increased use of proven interventions to reduce HIV/STD transmission	P.O. 4.1 Effective interventions to reduce sexual transmission of HIV/STD identified, strengthened, implemented and evaluated in emphasis countries
	P.O. 4.2 Improved methods and tools for reducing perinatal and parenteral HIV transmission available for program use in emphasis countries
	P.O. 4.3 Enhanced capacity of public, private, NGO and community-based organizations to design, implement and evaluate effective HIV/STD prevention and care programs
	P.O. 4.4 Knowledge, availability and quality of HIV/STD services increased in emphasis countries

### 1. Rationale

WHO estimates that 18 million adults and 1.5 million children throughout the world have been infected with the human immunodeficiency virus (HIV). According to WHO, the global total could double to 40 million by the year 2000. The majority of this increase will take place in the developing world, which has over 85 percent of current cases (WHO/GPA 1995).

Unlike other major communicable diseases (malaria, measles, infectious diarrheas, etc.), HIV/AIDS primarily affects young adults, generating prolonged morbidity and death in their most productive years. HIV has become the leading cause of adult deaths in high prevalence countries, overburdening fragile hospital and community-based health care systems, robbing children of HIV-positive parents, and facilitating the resurgence of other killers such as tuberculosis. Young women are at greater biological and social risk of HIV infection than their male counterparts, highlighting the need to address gender and other inequities.

HIV prevention is critical, since infection and infectiousness are irreversible, and have enormous personal and societal consequences. HIV has profound direct impacts on family, community, and national economies. In the most severely affected countries of Asia and East Africa, approximately 25-30 percent of household income is being devoted to care and support costs for family members with HIV-related illness. In many areas, individual and family reserves that could otherwise be devoted to economic advancement, education, and civic participation are exhausted. In the most seriously affected countries, the epidemic will reduce productivity and GNP per capita, and create an enormous human and financial burden for the health care system. The potential political and economic destabilizing effects are of great concern.

In 1987, USAID launched a major initiative to address the global HIV/AIDS pandemic. Since then, the Center has become the acknowledged leader in the design and implementation of HIV/AIDS prevention and control programs. Center leadership has been able to mobilize

technical expertise, from both the U.S. and developing countries, in areas such as epidemiology, STD control, international health, and behavior change communications to address this issue.

The Center has worked closely with host country and other donor colleagues to develop and test innovative approaches to delivering HIV/AIDS prevention services. These include, for example:

- incorporating HIV/AIDS and other STD messages into ongoing social marketing programs;
- the design and implementation of community-based approaches to educating persons about HIV/AIDS and promoting safe sexual practices;
- strengthening condom distribution systems;
- using local media (e.g., street theater) to educate about HIV/STDs and to promote safe sex;
- using highly participatory approaches, often involving high-risk groups, to plan and implement program interventions; and
- developing and testing simple and effective approaches to improve the diagnosis and treatment of STDs.

## **2. Problem Areas to be Addressed**

Despite the success to date in increasing knowledge about HIV/AIDS and making condoms more available, much remains to be done. Interventions successfully tested on a small-scale need to be expanded. Reliable condom supply and distribution systems for HIV/AIDS prevention are still not in place in many countries, and techniques for involving the community in planning and implementing programs are only beginning to be applied. New, simplified approaches to diagnosing and treating STDs, though demonstrated to be effective, remain to be adopted in many national programs.

In the absence of effective drug therapy or a vaccine, USAID will continue to refine and expand prevention interventions. Among the important unmet needs are improved female-controlled methods, such as vaginal microbicides, and improved, low-cost diagnostics, both for STDs as well as HIV.

The Center strategy continues to make prevention of sexual transmission the first priority, since this activity is likely to have the greatest impact. The Center will also continue to build local capacity, strengthen NGO involvement and provide technical assistance in the following three areas:

- HIV/STD prevention programs using proven strategies to prevent transmission;

- policy reform addressing social, cultural, regulatory and economic issues related to HIV/AIDS and other STDs; and
- development and testing of new strategies and methods to prevent transmission.

While the Center will focus on prevention, there is a critical need to develop affordable approaches to assisting people infected with, and affected by, HIV. This need is most critical in Africa where HIV prevalence has reached very high levels. NGOs and community-based organizations, together with people living with HIV, are key to designing and implementing effective programs.

Finally, resources are insufficient to address the pandemic. While the U.S. has been a major contributor to this global effort from the outset, support from other international donors has been disappointing as has been host country financial allocations to combat the epidemic. The Center looks to the new UN Joint and Co-sponsored Program (UNAIDS) to mobilize increased host country and donor support for this global emergency.

### 3. Program Results

The primary focus of USAID's program strategy will be to build upon and scale-up program interventions that have been shown to be effective in reducing the risk of HIV transmission. This will include increasing the correct use of condoms (and female-controlled methods) among high-risk groups, increasing the use of effective STD diagnosis and treatment services, and increasing the use of new technologies for reducing the risk of perinatal and parenteral transmission.<sup>7</sup> Finally, the Center expects that new community-level approaches for caring for persons living with HIV will be in place in selected priority countries.

It is important to emphasize that unlike other diseases, HIV/AIDS must be addressed before it surfaces as a major cause of morbidity and mortality. For that reason, criteria that will govern the allocation of Center resources for HIV/AIDS will consider not only those countries already seriously affected, but those countries (particularly in Asia) where the potential is high for the rapid spread of the disease. Four program results will contribute to achieving Strategic Objective #4.

**P.O. 4.1: Effective interventions to reduce sexual transmission of HIV/STD identified, strengthened, implemented, and evaluated in emphasis countries.** The Center will focus on improving technologies and approaches aimed at reducing the sexual transmission of HIV/STD. Technologies to be developed, such as female-controlled methods, are integral to successful risk reduction along with prevention programs that offer increased access (e.g. through condom social marketing) to condoms and enhanced skills to empower women to protect themselves. New approaches to behavior change communications, community-based service delivery and case management of STDs will be evaluated and results disseminated. These efforts will result in new and effective tools for program implementation.

---

<sup>7</sup> Parenteral refers to transmission through blood.

**P.O. 4.2: Improved methods and tools for reducing perinatal and parenteral HIV transmission available for program use in emphasis countries.** The Center will invest in the development and testing of new approaches and technologies for reducing perinatal and parenteral transmission of HIV. This will include, for example, use of vitamin A to reduce the risk of perinatal transmission, and the testing of new blood pooling techniques to reduce the cost of screening. Large-scale use of these technologies/approaches, once successfully tested, may be financed by local governments or other donors.

**P.O. 4.3: Enhanced capacity of public, private, NGO, and community-based organizations to design, implement, and evaluate effective HIV/STD prevention and care programs.** The Center will work with key public and private sector organizations to build host country capacity to design and manage effective HIV/AIDS programs. Participatory approaches to program planning, involving people living with HIV and high-risk groups (e.g., commercial sex workers, truckers, etc.) will be used. Under this initiative, the Center will assist host countries in mobilizing local financial resources to support HIV/STD prevention programs.

**P.O. 4.4: Knowledge, availability and quality of HIV/STD services increased in emphasis countries.** Under this program outcome, an effort will be made to enhance the number of public and private sector service delivery points where STD/HIV information and services can be obtained. This will include, for example, the introduction of STD/AIDS messages into social marketing programs, establishment of new condom outlets, and training of private sector service providers. STD diagnosis and treatment will be strengthened through the introduction of new standards of practice for STD/HIV screening, clinical case management and surveillance of STDs. Behavior change communications programs, designed to alter high-risk behaviors and enhance community awareness of STDs and demand for STD treatment will also be implemented.

The Center is uniquely capable of influencing the achievement of these outcomes. Through its network of regional and country-level technical staff, the Center is able to provide continuous on-site technical assistance. No other donor possesses this capacity. In addition, USAID is the largest donor to the UN Joint and Co-sponsored Program on AIDS (UNAIDS). Through USAID financial and technical support, the Center will play a critical role in shaping the implementation of this important program.

#### **4. Key Assumptions**

Strategic Objective #4 and associated program results can be achieved if:

**The transition from the Global Program on AIDS to the Joint and Co-sponsored Program does not interrupt ongoing country-level technical assistance and program activities.**

**The new Joint and Co-sponsored Program is successful in mobilizing the increased donor and host country financing for the implementation of national HIV/AIDS prevention programs.**

**International donor and host government financing is available to help finance the growing requirement for condoms and for drugs to treat STDs.**

**The level of political will and commitment to addressing the HIV/AIDS issues increases rapidly, especially in countries currently seriously-affected and in those likely to be seriously affected in the future.**

## **5. Monitoring and Evaluation**

Measuring success in the area of HIV/STDs is challenged by factors including the stigma attached to HIV/STD conditions, the absence of a protective vaccine or cure for HIV, the asymptomatic nature of many sexually-transmitted diseases and the biological, social and geographic dynamics of HIV/STD transmission. For example, due to the latency period between infection and disease, sometimes up to ten years, even in the presence of extremely effective prevention interventions, decreases in HIV prevalence will not be measured for at least five to 15 years at a national level. Thus, HIV/STD program performance measurement relies on the use of interim markers and indicators with an approach that distinguishes between short- (program process), medium- (program outcome) and long-term (program impact) tiers. The state-of-the-art in HIV/STD performance measurement is evolving rapidly and many of the indicators discussed here are in the development and field-trial stages.

Through the Center, USAID collaborated with WHO to establish a set of global prevention indicators to be used both by national HIV/AIDS control programs and by the donor community. At the process and outcome measurement level, these indicators include: knowledge by the target audience of preventive practices, condom availability, use of condoms, proportion of the population who report "non-regular" sex partners and the quality of STD case management. At least three of these indicators appear in the Center plan for performance measurement. Selected for their usefulness for program monitoring and relative ease of measurement, these indicators are measured through: community surveys for condom outlet assessment, health facility surveys, and cross-sectional studies conducted in antenatal clinics. In addition, an HIV/AIDS module recently developed by the DHS provides data on several of these indicators. To date, DHS AIDS/STD surveys are completed for several HIV/STD emphasis countries.

With the increased emphasis on curable STDs which exacerbate the HIV epidemic, and on integrating HIV/STD prevention and management interventions into family planning and other health care settings, new indicators for evaluation are being developed by the Center. These would assess the awareness and demand for appropriate medical treatment of microbial STDs and the degree of integration, quality and utilization of services. Priority outcome measures will include the level of "safer sex" practice in both conjugal and casual relationships. The world-wide "double-standard" in sexual practices requires gender-specific HIV/STD programming and these indicators thus disaggregate progress in male and female behavior change.

USAID experience demonstrates that national commitment and community-level participation are essential for long-term, sustainable HIV/STD prevention and care. New indicators have

been developed to track progress in strengthening the participation of affected communities and commitment to HIV/STD prevention at the national level.

#### **D. Activities Not Supported**

The Center will design, implement and evaluate a wide range of activities to achieve its program results and strategic objectives. Within each strategic objective area the Center focuses on the most efficacious and cost-effective interventions. Described below are interventions that, in general, will not be supported.

**Under Strategic Objective #1: Increased use by women and men of voluntary practices that contribute to reduced fertility.** Foreign assistance legislation prohibits the use of funds by USAID "for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions."<sup>8</sup> Consistent with this legislation, USAID does not provide any support for abortion information and services. Indeed, one of the aims of providing broader access to quality family planning services is to reduce the incidence of abortion. The Center will not support infertility treatments; however, it does support efforts to prevent the spread of STDs, a major cause of infertility.

**Under Strategic Objective #2: Increased use of safe pregnancy, women's nutrition, family planning, and other key maternal health interventions.** The Center will support safe delivery care and timely detection and case management of complications. However, although included in the WHO package of essential obstetric services, the Center will not support caesarean sections, blood transfusions, or the provision of essential drugs and supplies.

**Under Strategic Objective #3: Increased use of key child health and nutrition interventions.** The Center will not support isolated campaign approaches for immunization, production facilities for ORS and essential drugs, or the construction/renovation of facilities. Research on or programs addressing hepatitis, yellow fever or other diseases outside the key program areas (CDD, EPI,<sup>9</sup> malaria and ARI) will not be supported.

**Under Strategic Objective #4: Increased use of proven interventions to reduce HIV/STD transmission.** The Center recognizes the need for treatment of opportunistic infections for individuals living with HIV. However, given the program's primary focus on preventing HIV/STDs, the Center will not supply or distribute drugs to mitigate the impact of HIV/AIDS or STDs.

In general, the Center will not support long-term training or basic research. Other units of the Agency are responsible for training activities. The Center's biomedical, demographic, social science and operations research program focuses on meeting practical program needs. The Center's research focus is on short- to medium-term research that enhances program operations and impact.

---

<sup>8</sup> 22 U.S.C. § 2151b(f)(1) (1992)

<sup>9</sup> EPI refers to Expanded Program of Immunization.

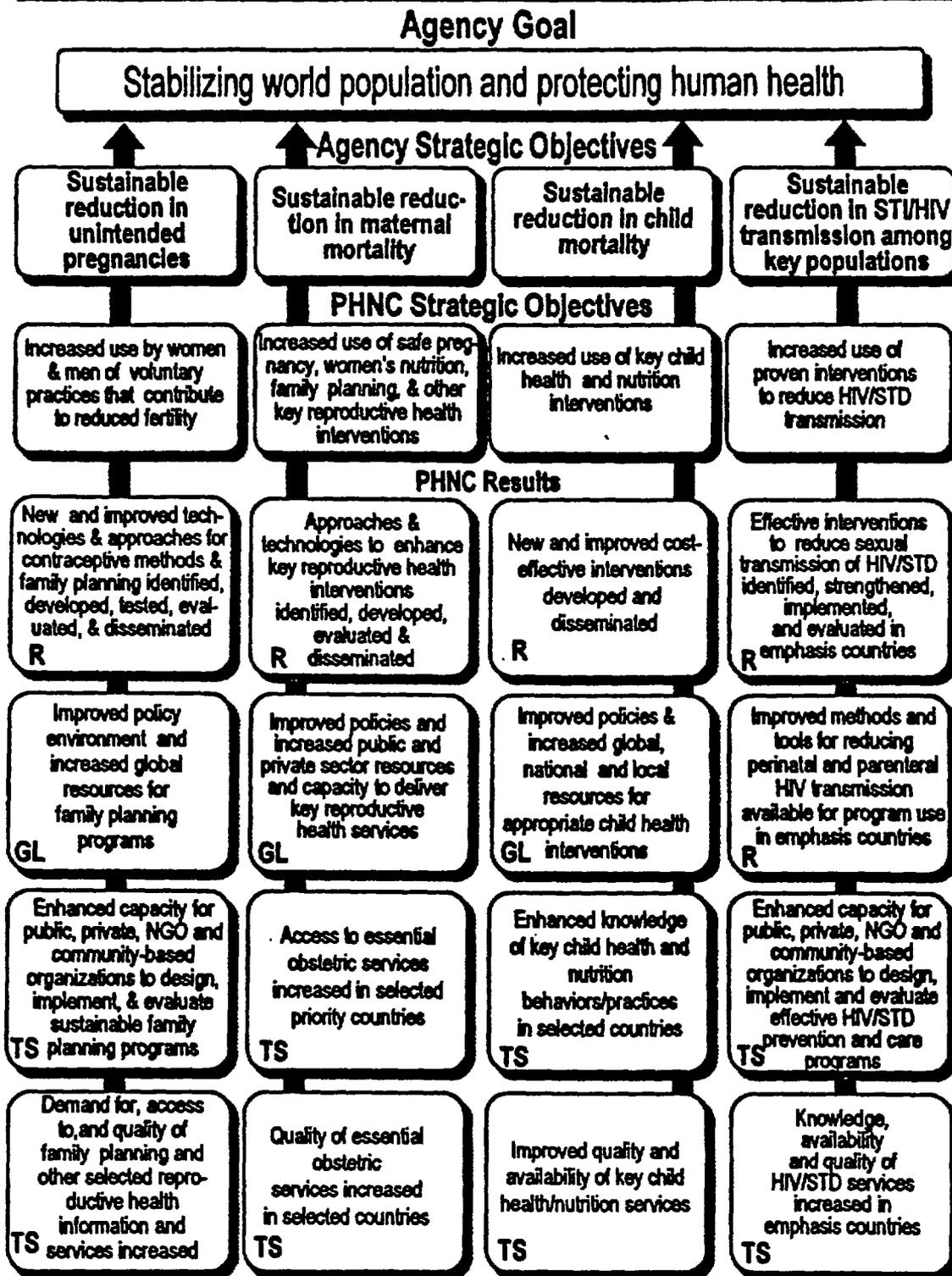
## **E. Agency-wide Review Process**

In the course of developing this strategic plan, Center management and staff interviewed management and staff of other Centers in the Global Bureau, regional bureaus and selected missions. These interviews, in person and through e-mail, were designed to obtain information from Agency colleagues that would contribute to defining PHN strategic objectives, focusing PHN programs, and enhancing the impact of activities. This strategic plan reflects this input.

In addition the Center Strategic Plan has been shared widely with colleagues in the Agency (bureaus, missions), as well as multi- and bilateral donors and lenders, and the Center's Cooperating Agencies. Input received from Center staff and all other reviewers has been incorporated into this final version of the Strategy.

# Attachment A: Strategic Objective Tree

## Strategic Objective Tree: PHN Center



**Predominant focus:** R = Research & evaluation GL = Global leadership TS = Technical support

## Attachment B: Joint Programming, Planning and Special Circumstances Countries and Regions

Joint Programming Countries	Special Circumstance Countries	Joint Planning Countries	Joint Planning Regions
<p><b>Africa</b></p> <p>Ethiopia Ghana Kenya Nigeria South Africa Tanzania Uganda</p> <p><b>Asia</b></p> <p>Bangladesh Egypt India Indonesia Morocco Nepal Philippines</p> <p><b>Latin America</b></p> <p>Peru</p>	<p><b><u>Significant investment</u></b></p> <p>Brazil Colombia Mexico Turkey</p> <p><b><u>Policy</u></b></p> <p>Cambodia West Bank/Gaza Pakistan Regional Support Mission (RSM) Russia</p> <p><b><u>Crisis</u></b></p> <p>Haiti Rwanda/Burundi</p>	<p><b>Africa</b></p> <p>Benin Eritrea Guinea Madagascar Malawi Δ Mali Δ Niger Δ Zambia Δ Mozambique Senegal Zimbabwe</p> <p><b>Asia/NE</b></p> <p>Jordan Yemen</p> <p><b>ENI</b></p> <p>Ukraine Romania Krygyz Republic Tajikistan Turkmenistan Uzbekistan</p> <p><b>Latin America</b></p> <p>Dominican Republic Bolivia Δ Ecuador El Salvador GuatemalaΔ Honduras Jamaica Nicaragua Paraguay</p>	<p>West Africa</p> <p>Southern Africa</p> <p>Greater Horn of Africa</p> <p>LAC Regional</p> <p>Central American Regional</p>
<p>Δ FOR RECONSIDERATION OF DESIGNATION IN 1996</p>			

## Attachment C: Strategic Objectives and Results

Performance indicator	Primary data source	Data availability
<b>STRATEGIC OBJECTIVE 1: Increased use by women and men of voluntary practices that contribute to reduced fertility</b>		
1. Modern contraceptive prevalence rate for currently married women	Demographic and Health Surveys; Contraceptive Prevalence Surveys	A
2. Modern contraceptive prevalence rate for currently unmarried women	Demographic and Health Surveys; Contraceptive Prevalence Surveys	A
3. Proportion of women fully breastfeeding for six months	Demographic and Health Surveys; Centers for Disease Control	A
4. Proportion of women who had a birth before age 20	Demographic and Health Surveys; Centers for Disease Control	A
5. Proportion of women who have had intercourse before age 20	Demographic and Health Surveys; Centers for Disease Control	A

The data availability column provides an assessment of availability based on existence of collection systems and costs of collection.

"A" indicator data are available through the DHS or DHS-like surveys and reporting mechanisms.

"B" indicator data are collected by various sources but not as readily available as A-type data. For example, country-specific data compiled by UN agencies or other partner organizations. In some cases, these indicators are being operationalized and validated.

"C" indicator data are proposed for performance monitoring and will be validated in the field through operations research and indicators for program use and data collection systems and sources established.

Performance indicator	Primary data source	Data availability
<b>Program Outcome 1.1: New and improved technologies and approaches for contraceptive methods and family planning identified, developed, tested, evaluated and disseminated</b>		
<b>1. Number of new contraceptive products in each of the following categories:</b> a) Pre clinical studies in progress b) Pre clinical studies completed c) Phase I trials in progress d) Phase I trials completed e) Phase II trials in progress f) Phase II trials completed g) Phase III trials in progress h) Phase III trials completed i) Phase IV trials in progress j) Phase IV trials completed k) FDA approvals in progress l) FDA approvals granted m) No. of methods adopted by no.of country programs	Conrad, FHI	B
<b>2. Number of strategies/sub-system improvements tested or demonstrated:</b>	Population Council	B
<b>3. Major findings identified for application in programs</b>	Population Council	B
<b>4. Service delivery programs and/or policies that incorporated changes based on Operations Research results</b>	Population Council	B

Performance indicator	Primary data source	Data availability
<b>Program Outcome 1.2: Improved policy environment and increased global resources for family planning programs</b>		
1. Number of countries with formal population policies.	PRB Policy Files	B
2. Number of countries where population concerns are integrated into national development plans	PRB - U.N. Global Review and inventory of Population Policies (1991,1993)	B
3. Contraceptive Policy Index (CPI)	PRB, UNFPA & POP Council; <u>Family Planning and Population: A Compendium of International Statistics, 1993</u>	B
4. Resources (per WRA) for family planning and reproductive health in USAID joint programming countries	PRB - PAI <u>Financing the Future: Meeting the Demand for Family Planning 1994</u>	B
5. LDC resources (per WRA) for family planning and reproductive health in USAID joint programming countries	PRB - PAI <u>Financing the Future: Meeting the Demand for Family Planning 1994</u>	B
6. Share of service delivery by LDC private sector	Demographic and Health Surveys	A

Performance indicator	Primary data source	Data availability
<b>Program Outcome 1.3: Enhanced capacity for public, private, NGO and community-based organizations to design, implement and evaluate sustainable family planning programs</b>		
1. Scale for capacity building/sustainability		C

Performance indicator	Primary data source	Data availability
<b>Program Outcome 1.4: Demand for, access to and quality of family planning and other selected reproductive health information and services increased</b>		
1. Mean desired family size	Demographic and Health Surveys	A
2. Percent of women of reproductive age who want another child	Demographic and Health Surveys	A
3. Percent of women of reproductive age who want to space next birth at least 24 months	Demographic and Health Surveys	A
4. Mean number of modern methods known by women of reproductive age	Demographic and Health Surveys	A
5. Percent of women who can travel to the source within half an hour	Demographic and Health Surveys	A
6. Mean length of using a temporary modern contraceptive method	DHS	A

Performance indicator	Primary data source	Data availability
<b>STRATEGIC OBJECTIVE 2: Increased use of safe pregnancy, women's nutrition, family planning and other key reproductive health interventions</b>		
1. Percent of women attended at least once during pregnancy by medically trained personnel for reasons related to pregnancy	Demographic and Health Surveys	A
2. Percent of births in selected priority countries attended by medically trained personnel	Demographic and Health Surveys	A
3. Percent of women with serious obstetric complications receiving emergency obstetric care	Project reporting	B/C
4. Percent of antenatal clients receiving iron supplements in selected priority countries (per recommended guidelines)	Project reporting	C
5. Percent of births at high risk due to maternal age, parity or spacing	Demographic and Health Surveys	A

The data availability column provides an assessment of availability based on existence of collection systems and costs of collection.

"A" indicator data are available through the DHS or DHS-like surveys and reporting mechanisms.

"B" indicator data are collected by various sources but not as readily available as A-type data. For example, country-specific data compiled by UN agencies or other partner organizations. In some cases, these indicators are being operationalized and validated.

"C" indicator data are proposed for performance monitoring and will be validated in the field through operations research and indicators for program use and data collection systems and sources established.

Performance indicator	Primary data source	Data availability
<b>Program Outcome 2.1: Approaches and technologies to enhance key reproductive health interventions identified, developed, evaluated, and disseminated</b>		
<b>1. Technologies evaluated and available (e.g.):</b> a) impact of low-dose vitamin A on post-partum and neonatal sepsis	Project reporting	A
<b>2. Approaches evaluated and available (e.g.):</b> a) models for obstetric care training b) models to enhance access/use of essential reproductive health services by young adults c) costs of provision of essential obstetric care d) interventions to improve dietary intake of iron	Project reporting	A  A  A  A

Performance indicator	Primary data source	Data availability
<b>Program Outcome 2.2: Improved policies and increased public and private sector resources and capacity to deliver key reproductive health services</b>		
<b>1. Number of priority countries with policies and implementation plans in place for</b> a) safe pregnancy b) breastfeeding promotion	Project reporting	A  A
<b>2. Number of selected priority countries with competency-based training for selected reproductive health interventions incorporated into national curricula (e.g. life saving skills training and breastfeeding promotion)</b>	Project reporting	B

Performance indicator	Primary data source	Data availability
<b>Program Outcome 2.3: Access to essential obstetric services increased in selected countries</b>		
<b>1. Percent of adults with knowledge of complications related to pregnancy and childbirth</b>	<b>Project reporting or modification of existing surveys</b>	<b>C</b>
<b>2. Percent of adults with knowledge of the location of essential obstetric services</b>	<b>Project reporting or modification of existing surveys</b>	<b>C</b>
<b>3. Number of selected priority countries with systems in place to monitor access to essential obstetric care (EOC)</b>	<b>Project reporting</b>	<b>C</b>

Performance indicator	Primary data source	Data availability
<b>Program Outcome 2.4: Quality of essential obstetric services increased in selected countries</b>		
<b>1. Number of facilities adopting prototype systems for:</b>		
<b>a) recording and aggregating complications by cause</b>	<b>Project reporting</b>	<b>B</b>
<b>b) monitoring admission-intervention interval for hemorrhage as part of a quality assurance program</b>	<b>Project reporting</b>	<b>B</b>
<b>c) monitoring case fatality rates</b>	<b>Project reporting</b>	<b>B</b>

Performance indicator	Primary data source	Data availability
<b>STRATEGIC OBJECTIVE 3: Increased use of key child health and nutrition interventions</b>		
<b>1. Prevention</b> Percent of: a) children fully immunization by age 1  b) children age 6-60 months receiving vitamin A supplementation  c) infants less than 4 months of age exclusively breastfed	Demographic and Health Surveys and other household surveys	a) A  b) B  c) A
<b>2. Treatment of illness:</b> Percent of: a) children under age five receiving ORS, recommended home fluids or increased fluids for diarrhea  b) Acute respiratory infections cases correctly managed	Demographic and Health Surveys, other household surveys and project reporting systems	a) A  b) B

The data availability column provides an assessment of availability based on existence of collection system and costs of collection.

"A" indicator data are available through the DHS or DHS-like surveys and reporting mechanisms.

"B" indicator data are collected by various sources but not as readily available as A-type data. For example, country-specific data compiled by UN agencies or other partner organizations. In some cases, these indicators are being operationalized and validated.

"C" indicator data are proposed for performance monitoring and will be validated in the field through operations research and indicators for program use and data collection systems and sources established.

Performance indicator	Primary data source	Data availability
<b>Program Outcome 3.1: New and improved cost-effective interventions developed and disseminated</b>		
<b>1. Technologies evaluated (e.g.):</b> a) ARI vaccines b) malaria vaccines c) vaccine vial monitors d) malaria diagnostics	Project reporting	a) A b) A c) A d) A
<b>2. Approaches evaluated (e.g.):</b> a) integrated case management of the sick child b) methods to sustain behavior change c) integrated supervision d) methods to increase availability of impregnated bednets	Project reporting	a) A a) A a) A a) A

Performance indicator	Primary data source	Data availability
<b>Program Outcome 3.2: Improved policies and increased global, national, and local resources for appropriate child health interventions</b>		
<b>1. a) Number of countries financing child vaccines from national budget</b> <b>b) Number of countries meeting vaccine self-financing levels</b>	Data collection through Vaccine Independence Initiative	a) B b) B

Performance indicator	Primary data source	Data availability
<b>Program Outcome 3.3: Enhanced knowledge of key child health and nutrition behaviors/practices in selected countries</b>		
<b>1. Percent of caretakers with correct knowledge of:</b> a) the symptoms and signs of acute respiratory infection needing assessment  b) appropriate treatment of diarrhea I) careseeking II) increased fluids III) continued feeding	<b>Demographic and Health Surveys and other household surveys</b>	   a) A   a) A

Performance indicator	Primary data source	Data availability
<b>Program Outcome 3.4: Improved quality and availability of key child health/nutrition services</b>		
<b>1. Percent of facilities:</b> a) capable of providing standard case management for ARI  b) capable of providing case management for diarrhea	<b>Facility-based surveys conducted by projects and partners</b>	   a) B  b) B
<b>2. Number of selected countries where key health commodities are available at affordable prices through commercial outlets and private providers (e.g.)</b> a) ORS b) ARI drugs c) bednets d) iron and mineral supplements	<b>Project level reporting</b>	   B
<b>3. Number of selected countries with program guidelines in place for:</b> a) micronutrient deficiencies b) integrated case management of sick children c) quality assurance techniques incorporated into pre-service and in-service training	<b>Data available through projects and partners</b>	   B

Performance indicator	Primary data source	Data availability
<b>STRATEGIC OBJECTIVE 4: Increased use of key interventions to reduce HIV/STD transmission</b>		
1. General urban population access to condoms in HIV emphasis countries (WHO/GPA PI3)	DHS and other population-based surveys, national AIDS programs, project reporting systems	B
2. Percent of male and female population of reproductive age reporting low-risk sexual behavior (Evaluation Project safer sex composite indicator)	DHS and other population-based surveys	C
3. Percent of men reporting STD symptoms who sought medical diagnosis and treatment	Demographic and Health Survey Male survey	A
4. Percent of male and female population of reproductive age reporting condom use in: a) in-union partner relations and b) "casual" partner relations in HIV emphasis countries	Demographic and Health Survey Core; DHS male survey;	A

The data availability column provides an assessment of availability based on existence of collection systems and costs of collection.

"A" indicator data are available through the DHS or DHS-like surveys and reporting mechanisms.

"B" indicator data are collected by various sources but not as readily available as A-type data. For example, country-specific data compiled by UN agencies or other partner organizations. In some cases, these indicators are being operationalized and validated.

"C" indicator data are proposed for performance monitoring and will be validated in the field through operations research and indicators for program use and data collection systems and sources established.

Performance indicator	Primary data source	Data availability
<b>Program Outcome 4.1: Effective interventions to reduce sexual transmission of HIV/STD identified, strengthened, implemented, and evaluated in emphasis countries</b>		
<b>1. Technologies evaluated and available (e.g.):</b> a) female condoms b) safe and effective vaginal microbicide c) rapid, simple, low-cost STD diagnostics	<b>PHNC Project Data re. stage of product/project development</b>	a) A b) A c) A
<b>2. Approaches evaluated and available for :</b> a) personal risk assessment & behavior change (BC) planning b) Community norm change to support and maintain HIV/STD risk behavior change c) Formative research to improve STD/TB care and treatment seeking. d) Education and training to improve adherence to out-patient treatment for HIV related diseases (e.g. STDs, TB) e) Syndromic management of STDs f) Community-based delivery of HIV/AIDS services	<b>PHNC Project Data re. stage of product/project development</b>	a) A b) B c) A d) C e) A f) B

Performance indicator	Primary data source	Data availability
<b>Program Outcome 4.2: Improved methods and tools for reducing perinatal and parenteral HIV transmission available for program use in emphasis countries</b>		
<b>1. Technologies evaluated and available (e.g.):</b> a) vitamin A prophylaxis for reduced perinatal HIV transmission b) vaginal irrigation for reduced perinatal HIV transmission c) blood pooling for low-cost screening to prevent parenteral transmission	PHNC project reporting data	a)     A b)     A c)     A

Performance indicator	Primary data source	Data availability
<b>Program Outcome 4.3: Enhanced capacity for public, private, NGO and community-based organizations to design, implement and evaluate effective HIV/STD prevention and care programs</b>		
<b>1. Proportion of PHNC-funded indigenous HIV/AIDS prevention and service organizations with:</b>  a) Active participation by PLWH  b) for HIV/STD project design and implementation;  c) a strategic plan	<b>Project Data</b>	a) C  b) B  c) A
<b>2. Number of people covered by large public and private employers in HIV emphasis countries which provide technically sound HIV/STD education to their employees.</b>	<b>PHNC Project Data</b>	<b>B</b>
<b>3. Number of emphasis countries that finance at least 10% of the national HIV/STD program</b>	<b>UNAIDS and PHNC Project Data</b>	<b>B</b>

Performance indicator	Primary data source	Data availability
<b>Program Outcome 4.4: Knowledge, availability and quality of HIV/STD interventions increased in emphasis countries</b>		
1. Proportion of people presenting with STD complains at health facilities who are treated accorded to national standards  WHO/GPA PI 6	UNAIDS; PHNC Project Data	B
2. Percent of the population aware of treatable STDs	DHS STD Module and Male survey; Project KABP surveys	B
3. Percent of population with correct knowledge of HIV transmission	DHS and Project KABP surveys	A
4. Proportion of HIV emphasis and JPP countries with STDs in the national HIS and/or other data collections systems	USAID Missions	B
5. Proportion of PHNC-funded reproductive health/family planning (public and NGO) service delivery programs providing comprehensive <sup>10</sup> STD services	USAID Missions	B
6. Total annual volume of condoms sold or distributed	PHNC Project Data	A
7. Volume of condoms sold/distributed per population age 15-49 in HIV emphasis countries	PHNC Project Data	A

<sup>10</sup>Comprehensive STD services include history-taking, examination and treatment, and "the 4 C's" : counselling about STD risk reduction; condoms; contact tracing/partner follow-up; and education to promote adherence to treatment regimens ("compliance").